

# **“Hear Us Speak”**

Listening to women’s experiences of perinatal distress and the Transactional Analysis psychotherapy treatment they received

**Haynes Emma**

School of Health and Society  
University of Salford, Salford, UK

Submitted in Partial Fulfilment of the Requirements of the  
Degree of Doctor of Philosophy, January 2019

# Contents

	Page Number
Acknowledgments	ix
Abbreviations	x
Definitions	x
List of Tables	xi
List of Diagrams	xi
Abstract	xii
<b>Chapter 1 Introduction</b>	<b>1</b>
1.1 Background	1
1.2 Perinatal distress	2
1.3 The effects of perinatal distress	5
1.3.1 The monetary cost	5
1.3.2 The emotional cost to the infant	5
1.4 Perinatal distress prevalence	7
1.4.1 Perinatal mental illness prevalence	8
1.4.2 Postnatal depression prevalence	9
1.4.3 Perinatal depression prevalence	9
1.4.4 Perinatal stress and anxiety prevalence	9
1.4.5 Puerperal psychosis prevalence	10
1.5 The UK Government policy on Mental Health and Perinatal Mental Health	11
1.6 Conventional treatment for perinatal mental health conditions	15
1.7 Barriers to Treatment	17
1.7.1 Stigmatisation	18
1.7.2 Shame	19
1.7.3 Silence – The consequence of stigma and shame in perinatal mental illness	19
1.8 Psychotherapy	20
1.9 Transactional Analysis psychotherapy	21
1.9.1 The origins of Transactional Analysis	21
1.9.2 The diversity and versatility of Transactional Analysis psychotherapy	22
1.10 My rationale for undertaking this study and my own knowledge	24
<b>Chapter 2 Literature Review</b>	<b>27</b>
2.1 Introduction	27
2.2 Women’s experiences of perinatal mental illness	28

2.2.1	Help-seeking experiences	31
2.2.2	Help-seeking barriers	32
2.2.3	Help-seeking barriers and facilitators	35
2.2.4	Women's lived experiences of perinatal mental illness	37
2.2.5	Women's experiences of puerperal psychosis	39
2.2.6	Cultural aspects of perinatal mental illness	41
2.2.7	Summary	44
2.3	The review on psychological treatment options	45
2.3.1	Results	47
2.3.2	Counselling and psychotherapy treatment modalities	49
2.3.3	Discussion	53
2.4	Review on TA psychotherapy for depression and anxiety	55
2.4.1	A critique of the research into TA psychotherapy for depression and anxiety	58
2.5	Conclusion	59
2.6	Aims and Objectives	61
<b>Chapter 3 Methodology</b>		<b>62</b>
3.1	Research paradigm	62
3.2	The value of qualitative research for psychotherapy	62
3.3	Feminism	64
3.3.1	The social construction of gender	65
3.3.2	The study of women's diverse lives and personal narratives	66
3.3.3	The context of the research question	66
3.3.4	The critical self-reflections of the researcher	67
3.3.5	Feminist research relationships	67
3.4	Social constructionism	68
3.5	A narrative approach	69
3.5.1	Data collection – Free Association Narrative Interviewing	71
3.5.2	Data collection using a creative methodology	72
3.5.3	Merging the two data collection styles	73
3.5.4	Data analysis – The Listening Guide Method	74
3.6	A critique of narrative research	75
<b>Chapter 4 Methods</b>		<b>77</b>
4.1	Methods	77
4.2	Sampling and recruitment	77
4.3	Inclusion – exclusion criteria	78
4.4	The recruitment process	80
4.4.1	The five participants	80
4.4.2	Biographical information and diversity	81
4.5	Participant compensation	83

4.6	Interview settings	85
4.7	The data collection procedure	85
	4.7.1 Participant interview	85
	4.7.2 Creative method	87
4.8	The data analysis procedure	88
	4.8.1 The first listening: Listening for the plot	90
	4.8.2 The second listening: Listening for the “I”	91
	4.8.3 The final listening: Listening for contrapuntal voices	91
	4.8.4 A critique of the Listening Guide Method	92
4.9	Ethical considerations	92
	4.9.1 Autonomy - informed consent	93
	4.9.2 Non-maleficence - do no harm	94
	4.9.3 Beneficence	94
	4.9.4 Justice	94
	4.9.5 Fidelity – confidentiality	94
	4.9.6 The ethics of power and politics within qualitative research	95
	4.9.7 The ethics of the duality or roles – researcher/therapist	96
	4.9.8 Feminist ethics – The ethics of care	96
	4.9.9 The ethics of interpretation	97
	4.9.10 The ethics of creative visual methodologies	98
	4.9.11 The ethics of lone worker policy in research	98
	4.9.12 Safeguarding	99
4.10	Summary	99
 <b>Chapter 5 Lucy’s Story</b>		 100
5.1	“The Madness of Thinking”	100
	5.1.1 Becoming unwell	101
	5.1.2 Panic attacks	103
	5.1.3 Lucy’s continuum of illness	103
	5.1.4 Pressure	105
	5.1.5 The impact on Lucy’s relationships	106
5.2	Therapy	108
	5.2.1 Lucy’s script	110
	5.2.2 Discounting	111
	5.2.3 Gallows laughter	111
5.3	Other notable aspects of the analysis	112
5.4	Listening for Lucy’s other voices	112
5.5	Listening for Lucy’s “I” poems	114
5.6	Exploring Lucy’s object – a poem ‘Masks’ (author unknown)	115
5.7	Reflections on Lucy’s interview	120
5.8	Conclusion	121
 <b>Chapter 6 Shoshana’s Story</b>		 122
6.1	“Pushed off the precipice”	122

6.1.1	Previous illness and treatment	123
6.1.2	A premature baby	124
6.1.3	Being unwell	125
6.1.4	Panic leading to panic attacks	127
6.1.5	Motherhood – the extremes of emotion	127
6.1.6	The ability to mother	129
6.1.7	The father’s experience	129
6.2	Therapy	130
6.2.1	The significance of TA theory	131
6.2.2	Discounting	132
6.2.3	The importance of the therapist	132
6.2.4	The importance of couples therapy	133
6.2.5	The impact on the relationship with her daughter	134
6.2.6	Unlocking relationships	135
6.2.7	Experiencing the end of therapy	136
6.3	Other notable aspects of the analysis	138
6.4	Listening for Shoshana’s other voices	139
6.5	Listening for Shoshana’s “I” poems	140
6.6	Exploring Shoshana’s object – a memory	142
6.7	Reflections on Shoshana’s interview	144
6.8	Conclusion	144
<b>Chapter 7 Jane’s story</b>		<b>146</b>
7.1	“Mortified” - The trauma of puerperal psychosis	146
7.1.1	Previous illness	147
7.1.2	Becoming unwell	149
7.1.3	Experiencing psychosis	150
7.1.4	Abandoned	152
7.1.5	Parallel process	153
7.1.6	Guilt – the absent mother	154
7.1.7	Shame	155
7.2	Therapy	156
7.2.1	Gallows laughter	158
7.2.2	Asking for help	159
7.2.3	Jane’s script	160
7.2.4	Discounting	160
7.2.5	Miscarriage	161
7.2.6	Fear of the future	162
7.3	Other notable aspects of the analysis	162
7.4	Listening for Jane’s other voices	163
7.5	Listening for Jane’s “I” poems	164
7.6	The role of psychotherapy in puerperal psychosis	164
7.7	Exploring Jane’s object – Teddy	167
7.8	Reflections on Jane’s interview	169
7.9	Conclusion	170

<b>Chapter 8</b>	<b>Julija's story</b>	172
8.1	The lonely child	172
8.1.1	Previous illness – depression	173
8.1.2	Becoming unwell	174
8.1.3	Historical anxiety	175
8.1.4	Guilt and shame	176
8.1.5	The partner's experience	178
8.2	Therapy	178
8.2.1	Getting help	180
8.2.2	Distinguishing between thinking and behaviour	181
8.2.3	Script – perfectionism	182
8.2.4	Expressing emotions	183
8.2.5	Permission	184
8.2.6	Acceptance	185
8.2.7	Group therapy	186
8.2.8	Theory or therapist	188
8.3	Other notable aspects of the analysis	188
8.4	Listening for Julija's other voices	189
8.5	Listening for Julija's "I" poems	190
8.6	Exploring Julija's object – collage	190
8.7	Reflections on Julija's interview	194
8.8	Conclusion	195
<b>Chapter 9</b>	<b>Sarah's story</b>	196
9.1	"This feeling isn't me"	196
9.1.1	Becoming unwell	197
9.1.2	Shame and stigma	197
9.1.3	Extremes of feelings	198
9.1.4	Asking for help	199
9.1.5	The consequences	200
9.2	Therapy	202
9.2.1	The differences between psychoanalysis and TA	202
9.2.2	The power of TA	202
9.3	Other notable aspects of the analysis	203
9.4	Listening for Sarah's other voices	204
9.5	Lack of an object	204
9.6	Listening for Sarah's "I" poems	205
9.7	Reflections on Sarah's interview	206
9.8	Conclusion	207
<b>Chapter 10</b>	<b>Reflexivity</b>	209
10.1	Introduction	209
10.1.1	Lack of TA research	209
10.2	Methodology	209

10.2.1	An eclectic path	209
10.2.2	Congruence	210
10.2.3	The dual role of psychotherapist and researcher	211
10.2.4	Intertwining methodologies	213
10.2.5	Finding my own identity	213
10.3	Methods	215
10.3.1	The interview	215
10.3.2	Free Association Narrative Interviewing	215
10.3.3	The creative object	216
10.3.4	The analysis	216
10.4	Summary	217
 <b>Chapter 11 Discussion</b>		 218
11.1	Introduction	218
11.2	Common themes	219
11.2.1	'Attacked'	220
11.2.2	Disconnection	221
11.2.3	Health anxiety	222
11.2.4	Madness	222
11.2.5	Emotional extremes	223
11.2.6	Seeking help at crisis level	224
11.2.7	Masks	225
11.3	TA psychotherapy	226
11.3.1	Addressing the cause of illness	226
11.3.2	Identifying needs	227
11.3.3	Relationships	227
11.3.4	Durability	228
11.3.5	A good therapist	228
11.3.6	Transgenerational trauma	229
11.4	Known barriers to treatment	229
11.3.1	Stigma	229
11.3.2	Shame	232
11.3.3	Silence	233
11.5	Facilitative factors for engagement in treatment	235
11.6	Specific time points of illness	236
11.7	Past history of mental illness	236
11.8	Method	237
11.8.1	The creative method	237
11.8.2	Analysis	239
11.8.3	Reflexivity	240
11.9	TA – a shared language	240
11.10	Puerperal psychosis	242
11.11	Style of treatment – group/one-to-one/couples	243
11.12	'Postnatal depression': A change needed in terminology	243
11.13	Study strengths and limitations	244
11.14	Contributions to knowledge	247
11.15	Future research	248

<b>Chapter 12</b>	<b>Conclusions and Implications for Practice</b>	<b>250</b>
12.1	Introduction	250
12.2	Conclusions	250
12.3	Recommendations	252
12.4	Practice implications	253
	12.4.1 TA psychotherapy practice implications	254
	12.4.2 Maternal mental health practice implications	255
	12.4.3 Implications for midwifery and health visiting	256
12.5	Where next?	256
<b>Appendices</b>		<b>258</b>
1	Glossary of TA terms	258
2	Qualitative research studies on women's experiences of perinatal mental illness	262
3	Research studies included in the literature review on psychological treatment options	265
4	Pro Forma	268
5	Ethical Approval – Letter of Consent	269
6	Lucy's Transcript	270
7	Lucy's 'other' voices	287
8	Shoshana's 'other' voices	290
9	Jane's 'other' voices	292
10	Julija's 'other' voices	297
11	Sarah's 'other' voices	302
<b>Reference List</b>		<b>305</b>



## ACKNOWLEDGEMENTS

This thesis is dedicated to all the women I have seen throughout my career as a psychotherapist working in perinatal mental health. Every one of these women has inspired me to research this illness and to look for, learn about and provide better treatment for them, to give them, their infants and families hope for the future.

I would like to thank my husband Andy for his dedicated and continual support throughout the years it has taken me to complete this work. Without him I would never have been able to achieve this. I would also like to thank my children for their understanding during this long time.

My supervisors, Professor Alison Brettell, Dr Fiona MacVane Phipps and Dr Mark Widdowson have given me the encouragement and full support that I needed, throughout this journey. Thank you all for continuing to believe in my research.

I would also like to thank my family and many friends who have supported me, guided me, encouraged me, and sometimes needed to buoy me up in the difficult patches, you have been invaluable. In particular, I would like to mention Lou Walker who took on the huge job of proof reading for me and offered me such encouragement and professionalism, thank you.

## Abbreviations

CBT	Cognitive Behavioural Therapy
EATA	European Association of Transactional Analysis
IJTAR	International Journal of Transactional Analysis Research
TA	Transactional Analysis
TAJ	Transactional Analysis Journal
UKCP	UK Council for Psychotherapy

## Definitions

Epigenetics	<i>“the study of heritable changes in gene function that do not involve changes in DNA sequence”</i> (Merriam-Webster Dictionary)
Perinatal	<i>‘during pregnancy or in the first year following the birth of a child’</i> (NHS Choices - England, 2016)
Puerperal Psychosis	<i>“a severe episode of mental illness which begins suddenly in the days or weeks after having a baby. Symptoms vary and can change rapidly. They can include high mood (mania), depression, confusion, hallucinations and delusions. Postpartum psychosis is a psychiatric emergency”</i> Royal College of Psychiatrists: Leaflets – Postpartum Psychosis – severe mental illness after childbirth (2015)
Psychological distress	<i>‘depression, anxiety and/or perceived stress’</i> (Staneva et al., 2015)

## **List of Tables**

Table 1.1	The Whooley & Arroll questions
Table 2.1	Psychological treatment options - inclusion and exclusion search criteria
Table 2.2	TA research studies on the treatment of depression and/or anxiety
Table 4.1	The five participants
Table 4.2	Relevant participant information
Table 11.2	Themes drawn from the participants' stories

## **List of Figures**

Figure 2.1	Flow chart showing search procedure for review of womens' experiences of perinatal mental illness
Figure 2.2	Flow chart showing search procedure for psychological treatment options
Figure 2.3	Flow chart showing search criteria used for TA research articles

## ABSTRACT

This PhD study examines Transactional Analysis (TA) psychotherapy as a treatment for perinatal mental illness, by listening to the experiences of women who have received it within a private practice, psychotherapeutic setting. The study also addresses the gap in research into women's experiences of perinatal mental illness. In this study, 'perinatal mental illness' includes stress, anxiety, depression and puerperal psychosis.

Perinatal mental illness is common and has wide-reaching consequences. Historically, research has focused on postnatal depression. However, many women become unwell in pregnancy, and research shows that stress and anxiety could be more prevalent than depression. Significant barriers to treatment are stigma and shame, causing women to silence themselves as a consequence. Engaging women into treatment and subsequent compliancy is difficult. Conventional treatment, of antidepressants, is controversial due to the risk of medication in utero and breast milk. Women say they would prefer psychological therapy, yet there is little research into suitable types. TA psychotherapy offers a plausible, diverse and versatile treatment, which can be shaped towards the client needs, an important factor in perinatal mental illness.

A qualitative, narrative approach has been used to facilitate an exploration of women's experiences. Data collection was by Free Association Narrative Interviewing and a creative methodology, forming a deeper, richer understanding of personal perspective, using the visual and the narrative as a co-creative construction. Data analysis used The Listening Guide Method to highlight difference and hear the multiple voices in one person's narrative, as well as taking notice of temporal movement within the narrative.

Key findings: i) TA psychotherapy was found to be a useful and treatment for the five participants; ii) TA addressed the specificity of illness; iii) TA was found to be a durable treatment; iv) the relational dyad was found to be a factor in treatment; v) TA offered a plausible alternative to CBT and medication; vi) TA was found to be useful in each format – couples, one-to-one or group therapy; vii) all participants had experienced mental illness in their past, and again in the perinatal period; viii) TA psychotherapy had a role within treatment for puerperal psychosis for one participant; ix) stigma and shame remain significant barriers to treatment; x) there is a need for a change in terminology within both the medical profession and wider society, to encompass all types of mental illness within the entire perinatal period; xi) language held significance through co-creation of language in therapy and within the interview; xii) TA offered a 'shared' language that was easily understood, demystified the treatment process and clarified what was happening.

The contributions to knowledge are: i) this is the first study to ask women about their experiences of their therapy; ii) this is the first study to explore TA psychotherapy in relation to its use in perinatal mental health and the first qualitative TA study; iii) this is the first TA research study to use narrative analysis; iv) this is the first study on perinatal mental illness to use narrative analysis; v) the use of creative objects as part of the data collection process is unique in psychotherapy research; vi) the use of FANI for data collection, in combination with the Listening Guide analysis style is unique; vii) the Listening Guide style of analysis highlighted Ego State theory in TA, which is a unique contribution to TA theory; viii) this is the first study to highlight psychotherapy as a possible adjunct treatment for puerperal psychosis; ix) the durability of TA therapy has not been studied before; x) the immediacy and usefulness of TA language and the ability for it to be shared between therapist and client was evident within this study; xi) couples therapy as a suitable style of therapy for perinatal mental illness has not been researched prior to this study.

There are implications for psychotherapy and midwifery practice, as well as for maternal mental health. These are: i) there is a need for more treatment to be offered within the NHS, specifically broadening the scope to incorporate wider ranges of treatment to address specificity of illness. Funding allocation remains a difficulty within the NHS and may prove a difficulty for research; ii) the 'booking-in' appointment is an ideal opportunity of targeted diagnosis, although this would need to be backed up with suitable treatment pathways. iii) a protocol for using TA psychotherapy for perinatal mental illness would be a useful addition to theory. This may be a combination of treatment and psycho-education to enhance knowledge of this condition. An element on couples therapy for this condition would also be useful.

## CHAPTER 1 Introduction

### 1.1 Background

This study examines Transactional Analysis (TA) psychotherapy as a treatment for perinatal mental illness, through listening to the experiences of women who have received it within a private practice, psychotherapeutic setting. It also addresses the gap in research into women's experiences of perinatal mental illness. Perinatal mental health issues are common and affect both the mother and child (Alder et al., 2007; Murray et al., 2010; Oates, 2003; Pawlby et al., 2008; Stuart & Koleva, 2014). They are the leading cause of maternal mortality (Austin et al., 2007; Lewis, 2007; Oates, 2003; Palladino et al., 2011). In the most recent Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) Report (Knight et al., 2017) maternal suicide is still the leading cause of death during pregnancy and the first year post birth. Historically, research has focused mainly on the postnatal period and particularly on depression. In the recent past such mental health issues have tended to be diagnosed as one of three separate conditions: baby blues (Buttner, O'Hara & Watson, 2012), postnatal depression (Buultjens & Liamputtong, 2006) or postpartum/puerperal psychosis (O'Hara & McCabe, 2013), all of which were deemed to occur in the postnatal period. This focus on postnatal depression may be due to a lack of consensus of agreement on the causes and effects of mental illness and the lack of agreement between health professionals on the pathogenesis of mental illness within this period. More recently, the term 'perinatal' has been more widely used, reflecting a shift in comprehension of the depth and breadth of this condition (Glover & O'Connor, 2002; Haynes, 2017). In fact, the term 'peripartum' has now been adopted within the Diagnostic and Statistical Manual of Mental Health (DSM-V) (APA, 2013), due to an increased understanding that 50% of diagnoses of postnatal depression actually begin within the antenatal period (APA, 2013, p152).

Many differing hypotheses or theories exist about the aetiology of perinatal mental illness as do philosophical debates concerning the most effective forms of diagnosis and treatment. Research highlights that mental illness is often present throughout the entire year post birth, rather than only the initial few months (O'Hara & McCabe, 2013; Rallis et al., 2014). This is not recognised in the DSM, with only the first four postnatal weeks seen as relevant (APA, 2013) for diagnosis. Gaps in knowledge about perinatal mental illness remain.

Conventional treatment, using psychopharmacology, is a controversial subject, due to the known and unknown risks of medication in utero and in breast milk (Bérard et al., 2015; Fitelson et al., 2011) and due to adverse effects on the fetus

(see Udechuku et al., 2010 for a review). In those studies where women have been asked about treatment preferences, women prefer psychological therapies rather than pharmacotherapy (Battle et al., 2013; Dennis & Chung-Lee, 2006; Goodman, 2009; O'Mahen & Flynn, 2008). Psychotherapy is the treatment women say they would prefer as a first option for postnatal depression, as it does not involve the risks associated with medication (Fitelson et al., 2011; Kim et al., 2010; Pearlstein et al., 2006).

## **1.2 Perinatal distress**

The term 'perinatal distress' encapsulates the most common forms of mental illness, depression, stress and anxiety. The term 'distress' has not been widely used. However, research increasingly acknowledges that there is more to perinatal illness than just depression, such as anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), which can occur on their own or can coexist with depression (MBBRACE, 2018). Research is also beginning to show an increased risk of perinatal mental illness from fear of childbirth, birth trauma, bereavement, assisted fertility and fear of/ or actual removal of the child. Perinatal distress could also capture puerperal psychosis, an unusual, but distressful mental health condition at the extreme of mental illness, about which there is little qualitative research. Puerperal psychosis is almost always excluded from research into perinatal mental health as it only affects a very small proportion of postnatal women. However, it is mental illness specifically after childbirth, similar to bipolar disorder (Boyce & Barriball, 2010), and therefore has been included within this study. It is normal for women to have some changes in their mental state in pregnancy and the postnatal period. It is deemed to be normal to experience symptoms such as appetite change, sleep disturbance, low mood, tiredness, loss of libido and anxious thoughts (NICE CG192, 2018). More severe types of mental illness are postpartum psychosis, severe depressive illness, schizophrenia, and bipolar illness. Anxiety and stress are frequently comorbid with depression within this period (Austin et al., 2007; Da Costa et al., 2000; Grant et al., 2008; Hirschfield, 2001; Preisig et al., 2001; Rallis et al., 2014). Stress can negatively affect fetal brain development in utero (Schuurmans & Kurasch, 2013) therefore, it seems appropriate to include stress within this research. Including it as a distinct affective state will allow clinicians to gain a more accurate and comprehensive understanding of the challenges women face within the transition to motherhood (Rallis et al, 2014). Many women entering treatment for perinatal mental illness speak about their distress and how they are struggling with motherhood and their life in general (Bilszta et al., 2010; Haynes, 2017; Mauthner, 2002) rather than speaking about being depressed. This could be because of their reluctance to accept their mental illness, or due to

a fear of clinical diagnosis (Bilszta et al., 2017; Buist et al., 2005). It is also possible that mothers perceive perinatal illness as a life struggle. Rallis et al. (2014) used the term 'perinatal distress', arguing that women suffer from all three conditions, stress, anxiety and depression, perinatally. The terms 'perinatal distress' and 'perinatal mental illness' are used interchangeably within this thesis.

Risk factors for postpartum depression are given by the NHS as:

- history of mental health problems
- childhood abuse and neglect
- domestic violence
- interpersonal conflict
- inadequate social support
- alcohol or drug abuse
- unplanned or unwanted pregnancy
- migration status

(PHE JSNA Toolkit, 2017)

There is a significant difference in the way perinatal mental illness is treated, according to the severity of the illness. Women with mild to moderate perinatal mental health problems highlighted by a midwife, health visitor or other health professional, during pregnancy or in the postnatal period, would usually be managed within primary care as set out in the NHS Perinatal Mental Health care pathways (2018). Referral for GP or specialist assessment and discussion may lead to treatment via pharmacological and talking therapies available locally such as Improving Access to Psychological Therapies (IAPT) services. Women assessed as higher risk would be referred to Specialist Perinatal mental health teams to provide intensive mental health support. Women with severe perinatal mental illness or puerperal psychosis may require treatment in a psychiatric Mother and Baby unit, or if not available, general adult psychiatric units.

The pathogenesis of perinatal depression, stress and/or anxiety is, as yet, unknown. However, research focuses mainly on biomedical explanations (Meltzer-Brody, 2011), and symptoms are commonly described in nosological terms of classification, with an emphasis on medical diagnostic criteria such as within DSM-5 (APA, 2013), which are not specific to the perinatal period. The actual symptoms may not adhere to the diagnostic criteria of psychiatric disorders in the DSM (Highet et al., 2014).

Such criteria are:



### **Unspecified Bipolar and Related Disorder – 296.80:**

*This category applies to presentations in which symptoms characteristic of a bipolar and related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the bipolar and related disorders diagnostic class.*

*With peripartum onset –*

*This specifier can be applied to the current or, if the full criteria are not currently met for a mood episode, most recent episode of mania, hypomania, or major depression in bipolar I or bipolar II disorder if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery. Women with peripartum major depressive episodes often have severe anxiety and even panic attacks. Prospective studies have demonstrated that mood and anxiety symptoms during pregnancy, as well as the “baby blues” increase the risk for a postpartum major depressive episode (DSM-V) (APA, 2013, p152)*

### **Unspecified Depressive Disorder – 311:**

*This category applies to presentations in which symptoms characteristic of a depressive disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the depressive disorders diagnostic class.*

*With peripartum onset –*

*This specifier can be applied to the current or, if full criteria are not currently met for a major depressive episode, most recent episode of major depression if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery (DSM-V) (APA, 2013, p186)*

There is also a lack of consensus within the medical profession on the causes of puerperal psychosis, with hormone dysregulation and environmental life stressors being possible factors (Sharma et al., 2004). However, causal links between puerperal psychosis and hormones, environmental stressors, or even genetics (Jones & Craddock, 2001) have yet to be identified (Boyce & Barriball, 2010).

### **1.3 The effects of perinatal distress**

#### **1.3.1 The monetary costs**

The first economic study on maternal mental illness attributes the long-term costs to the mother, the infant, the wider family and the economy (Bauer et al., 2014; 2015). This research, from the South London Child Development Study, focused on perinatal depression and anxiety and showed a substantial cost to the UK economy of around £6.6 billion per annum. This research used decision-analytic modelling, to give present value of total lifetime costs of perinatal depression and anxiety over the lifetime of mothers and their children. The majority of costs related to the negative effects on the children, with nearly a fifth of those costs borne by the public sector (Bauer et al., 2015). However, more research is needed into the true costs (as opposed to the modelled costs) of perinatal mental illness throughout a child's entire life. This would allow a cost/benefit analysis of treatment versus non-treatment to be conducted and would highlight whether it was more beneficial, socially and economically, to treat the condition early in pregnancy, therefore reducing the likelihood of the child becoming unwell.

#### **1.3.2 The emotional cost to the infant**

The long-term implications of maternal mental distress on the psychological development and mental health of the fetus/infant/child are gradually being understood (Agnafors et al., 2013; Deave et al., 2008; Field et al., 2010; Glover, 2014), but remain inconclusive. A significant consequence of this condition is the effect on the infant (Agnafors et al., 2013; Deave et al., 2008; Dunkel Schetter, 2009; Field et al., 2010; Glover, 2014; Smith-Neilson et al., 2016); research also exists on the effect on the woman's partner and family (Fisher et al., 2012). Research by Lester et al. (2013) shows a four-fold increase in the likelihood that the infant of a mother suffering from antenatal depression will also develop depression within the infant's lifetime. Negative correlations have been found between perinatal mental illness and the behavioural development of the infant (Deave et al., 2008), adverse neurodevelopmental outcomes (Dunkel Schetter & Tanner, 2012), low birth weight and pre-term birth (Copper et al., 1996; Dunkel Schetter, 2009; Dunkel Schetter & Tanner, 2012; Field et al., 2004), impaired maternal-fetal attachment (Lindgren, 2001), trans-generational changes (Kaplan et al., 2013), symptoms of attention deficit hyperactivity disorder (Glover, 2014) and delayed language development in infants of 12 months (Smith-Nielsen, et al., 2016).

Research has begun to demonstrate the epigenetic effects on the child of maternal mental illness during pregnancy and in early infancy and childhood

(Carey, 2012; Fisher, 2011; Schuurmans & Kurrasch, 2013): *'in some cases, the adult may have absolutely no recollection of the traumatic events, and yet they may suffer the consequences for the rest of their lives.'* (Carey, 2012, p6). However, this research is controversial, as it is a fast-moving, relatively new field, changing rapidly with the breakthroughs in human genome sequencing and DNA methylation. Research in this field suggests a transmission of maternal depression to the fetus through epigenetic mechanisms, which may cause a reprogramming of placental genes, impacting serotonin levels and the hypothalamic-pituitary-adrenal (HPA) axis as well as physiological systems (Lester et al., 2013). This may result in increased cortisol secretion and a reduction in serotonin levels and could make the infant more susceptible to the effects of depression, and chronic stress in the postnatal period (Lester et al., 2013). Epigenetic research increasingly shows that antenatal stress affects brain development in utero, which continues into adulthood (Schuurmans & Kurrasch, 2013). Schuurmans & Kurrasch's (2013) comprehensive review showed that maternal distress can negatively impact the unborn fetus' brain, particularly at key neurodevelopmental stages. They concluded that brain development is multi-phasic, beginning in utero and continuing dynamically into adulthood. A negative environment in pregnancy may cause brain development abnormalities that could continue over the lifetime of the person affected. However, they acknowledged that research has yet to uncover how brain disturbances at different time points (prenatal, neonatal, postnatal), combined with the degree of intensity of the disturbance, contribute to the aetiology of conditions and diseases in later life (Schuurmans & Kurrasch, 2013).

As well as the potential effects in utero, the effects on the growing infant post birth are also worthy of consideration, due to the mother-infant bond and its necessity to the survival of the infant (Bollas, 1987; Bowlby, 1979; Gerhardt, 2009; 2004; Klein, 1987; Piontelli, 1992; Stern, 1985; Winnicot, 1962). Perinatal mental illness can harm the mother-infant interaction in the first year after birth (Beck, 1995; Field, 2010; Gerhardt, 2009). It can also affect a woman physically due to somatisation, when a woman has multiple medically unexplained symptoms, due to psychological distress (Fink et al., 2002; Lipowski, 1987). As the infant is so reliant on the mother-infant bond, it adjusts itself to her distress. Gerhardt (2009) believes that babies of depressed mothers adjust to the lack of positive stimulation they receive. Similarly, she believes that babies born to agitated mothers either attempt to switch off their feelings altogether in order to cope, ceasing to cry, or stay over-aroused and distressed (Gerhardt, 2009). Epigenetics, neuroscience and biochemistry literature provide a greater understanding of how a disturbed or malfunctioning relationship between mother and infant, due to illness either physically or mentally, can affect the infant. It is therefore important that women receive treatment, not only for themselves, but also for the sake of the infant. Successful treatment may not

only positively affect the future functioning and psychopathology of the child (Cuijpers et al., 2015), but also the mother and wider family. Research shows that perinatal illness is treatable (Kennedy et al., 2002; Sockol et al., 2011).

#### **1.4 Perinatal distress prevalence**

Goldbort (2006) found that postnatal depression occurs within all cultures. Cross-cultural studies demonstrate an on-going tension between whether postpartum depression is a biological or cultural phenomenon (Mauthner, 2001). Western cultures tend to attribute it to biological factors, whereas non-Western cultures attribute it to social causes (Dennis & Chung Lee, 2006; Edge et al., 2004; Goldbort, 2006; Kim & Buist, 2005). Feminist perspectives have challenged the view that perinatal mental illness needs to be medicalised, and offer differing ideologies and perspectives on its causes (Brown & Harris, 1978; Brown et al., 1994; Oakley, 1981; Polatnick, 1996). Other researchers believe it is part of a grieving process, due to unmet expectations, loss of a sense of self, resentment at the enormous life change, and feelings of self doubt (Choi et al., 2005; Highet et al., 2014; Staneva & Wittkowski, 2012).

Perinatal psychiatric research focuses mainly on the medical disorders of depression and anxiety (Dunkel Schetter & Tanner, 2012; Leight et al., 2010; Matthey, 2004; Miller et al., 2006). Dunkel Schetter & Tanner (2012) believe that current medical understanding of perinatal mental illness is based largely on symptomatology, rather than evidence of confirmed diagnoses of perinatal mental illness. This is corroborated by Nagandla et al. (2016) and may result from constraints in resources to conduct clinical interviews to confirm diagnoses (Nagandla et al., 2016). Many women say they have had some form of mental illness prior to pregnancy (Cohen et al., 2006; Haynes, 2017; Patton et al., 2015). Patton et al. (2015) found historical mental health problems prior to conception in a majority of pregnancies where symptoms of perinatal depression were present. Cohen et al. (2006) showed that 50% of women with a prior diagnosis of severe mental illness suffered a relapse during the perinatal period. Choi et al. (2017) found a link between childhood trauma and an increased susceptibility to postpartum depression within the first six months after childbirth. They demonstrated that this resulted in negative child outcomes at one-year post birth. It is therefore possible that women may be more susceptible to mental illness within the perinatal period if they have history of prior mental illness or trauma. This possible link is important and will be explored within this research, although an in-depth investigation is beyond the scope of this study.

Currently, few data exist that combine depression, anxiety and stress in the entire perinatal period, although some data exist that combine depression and anxiety. As studies are heterogeneous in design, data are difficult to synthesise

and analyse. For ease of understanding the following data have been grouped into particular conditions, within a specific timescale. The data for puerperal psychosis are also given.

#### 1.4.1 Perinatal mental illness prevalence

Public Health England (PHE) states that perinatal mental illness affects up to 20% of women from pregnancy to the first year post birth (PHE, Joint Strategic Needs Assessment Toolkit, 2017), although they did not state this data's source.

An Australian study used the Depression Anxiety Stress Scale (DASS 21) as well as the Edinburgh Postnatal Depression Scale (EPDS) to broaden the assessment of postnatal depression into postnatal distress (Miller, Pallant & Negri, 2006). This study showed that 29% of women had at least one of the classifications of depression, stress or anxiety, with either an extremely severe, severe, moderate or mild category of mental illness.

Norhayati et al. (2015) reviewed the magnitude of 'postnatal mental health symptoms' globally and found prevalence varied from 5.2% to 74% in developing countries, and from 1.9% to 82.1% in developed countries. Such differences in prevalence magnitude raise doubt about validity and suggest that cultural factors may also be implicated. The included studies used a variety of self-reported questionnaires such as Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987), Centre of Epidemiologic Study-Depression (CES-D) (Radloff, 1977), Beck Depression Inventory (BDI) (Beck et al., 1961). Some combined structured clinical interviews with questionnaires. Furthermore, because Norhayati et al.'s study only considered postpartum symptoms, it cannot be determined what the levels would be if antenatal symptoms were also included. The extremes of these data make it difficult to derive meaningful conclusions as to the actual prevalence. More research is needed to determine why such variances exist.

World Health Organization (WHO) research on prevalence of 'common perinatal mental disorders' in low- and middle-income countries found a lack of research evidence in more than 80% of the 112 qualifying countries, 90% of which were the least developed (Fisher et al., 2011). This study highlights both the disparity in quantity of research conducted between countries of differing economic status, and that many countries have no working data. Fisher et al. state that prevalence in women in low and middle-income countries is substantially higher than the 10% (antenatal) and 13% (postnatal) figures for high-income countries (Fisher et al., 2011), although exact estimates were not given. Their conclusions (corroborated by the WHO Commission on the Social Determinants of Health,

2008) are that prevalence is far greater in women who are the most socially and economically disadvantaged.

#### 1.4.2 Postnatal depression prevalence

A large volume of literature exists on postnatal depression. A meta-analysis of postnatal depression including 59 studies suggests that 13% of all women suffer from depression in the postnatal period (O'Hara and Swain, 1996). This is a frequently cited figure given in the Cochrane Systematic Review (Dennis & Hodnett, 2007), where the estimate for postnatal depression is between 10% and 15%. However, a review of 143 studies on prevalence by Halbreich & Karkun (2006) stated it as between 0% and 60%. In Japan, the rate for postnatal depression appears higher, with prevalence reported as 20.4% of women in the first month after birth (Yamashita et al., 2000) while estimates from the United States are around 12% (O'Hara & Swain, 1996; Gaynes et al., 2005).

#### 1.4.3 Perinatal depression prevalence

Estimates of perinatal depression prevalence differ widely, few reviews giving a true global figure (Woody et al., 2017). Most prevalence studies are from high-income countries, yet there is evidence to suggest it is higher in low- and middle-income countries (Fisher et al., 2011), with Woody et al. (2017) showing a prevalence of 13.1% in low- to middle-income countries, compared to 11.4% in high income countries. Many studies, however, used self-reported symptom scales that may exaggerate the true extent (Gavin et al, 2005), or conversely may hide the true magnitude. Several studies from the United States show higher rates of perinatal depression in African American women (compared to white American women) and higher levels in low-income minority women (Howell et al., 2005; Orr et al., 2006; Segre et al., 2006). These studies substantiate the claims made by Woody et al. (2017) regarding the possibility of higher prevalence within middle and low-income countries. However, it is difficult to draw comparisons as Woody et al. were looking specifically at countries globally, while Howel et al. (2005), Orr et al. (2006) and Segre et al. (2006) were looking at low-income minority women in the United States only.

#### 1.4.4 Perinatal stress and anxiety prevalence

It is difficult to find data for stress and anxiety in the perinatal period. There appears to be no agreement about appropriate screening tools for anxiety in pregnancy (Dunkel Schetter & Tanner, 2012). However, Rubertsson et al. (2014) do give a figure of 15% for anxiety in the antenatal period. Others show that this figure rises to between 25% and 45% in the perinatal period (Britton, 2008; Faisal-Curry & Menzes, 2007). No studies were identified that investigated the

prevalence of stress within the perinatal period. However, there is research about the types of stressors that exist and their consequences. The more common stress factors in the perinatal period are low material resources, unfavourable employment conditions, demanding family and household responsibilities, strain in intimate relationships and pregnancy complications (Dunkel Schetter & Tanner, 2012). There is evidence of the consequences of stress in pregnancy, particularly in the African American population, which include low birth weight and babies born small for gestational age (Love et al., 2010). One important consequence is preterm birth, which is considered to be at epidemic proportions in the African American community where rates are nearly twice as high as rates for white women (Dunkel Schetter, 2009).

#### 1.4.5 Puerperal psychosis prevalence

Puerperal psychosis occurs only in the postnatal period and is uncommon in comparison to other mental illnesses. However, consequences can be extreme, such as suicide and infanticide (Jones et al., 2015); it can be a precursor of future, non-pregnancy related psychotic episodes (Munk-Olsen et al., 2006); and the distress to the woman and her family caused by psychosis can be severe.

Vanderkruik et al. (2017) performed a systematic review of the global prevalence of puerperal psychosis, as part of the WHO Maternal Morbidity Working Group. They found six studies that met the WHO criteria, which showed that the incidence of puerperal psychosis was between 0.89 and 2.6 births in 1,000, although one study reported five births in every 1,000. These figures show that the incidence of puerperal psychosis remains unchanged since 1987 (Kendall et al., 1987). However, due to heterogeneity in study design and limitation they concluded that no pooling of data could be made to allow for a global estimate. With only six studies meeting the criteria, a cross-country or global comparison was impossible. It was also impossible to state whether incidence of puerperal psychosis was higher in low and middle-income countries. The study concluded that there was a considerable gap in knowledge of prevalence worldwide.

From all the varying data above, there would seem to be a contradictory picture of the prevalence of perinatal mental health disorders. More accurate global estimates, covering countries with differing income levels, using standardised diagnostic instruments would be useful. Statistics for stress, anxiety and depression within all three time periods (antenatal, postnatal, perinatal) as well as more global statistics for puerperal psychosis would also provide a clearer picture.

Evidence reflects only those cases of perinatal mental illness reported within the various health services. As this type of distress can be isolating for women experiencing it, and can engender shame, a fear of engagement with services and the sense of being stigmatised (Mauthner, 2002; Staneva et al., 2015), it is probable that the actual levels are well in excess of those reported. Some women may be embarrassed by their illness, or indeed fearful that they will be institutionalised or separated from their baby (Boots Family Trust, 2013; Kennedy, et al., 2002). Highly distressed women may also have a perceived fear of harming their babies, even though they rarely actually commit abusive behaviours (Choi et al., 2010). Mauthner (2002) found that women with postnatal depression become quite passive, isolating themselves from social and intimate relationships, often due to fear and a lack of understanding of their illness. It is also possible that there are many hidden instances of perinatal mental illness that only emerge if there are other issues, for example child safeguarding issues. Possible barriers to treatment are explored in section 1.7 below.

### **1.5 The UK Government policy on Mental Health and Perinatal Mental Health**

In 1998 the Royal College of Psychiatrists (RCP) launched Changing Minds – every family in the land, a public campaign and educational initiative to reduce the stigma of mental health within society (Crisp, 1998). There was recognition that mental health was not receiving the attention or funding within the UK and the RCP strove to change this. In 1999 the UK government published the National Service Framework for Mental Health (DHSC, 1999), which acknowledged the serious lack of attention mental health had received from the Government. This framework set out quality standards for the mental health services within the National Health Service (NHS). It detailed the framework's aims and the development of quality standards, and how these should be implemented.

In 2011 the No Health Without Mental Health strategy (HMG, 2011) was launched by Nick Clegg, the then Deputy Prime Minister. Its implementation framework was published in 2012, in partnership with the Department of Health, the NHS Confederation's Mental Health Network, Mind, Rethink Mental Illness, Turning Point and Centre for Mental Health, as well as service users, individuals, families and carers. In 2012 the Department of Health and Social Care also pledged more support for women with postnatal depression, stillbirth and miscarriage (DHSC, 2012). However, according to a survey conducted by the National Society of Prevention of Cruelty to Children (NSPCC) of Primary Care Trusts in the UK in 2013, 64% did not have a perinatal mental health strategy, 73% of maternity services did not have a specialist mental health midwife, and



50% of Mental Health Trusts in the UK did not have a perinatal mental health service with a specialist psychiatrist (Hogg, 2013).

In 2014, National Institute for Health and Care Excellence (NICE) published Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (NICE, CG192, 2014), which set out clear priorities for women with mental illness within the perinatal period. However, in the 2017 Joint Strategic Needs Assessment (PHE, 2017) there remained recognition that *"historically there has been a lack of integrated physical and mental health care for women during pregnancy and in the weeks and months following birth, and a lack of specialist perinatal mental health services to support women who become unwell"* (PHE, 2017).

The most recent Government taskforce initiative is the Five Year Forward View for Mental Health (2016). In this plan the Mental Health Taskforce for NHS England set out again what needed to change within the NHS and reported that the implementation of the Mental Health Strategy (2011) had not been widespread, and had led to *"inadequate provision and worsening outcomes in recent years"* (Mental Health Taskforce, 2016, p4). The goal of this most recent taskforce is to have parity between mental and physical ill health in the NHS, although it is too soon to predict its outcome.

Over the last 18 years, successive governments have continually tried to prioritise mental health. However, each time this has not succeeded:

*"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services"*. (Mental Health Taskforce, 2016)

The National Audit Office (NAO) states the parity of esteem between mental and physical ill health to be a *"laudable policy objective"* (NAO, 2016). However, they state that this will be a difficult task with many competing claims to funding, as the Department of Health and the NHS lack the organised and comprehensive information needed to implement such a substantial change in policy (NAO, 2016, p 5). They also state that funding for the NHS is a combined amount with no monies earmarked for specific services, and with limited data on spending for mental health services. Clearly, specific funding allocation currently remains a difficulty within the NHS. Most recently NHS England declared a funding boost for mental health of £23 million to help up to 3,000 pregnant women or those who have recently given birth as part of their 'major programme of improvement and investment' (NHS England, 2018).

Psychological therapies within the NHS were not widely available through the NHS until recently. The IAPT system, which was instigated in 2008 in the UK, has begun to show some improvement in access to such therapies, and was one of only three priorities in the 2014 Department of Health and NHS England's impact assessment on mental health services. This assessment has focused on waiting times and increased access to mental health services. It has not focused on treatment outcomes.

There has also been recognition within the NHS that service users should be listened to, with various initiatives to implement this (Department of Health, 2008; the NHS Constitution 2009-2010). However, in 2011 there was recognition that these initiatives were not gaining ground. A NICE quality standard (QS 14) was therefore published in 2011, along with guidance for service users within mental health services (NICE, CG136, 2011). However, data from the uptake of service user involvement show that only 55% of service users felt they were involved in the choice of their therapy or medication (Evidence uptake, NICE, 2014).

The NHS has been further criticised regarding the lack of knowledge about perinatal mental illness on the part of health practitioners (Darwin et al., 2014; Jarrett, 2016; McCauley, et al., 2011; Ross-Davie et al., 2006; Stewart & Henshaw, 2002;), the first people women go to when in distress. In a study on the experiences of pregnant women and their care for depression, Jarrett (2016) found the majority of women were critical of the knowledge and understanding of GPs and midwives, describing them as 'sympathetic' but lacking in specialist skills. These women's perception was that the health practitioners had not received sufficient training in perinatal mental illness. In a study on how prepared midwives were to undertake their role to detect perinatal mental illness, Ross-Davie et al. (2006) found that 68% of midwives surveyed felt ill-equipped to fulfil this role, citing limited time, skills and knowledge as primary factors. Other causes for midwives' lack of confidence are identified as lack of pre-and post- registration training on perinatal illness, lack of available specialist services and poor continuity of care (Stewart & Henshaw, 2002; McCauley et al., 2011). Phillips & Thomas (2015) showed that women with a diagnosis of Bipolar Disorder viewed their midwives as having uncertain or unclear knowledge about how to discuss their particular mental illness and its impact on pregnancy and within the postnatal period. Darwin et al. (2014) found documentation of routine mental health assessments at the booking in appointment were inconsistent, with little monitoring of symptoms even when identified as at risk. Darwin et al. (2014) state their findings reflect a gap between '*best practice*' and '*actual practice*' (e21) and emphasise that women in their research were not deemed unwell enough to receive specialist care.

In 2007 NICE updated guidelines for midwives and health practitioners to include questions about past and present experiences of mental health conditions to improve specificity. These are referred to as the Whooley questions (Whooley et al., 1997), and the Arroll questions (Arroll et al, 2003) (see Table 1). However, further research by Darwin et al. (2016) questioned the validity of the Whooley questions, compared to the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987). Darwin et al. (2016) found the Whooley questions were not as accurate as the EPDS in identifying women with depression, as they failed to diagnose half of the possible cases of depression identified by the EPDS in their research. They also discovered that reliance on the Arroll ‘help’ item may be misguided as, within their research, this question missed nine in ten possible cases identified using the EPDS (Darwin et al., 2016). Furber et al. (2009) found that the Whooley questions missed those women who were suffering from psychological distress, such as anxiety and stress as the questions were too focused on depressive symptoms. There are no established surveys validating the Whooley questions within clinical practice (Darwin et al., 2016), and a synthesis of evidence completed by Hewitt et al. (2009) concluded that there was insufficient evidence for its continued clinical use. This may play a role in why many women with perinatal mental illness are being missed, or undiagnosed. The NICE guidelines have also been criticised for using these two tools (Martin & Redshaw, 2009), rather than the EPDS, which is the most

Table 1.1 The Whooley & Arroll questions

<p><b><u>Whooley questions</u></b> (Whooley et al., 1997)</p> <p>During the past month have you been bothered by:            (i) feeling down, depressed or hopeless,            (ii) having little interest or pleasure in doing things?</p> <p><b><u>The Arroll question</u></b> (Arroll et al., 2003)</p> <p>Is this something you feel you need/want help with?</p>
---

commonly used tool for diagnosing perinatal depression.

The most recent update in NICE Guidelines (CG192, updated 2018) for midwives at the booking-in appointment still states for a midwife only to “*consider asking the following depression identification questions as part of a general discussion*

*about a woman's mental health and wellbeing*" followed by the two Whooley questions. However, an addition has been made for midwives to then consider asking about anxiety using the 2-item GAD scale (GAD-2), with the possible addition of the EPDS or the 9-item PHQ questionnaire as part of a full assessment or to refer the woman to her GP or to a mental health professional (Antenatal and postnatal mental health: clinical management and service guidance, 2014 updated 2018). Under current NICE Guidelines mental health is still not a required discussion. It is quite possible, however, that many midwives have now incorporated this into the booking-in appointment. This cannot be corroborated without further research which is beyond the scope of this study.

Both the lack of specialist knowledge of perinatal mental health conditions and the choice of tools used to discern a diagnosis of perinatal mental illness could be important in research showing that 50% of cases of perinatal depression and anxiety go unnoticed and untreated by health professionals (Beck, 2006; Bonari et al., 2004). This high percentage of cases could also be due to misinterpretation of symptoms, an absence of treatment considered to be safe for mother and fetus and possible competing physical demands such as fatigue, work and family commitments (Vesga-Lopez et al., 2008).

## **1.6 Conventional treatment for perinatal mental health conditions**

Antidepressants remain the first line of treatment in the perinatal period (Meunier et al., 2013; Yonkers et al., 2009). Yet, there is disagreement about the effects of psychotropic drugs used both in the antenatal and postnatal period, with evidence that these drugs pass through both the placenta and breast milk (Müller et al., 2013). Controversy arises because of possible side effects to both mother and baby (Galbally et al., 2009; Lugo-Candelas et al., 2018; Rosenquist, 2013). Literature on both antenatal antidepressant effects and usage during breastfeeding is inconclusive about whether the antidepressant or the untreated depression is worse for the fetus/infant (Field, 2008). For a woman who is breastfeeding, deciding whether to accept medication is influenced by the woman's knowledge of and concerns about infant exposure to medication via breast milk (Chabrol et al., 2004; Epperson et al., 2003, Kim et al., 2010; Pearlstein et al., 2006).

Most recently there has been controversy around specific anti-depressant drugs called Selective Serotonin Reuptake Inhibitors (SSRIs). Recent research shows a negative association between an infant's exposure to SSRIs as a fetus, and its brain structure and connectivity once born, with an increase in susceptibility to anxiety and depression (Lugo-Candelas et al., 2018). Zoloft (known as Sertraline in the UK) was recently the subject of a lawsuit regarding birth defects after its usage in pregnancy (Mehrotra, 2016). There is also concern regarding another

SSRI, Fluoxetine, following reports of increased risk of cardiac malformations in the infant if used during pregnancy, although one study concludes that there is no increased risk (Riggin, et al., 2013). Evidence also suggests Fluoxetine is associated with increased risk of the fetus developing Autism Spectrum Disorder (Gentile, 2015; Man et al., 2015), or atrial/ventricular defects and craniosynostosis (Bérard et al., 2015). The use of Pregabalin for anxiety in the first trimester of pregnancy has been shown to result in the risk of increased major birth defects (Winterfeld et al., 2016). Rosenquist (2013) has raised concerns about the dependency arising from the usage of SSRIs, the difficulty of withdrawal and the increased knowledge of toxicity. There is also concern that neonates may be affected by 'neonatal serotonin discontinuation syndrome' (Galbally et al, 2009). This offers women a difficult choice between accepting pharmacotherapy treatment that may be harmful to themselves or their child, or possibly no treatment at all (Freeman, 2009; Wisner, et al., 2000).

In a small study of women offered psychotherapy and/or Sertraline, women who were breastfeeding were less likely to choose Sertraline than psychotherapy (Pearlstein et al., 2006). Yet funding for treatment other than psychotropic medication is limited on the NHS, and unavailable in some localities Clinical Commissioning Groups (CCG) (DH, 2014). Treatment strategies recommended in NICE guidelines (NICE, 2015) are either pharmacotherapy, or Cognitive Behavioural Treatment (CBT), offered often through the IAPT service. However, IAPT services are not always found to be suitable, or of benefit to women with perinatal mental health conditions (Improving Access to Perinatal Mental Health Services – A Review, NHS Improving Quality, 2015). This may be due to the specificity of perinatal mental illness, and the ways in which women perceive their illness. It is also possible that the specific delivery of IAPT, using mainly CBT, does not correlate to the practical and logistical barriers in perinatal mental health (Goodman, 2009; O'Mahen et al., 2012), or the way in which women actually feel. IAPT treatment may rely on medical determinants, which women may struggle to relate to their own experience. CBT in particular has had mixed results with some studies finding weak effects of CBT (Prendergast & Austin, 2001) or little outcome difference between CBT and non-specific counselling (Milgrom et al., 2005; Morrell et al., 2009). IAPT treatment may also be time-limited, which might not provide the depth and breadth of therapy needed by some women. Research shows that the perceived relevance of treatment is critical to engagement and treatment adherence, as is perinatal specific content (O'Mahen et al., 2015). The Perinatal Mental Health Guidance (PHE JSNA Toolkit, 2017), acknowledges that in 2015, 85% of NHS localities still did not have a specialist perinatal mental health service to the level required by NICE guidelines (NICE, 2014). Offering only pharmacotherapy or CBT provides a narrow and limited range of treatment choice. This may influence the attrition rates for treatment, which are high (O'Mahen et al., 2015).

A large-scale qualitative study of the experience and attributions of postnatal depression, found that 'talking therapies' were the preference of women, in a cross-cultural study incorporating 11 countries (Austria, France, Ireland, Italy, Japan, Portugal, Sweden, Switzerland, the United States, Uganda, and the UK) (Oates et al., 2004). This study found participants did not universally recognise a need for medical intervention, viewing the causes and remedies as lying in the psychosocial domain. Goodman (2009) also found a high level (92%) of preference for psychotherapy as a treatment option for depression in pregnancy, which concurs with studies into patient preferences in primary care for depression (Backenstrass et al., 2006; Dwight-Johnson et al., 2000; van Shaik et al., 2004).

Psychotherapy has been used effectively in the treatment of depression and anxiety in adults (Benelli et al., 2016; Biegler, 2011; Cuijpers et al., 2011; Robinson et al., 1990; Souza et al., 2016; Town et al., 2017; Van Rijn, & Wild, 2013; 2016; Van Rijn, Wild, & Moran, 2011; 2012; Widdowson, 2011; 2012a; 2012b; 2012c; 2013; 2014; 2015) but has not been used widely for the treatment of perinatal mental health conditions, particularly in the UK, as is apparent in the literature review (Chapter 2). In the UK many women with this condition never get any kind of treatment (Hogg, 2013).

## **1.7 Barriers to treatment**

In their research into the prevalence of psychiatric disorders during pregnancy in Sweden, Andersson et al. (2003) found that among those women who were diagnosed in pregnancy with a psychiatric or mood disorder, only 5.5% underwent any kind of treatment (either psychopharmacological or psychotherapeutic). This implies that 95% of women diagnosed with a mental illness in pregnancy received no treatment at all, although they did not suggest reasons. Yet, evidence shows that women with depression in pregnancy are far more likely to go on to have postnatal depression (Milgrom et al., 2008; O'Hara & Swain, 1996). Other research highlights the low percentage of women who receive treatment for postnatal depression (Goodman & Tyer-Viola, 2010; Horowitz & Cousins, 2006; Marcus et al., 2003). It is plausible that the large proportion of women receiving no treatment suggests significant barriers preventing access to treatment exist.

Barriers to treatment include stigma (Bilszta et al., 2010; Goodman, 2009; Myors et al., 2015; O'Mahen & Flynn, 2008), difficulty with transportation to appointment and demands on time (Goodman, 2009). Additionally, some women fear their baby being removed from their care if they admit to being depressed (Boots Family Trust, 2013; Dennis & Chung-Lee, 2006). For those that do access treatment, the compliance rates are often poor particularly for those

taking medication, with higher rates of discontinuation of medication (Munk-Olsen et al., 2012; Peterson et al., 2011). Attrition rates in psychological therapies are also high (O'Mahen et al., 2015), and often occur prematurely (Myors et al., 2015), possibly due to the nature and complexity of the perinatal period (O'Mahen et al., 2012). A mixed-methods study into the preferences and concerns of antidepressant usage aimed to highlight possible causal factors, which might explain why so many depressed women failed to engage in treatment within the perinatal period (Battle et al., 2013). This study showed a high comorbidity of anxiety with depression, which supported other studies of a similar nature (Grigoriadis et al., 2011; Wenzel et al., 2001), as well as the role of distress within a woman's relationships (Battle et al., 2013; Beck, 2001; Whisman et al., 2011). There is clearly a difficulty in diagnosis and this may be due to a perceived sense of stigmatization and shame, rendering women silent, not only with health professionals, but also within their own families (McLoughlin, 2013; Staneva et al., 2015). These barriers to treatment are important, as they hinder women firstly asking for treatment, then accessing and continuing treatment at a time when it is vital.

Many different barriers to treatment exist, some of which are highlighted within the literature review. A fuller discussion of the many barriers is beyond the scope of this thesis. The most significant barriers to treatment, which are cited in much of the research, are shame, stigma and silence, which are briefly outlined below.

### 1.7.1 Stigmatisation

Stigma, the negative attitudes towards and the rejection of those who are mentally ill, has been researched increasingly over recent decades (Byrne, 2001; Masuda & Latzman, 2011; Nosek et al., 2010) and is a well-documented barrier to engagement and compliance in treatment (Bates & Stickle, 2013; Vogel et al., 2013). Stigma is also prevalent within perinatal mental health disorders (Goodman, 2009; Mauthner, 2002; McLoughlin, 2013; Myors et al., 2015; O'Mahen & Flynn, 2008; Staneva et al., 2015). Mothers with mental illness say they can experience stigmatisation from society and from within their own families (Bilszta et al., 2010; Davies & Allen, 2007; Di Maschio et al., 2008; Edwards & Timmons, 2005; Hanley & Long, 2006; Holopainen, 2002; Krumm & Becker, 2006). This causes them to become hesitant in revealing their inability to cope, due to the shame they feel from admitting their 'weakness'. Mantle (2002) states that the reason postnatal depression continues to go undetected and untreated is due to stigmatisation.

### 1.7.2 Shame

DeYoung (2015) sees shame as a relational trauma which engenders self-protection mechanisms within the person, such as impaired capacity for connection (Heller & LaPierre, 2012). Brown (2007) calls shame the “*Silent Epidemic*” (p xvii) and states that it unravels our connection to others. She calls shame “*the fear of disconnection – the fear of being perceived as flawed and unworthy of acceptance or belonging*” (p xxv). Shame causes humans to pretend to be something they are not. Buultjens & Liamputtong (2007) highlight this in perinatal mental illness: “*Sadly, many women go undetected and suffer in silence for fear of disapproval and rejection*” (p87). McIntosh (1993) concluded that women who felt shame chose not to seek help, which was corroborated within research from Bilszta et al., (2010), Cheng et al. (1994) and Holpainen (2002). Women with traumatic backgrounds particularly felt shame (Talbot & Gamble, 2008). Women also avoided seeking help until the depression became debilitating (McIntosh, 1993). Shame may cause women to pretend to be okay, when in fact they are extremely unwell.

### 1.7.3 Silence – The consequence of stigma and shame in perinatal mental illness

Silence is a fundamental part of perinatal mental illness. Women with such mental illness say they find themselves on the margins of society. Many feminists write about women’s voices being silenced as a result of their experiences within a patriarchal society (Belenky et al., 1986; Brown & Gilligan, 1992; Jack & Ali, 2010). One of the purposes of this study is to encourage women to share what is usually left silent. Data from the silent aspects may provide different information and knowledge about this human, female condition.

Within their meta-synthesis of qualitative studies on depression, anxiety and distress in pregnancy, Staneva et al. (2015) believe women silence their voices and themselves in their relationships both intimately and socially due to their experiences of powerlessness. They found that women who felt misunderstood by their partners felt alone, or lacked resources and support and chose to remain silent. Those who remained silent seemed to have difficulties developing an attachment to their babies, and a more profound level of postnatal depression (Staneva et al., 2015). In their qualitative systematic review on postpartum depression help-seeking barriers, Dennis & Chung Lee (2006) found that women from culturally diverse backgrounds did not proactively seek help for their illness and stayed silent. This silence is a problem for treatment. If women stay silent and feel unable to admit to their distress and discount or minimise their illness, then this silence may contribute to the lack of diagnosis and treatment of this condition (Dennis and Chung-Lee, 2006).



## 1.8 Psychotherapy

Many women say they would prefer psychotherapy as a treatment, rather than drug therapy (Battle et al., 2013; Dennis & Chung-Lee, 2006; Goodman, 2009; O'Mahen & Flynn, 2008; Pearlstein et al., 2006). Psychotherapy is not always offered within the NHS for treatment of perinatal mental health, although some forms of it are offered through the IAPT service. Yet the evidence stated above regarding IAPT services (section 1.6) suggests that women do not necessarily find IAPT services relevant, suitable or of benefit (Improving Access to Perinatal Mental Health Services – A Review, NHS Improving Quality, 2015). O'Mahen et al. (2015) found that perinatal-specific treatment, and relevance is an important factor in treatment engagement and compliance. Therefore, research into alternative types of psychotherapeutic treatment options may show higher relevance to the perinatal period, which may engender higher compliance levels and lower rates of attrition within treatment.

'Psychological therapy' is a generic term used to describe any form of treatment designed to improve the psychological functioning of a person with any mental health condition (Segens Medical Dictionary, 2012). This is as opposed to medical treatments, such as pharmacotherapy (e.g. drug treatment). Psychotherapy is used specifically to treat mental health conditions and the term 'psychotherapy' covers a wide range of different modalities and styles, such as CBT, Interpersonal Therapy (IPT), Psychoanalysis, and Person-Centred Therapy. Psychotherapy is offered in many different ways such as through one-to-one sessions, for couples, for families and within group settings (Schonbeck, 2013). It is also sometimes described as 'talking therapy', although this can be misleading as many psychotherapists use other techniques, such as the arts, dance, or creative methods to explore people's emotions and struggles (Arrington, 2001; Dean, 2016). Psychotherapy can also be used to treat children and adolescents, although a psychotherapist would normally specialise in one age group (Blake, 2011), rather than treating all age groups. Psychotherapy is often seen as preferable to medication by people experiencing depression (Kwan et al., 2010; Prins et al., 2008; van Shaik et al., 2004). Kwan et al. (2010) also highlighted that people who received their preferred treatment of psychotherapy for depression were more likely to engage in and commence treatment, stay in treatment, and attend treatment appointments. This also had a positive impact on the early therapeutic alliance, which ultimately predicted the outcome of the treatment.

The premise of psychotherapy is that the therapist works with a client to help them to understand their difficulties. Some psychotherapies are more focused on the root cause of mental ill health, as in relational Transactional Analysis (TA) for example, but many are not so root cause-focused, such as many types of CBT,

Person-Centred, and Solution Focused psychotherapy. Although traditionally psychotherapy has been seen as more long term, many psychotherapists now work short term with clients, such as 6-12 sessions (IAPT services, and many charities). Differing tensions and theories exist about the optimum length of psychotherapy (Howes, 2014; Leichsenring & Rabung, 2011; Lorentzen et al., 2013). Controversy and debate also exist around the similarities and differences between psychotherapy and counselling, which are beyond the scope of this research. This research focuses on TA psychotherapy.

Currently, psychotherapy is available by referral through a GP within some areas (NHS Choices, Psychotherapy, 2015) or through IAPT services. NHS Choices (2015) state that NHS waiting lists are often long.

## **1.9 Transactional Analysis Psychotherapy**

TA psychotherapy is an approach shown to be beneficial to a wide-variety of mental illnesses and difficulties from which human beings suffer (Baba Neal, 2017, Dimitri et al., 2016; Golovan, 2015; Harford & Widdowson, 2014; van Rijn, Wild & Moran, 2011; 2012), including depression and anxiety. Therefore, it may be a suitable treatment for such conditions within the perinatal period (see Chapter 2 for a review on TA psychotherapy for the treatment of depression and anxiety). The depth and breadth of TA and its diversity give it versatility (Widdowson, 2010, pxiii) as a psychological therapy. It is this diversity and versatility that may be useful for women in the perinatal period, as TA has the ability within its theoretical model to be shaped towards the needs of the client.

### **1.9.1 The origins of Transactional Analysis**

TA is a theory and method of therapy initially developed by Eric Berne from his knowledge as a psychoanalyst in the 1960s and 1970s. Berne (1961) used Freudian principles of the “*resolution of infantile conflicts through the systematic use of free association, dealing with the phenomena of transference and resistance*” (p12), which he referred to as “*orthodox psychoanalysis*” (1961, p12). He challenged this classical psychoanalytic concept of the unconscious, instead emphasizing the role of the child in making its own adaptive script decisions (Cornell & Hargaden, 2005). Before Eric Berne, Freud’s theory of human personality was that its three component parts: Superego, Ego and Id, combined to form the complex behaviours found in humans. Freud believed these three components needed to be balanced to allow a person to be in mental health. Although originally drawing from Freud, Berne’s approach became different. Instead, Berne wanted to create a new form of psychotherapy, which would challenge classical psychoanalysis. He drew from other theorists such as Paul Federn, the neurosurgeon Dr Wilder Penfield, and Edward Weiss for his

influences on his own ego state theory. Berne believed that he could develop ego state theory from Freud's model. Rather than asking a client about their self, he said he was able to actually observe ego states through his client's transactions (for example words used, facial expressions, body language). He believed this enabled him to discover clients' difficulties, and this he did within a group setting to allow him to observe how the group participants interacted with each other. In this way, Berne identified three separate ego states from his observations, which he called Parent, Adult and Child and which he stated were "*not concepts like Superego, Ego and Id or Jungian constructs, but phenomenological realities*" (1961, p24). Berne believed that Freud's ego states, were unobservable and theoretical states. Berne's definition of an ego state (1966) is "*a persistent pattern of feeling and experience related to a corresponding consistent pattern of behaviour*" (1966, p. 364). It was this difference in thinking, as well as the refusal of the San Francisco Psychoanalytic Institute in 1956 to grant him full membership that catalysed Berne to part from the psychoanalytic movement and develop TA, stating that his concept of ego states and ego function is "*different from that of the majority of orthodox psychoanalysts*" (1966, p13).

At its most basic level, TA is a method for studying interactions between individuals. Berne was the first person to define an identifiable and measurable unit of analysis or psychotherapy:

*"From psychoanalysis, Berne drew his understanding of intrapsychic forces acting upon the person. His major works ... are only truly well understood given a sufficiently thorough grounding in psychoanalytic thinking... later readers, who may lack such background, may have missed some of this depth."* (Clarkson, 1992, p4)

Berne's approach to therapy was also cognitive through his theory of the Adult ego state and concepts such as contaminations. This approach did not exist at the time of his theoretical innovation (Schlegel, 1998; Widdowson, 2010). Since the 1960s, TA has been expanded by many different proponents into an internationally-recognised, professional approach to psychotherapy.

### 1.9.2 The diversity and versatility of Transactional Analysis psychotherapy

Berne purposefully developed a model of psychotherapy in which different theories and perspectives could co-exist (Cornell & Hargaden, 2005), seeking to create a humanistic psychotherapy "*that drew upon both cognitive/behavioural interventions through the Adult ego state ("social control," 1961, p 176 – 183) and those aimed at internal, structural change within the Child ego state (script level "cure," or "deconfusion of the Child," 1961, p162 – 164)*" (Cornell & Hargaden, 2005, p 7). Berne recognised that to deconfuse the Child, different styles and levels of

intervention were needed to work with the emotional and transference dynamics of the Child ego state.

TA psychotherapists learn a common body of theory, the most basic of which are the theory of ego states (Berne, 1961; 1964) and the theory of scripts (Berne, 1961; Erskine and Zalcman, 1979; Steiner, 1966; 1974; Stewart & Joines, 1987; Woollams & Brown, 1978). Berne himself developed much of the core theory, such as ego states, structural analysis, contamination, exclusion, functional analysis, transactional analysis, games and game analysis, scripts and script analysis (Widdowson, 2010). See Appendix 1 for definitions of TA terms.

One significant change in TA psychotherapy has been the growth of relational TA. This parallels the growth of relational psychotherapy itself, which DeYoung (2003) calls '*a general theory of psychotherapy*' (viii). This model has grown in the last 25 years and is very much driven by the client, their experiences and their needs (DeYoung, 2003).

The growth of relational TA and the relational movement has:

*"involved a change of emphasis from a focus on the development of insight as the primary means of psychological change, to an exploration of and engagement with patterns of relating. Thus it places relationship – to self and others, including the therapist, at the heart of the therapeutic work."* (Fowlie & Sills, 2011, pxxv).

This fundamental shift in theory results from developments in science, neurobiology, and advances in knowledge of human development, as well as a need to understand the ever more complex client presentations, which could not be explained by existing psychological theory (Fowlie & Sills, 2011). This framework of TA built upon the roots of object relations theory in the UK (Balint, 1968; Bowlby, 1977; Fairbairn, 1940; Klein, 1959; Winnicott, 1958) and the interpersonal psychoanalytic movement in the US (Sullivan, 1953). This relational movement was a move away from Freud, placing relationship at its heart (Fowlie and Sills, 2011). Relational TA draws upon psychoanalytic approaches to provide a methodology focused on non-conscious processes, conscious experience and implicit relational patterns:

*"Relational psychotherapy ... brings the psychoanalytic world's rigorous attention to the non-conscious inner world of implicit knowing and relating, together with the humanistic recognition that human beings exist in relationship and that real connection with another is the source of well-being and growth."* (Fowlie & Sills, 2011).

With no research on TA as a possible treatment for any form of mental illness within the perinatal period, this study initiates the research, by adding to and informing the emergent base of literature. This study cannot provide evidence of the effectiveness of TA. This would be too ambitious an aim at this stage.

TA psychotherapy is most often offered within a private psychotherapy practice setting. Private psychotherapy can be a long- or short-term treatment and there is no evidence, as yet, whether this type of TA psychotherapy is effective on a short-term basis. This cannot be included as an aim within this thesis. It could be part of the next stage of research, on completion of this study.

### **1.10 My rationale for undertaking this study and my own knowledge**

I am a TA psychotherapist, from a humanistic, relational background. I attribute significant importance to listening to, and hearing the narratives that human beings form about their experiences and my work is focused on helping my clients to interpret these experiences and the meaning and context attached to them. I work primarily as a relational Transactional Analyst, meaning that the relationship between myself and my clients, and my clients' relationships with themselves and others, past and present, is at the core of my clinical work. Relational TA as a theoretical model puts the deficit, or dysfunction within interpersonal and intrapsychic relationships in the primary position, within the treatment focus. From the moment of conception, pregnant women are in relationship with their fetus. For some women, this relationship may form even prior to conception, particularly if there has been difficulty in the conception of the baby, or it has been conceived through in vitro fertilisation. This relationship continues through birth and life, until there is a rupture. A woman experiencing perinatal mental illness may be struggling with this relational aspect. TA provides a therapeutic framework to work with women through this sometimes difficult and disturbing transition to motherhood. It highlights the importance of uncertainty, but also curiosity and creativity, and hopes to enhance a woman's ability to engage, attach and bond with her baby.

My work as a clinician is with clients who have been diagnosed as having depression, stress or anxiety in the perinatal period. I work in private practice and these clients can self-refer or alternatively are referred via a doctor, or health practitioner, such as a midwife or health visitor. Many of my clients tell me they have struggled to gain any kind of treatment for their distress, and as such have turned towards the private sector for help. I use TA psychotherapy in my work with my clients and I find it a useful form of treatment. I believe there are elements in TA theory, particularly within relational TA theory (Cornell & Hargaden, 2005; Fowlie & Sills, 2011; Hargaden & Sills, 2002), as well as Co-creative theory (Summers & Tudor, 2000) and Transgenerational Scripting

(Noriega, 2004), that are particularly useful and valuable in increasing a women's understanding of her distress. Relational TA theory also highlights the importance and value of a mother's bond with her infant, the importance of conscious and non-conscious patterns of relating and experience, the importance of the relationship, its co-creative nature, and the importance of the mother/father/caregiver in modelling behaviour both explicitly and implicitly within the infant/parent bond.

I wanted to research this modality of psychotherapy because I find it to be a useful model of therapy. I am curious to hear how women experience TA as a treatment option and whether it may be suitable for future adaptation into a protocol for this client group, which could be used in the NHS and elsewhere. I find the medical delineation of postnatal depression baffling as I have an inherent belief that women are suffering from distress in this period, which would include any kind of mental illness or trauma. I believe it is important to listen to, hear and understand the experiences and perceptions of women affected by this condition, as these seem to differ from the medical and biological attributions. Gaining insight into these women's experiences of the psychotherapy treatment they have received would fill a gap of much needed research. It would also enhance my own practice, allowing me to listen to, and understand the narratives of these women and their perceptions of treatment, rather than just assume I already have the knowledge, a position of power and authority that does not sit easily with me. I am deeply involved in, and curious about, what triggers women to become unwell.

Self-awareness is also part of my clinical and professional world. It is a part of my research, as is reflexivity. My own responses and my diary throughout the participant interview and analysis phase became important as elements of enrichment within my research, and form part of the reflexive element of this study.

At this point, it is necessary to touch on power and politics, and by this I mean my own agendas, both visible and hidden, within the research framework. I do seek to change policy within the context of perinatal mental health. I do want recognition for TA psychotherapy as a suitable treatment for these women, and I want it to gain greater recognition as a treatment for many other mental health difficulties. I believe there is a power imbalance within the NHS and in particular within maternity services, and within the politics of mental health. This power imbalance is possibly greatest within the context of gender specific mental health, in this case the mental health of women in the context of becoming mothers.

It is also necessary to acknowledge that this research may be biased towards the middle-classes, as private psychotherapy is expensive, and is not offered for free on the NHS. There is also a predominance of white (Western) middle-class women in psychotherapy practice, due to some extent to the length and the expense of training. This, coupled with the expectation of working pro bono within the charitable sector while in training, almost always precludes those who are unable to afford the high cost of training, supervision, and therapy involved for the lengthy period of time necessary to qualify.

## CHAPTER 2

### Literature Review

#### 2.1 Introduction

The purpose of this review is to give context for this research study by exploring the literature available within the three key areas of this study:

- Women's experiences of perinatal distress
- Psychological therapies that already exist as treatment strategies for perinatal mental illness
- TA psychotherapy for the treatment of depression, anxiety and stress

Such a review will provide better understanding of the treatment of research within the perinatal period, plus study findings and quality. It will also identify research and evidence gaps.

This study is not about proving the 'effectiveness' of TA psychotherapy as a treatment. Therefore, this review does not seek to search for evidence of effectiveness of psychological therapies available. Rather, this study focuses on ways to allow women's voices to be heard. It examines women's perceptions of their illness, and their beliefs around their illness's origins; potential barriers and facilitators that would preclude, or encourage them into, and keep them engaged in, treatment; and what they want from their treatment of choice. A more thorough understanding of these elements will help to focus treatment towards women's needs. Relevance of treatment has also been shown to be important to women with perinatal mental illness. Swift et al. (2011) identified that clients' preferences for treatment are a 'demonstrably effective' factor in determining their clinical outcomes and may be the primary motivator in engaging women and keeping those women engaged in treatment (Swift et al., 2011).

It is useful to know what other psychological therapies are being used to treat perinatal mental illness. This study does not seek to demonstrate whether one style of therapy is superior to another. Instead, it focuses on client choice of treatment, and is driven by the women's experiences and their needs. Offering a broader choice of treatment options may be more useful. Women may then be empowered to choose the style that is relevant, and that fits with their way of being in the world.

A search for literature in counselling and psychotherapy databases and the two TA journals, Transactional Analysis Journal (TAJ), and International Journal of Transactional Analysis Research and Practice (IJTARP), revealed that no



research exists on the use of TA to treat for perinatal mental illness. However, an exploration of the existing research on its use for depression, anxiety and stress in the adult mental health environment provides a context for its use to treat women experiencing such conditions in the perinatal period. As stated in section 1.9 (above), a rationale exists for TA as a suitable treatment option for women with this type of illness. However, the vulnerability of these women requires that the treatment selection is evidence-based, rather than randomly selected.

This chapter's conclusion will combine the relevant elements of these three parts, highlighting the research and evidence gaps to inform the aims and objectives of this study.

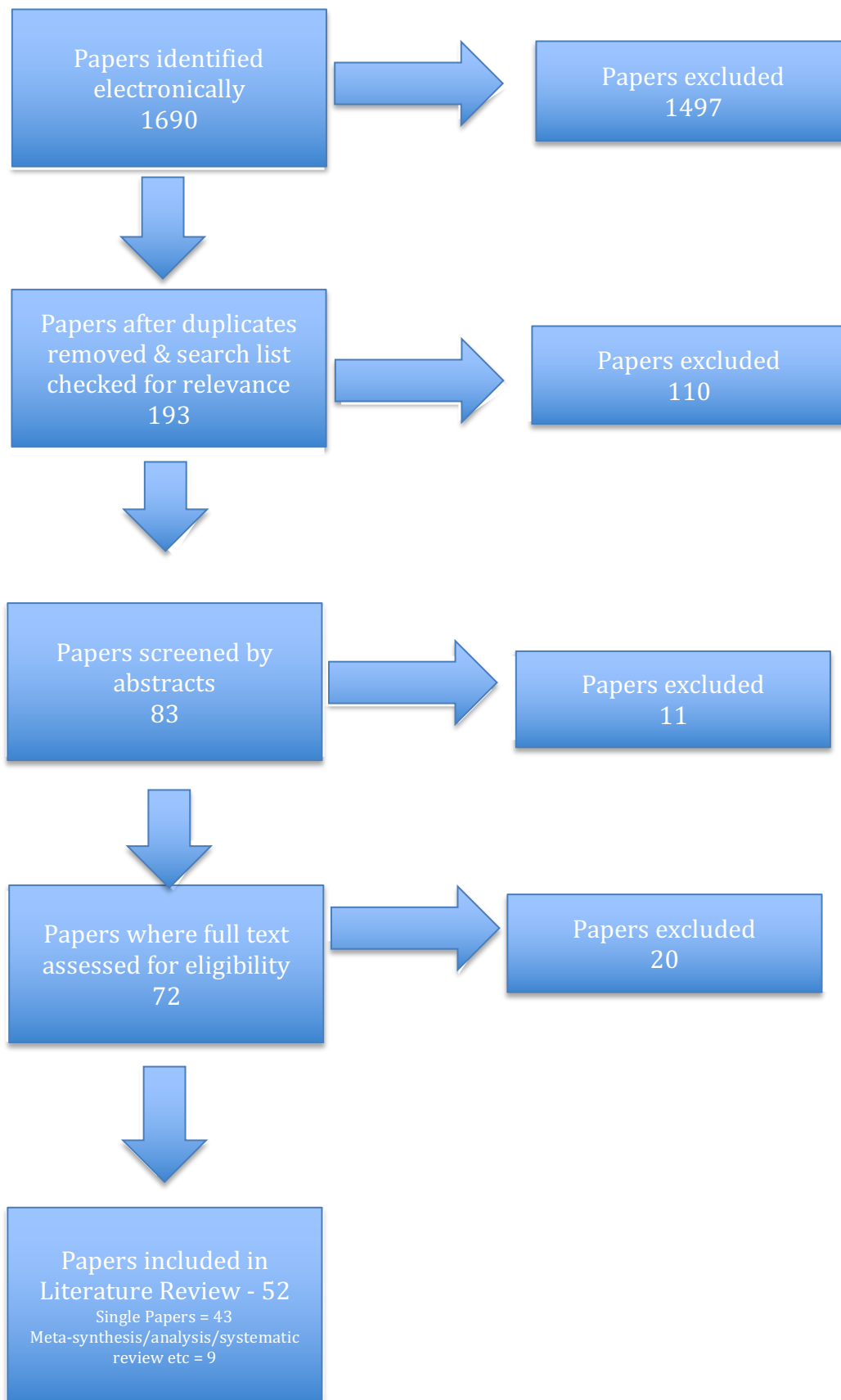
## **2.2 Women's experiences of perinatal mental illness**

The present review explored the existing literature and found some qualitative literature on women's experiences of mental illness within either the antenatal or postnatal period, a table of which is provided in Appendix 2. The review may not be exhaustive. Several databases were searched: CINAHL, PsycINFO (Ovid), MEDLINE (EBSCO, Ovid), Cochrane Library, PUBMED, Science Direct and Academic Search Premier. The search terms were: women's experiences, perinatal, postnatal, postpartum, antenatal, qualitative, mental health, mental illness. Forty-three articles were eligible for inclusion. In addition, nine further articles, either meta-syntheses or systematic reviews, were also located, represented in blue in Appendix 2. All the main themes from these articles have been covered within this review. The date criteria for this search was 1997 to December 2018.

Concurrent with the data explored within Chapter 1, qualitative literature on women's experiences was focused mainly towards the postnatal period and depression. Of the 43 articles, 27 are focused on the postnatal period (18 of which focus only on postnatal depression). Thirteen articles cover the perinatal period (again six of which focus only on depression). Only three articles focus on the antenatal period (and two of these articles focus on depression). Thus out of the 43 articles, 26 are focused on depression only. Eleven of the articles use the terminology 'mental health', 'mental disorder', or 'distress' rather than stipulating which mood disorder is being targeted. For ease, these different terminologies have been captured by one term: 'mental disorder' within the table. Only one article looks at a combination of disorders: depression and anxiety. Six articles examined women's experiences of puerperal psychosis, marked in red in the table. The experience of psychosis may have some similarities to other postnatal mental health disorders, and these articles may offer additional insights into barriers and enablers to care.

Although the most common focus of the 43 articles is on women's experiences of mental illness (33 articles), help-seeking facilitators and barriers to treatment were also explored. This could reflect acknowledged high rates of non-compliance within treatment, highlighted in Chapter 1, thus seeking an explanation for such high rates. It is also relevant that the studies on transition to motherhood, not relating this experience to a specific mental health condition, still found that women's experiences of the postpartum period were mostly negative (Choi et al., 2005; Mauthner, 1999), or that there was dissonance between their expectations of motherhood and the reality of it (Staneva & Wittkowski, 2012). Help-seeking experiences, the experience of psychosis, barriers and facilitators, are all addressed separately within this chapter from section 2.2.1 onwards. There is also a section on cultural aspects of perinatal mental illness. This relates to few articles but are nevertheless important considerations when developing appropriate care pathways for women in those countries that offer little or no care.

The majority of articles come from research in the UK (Boots Family Trust et al., 2013; Byatt et al., 2013; Coates et al., 2014; Edwards & Timmons, 2005; Furber et al., 2009; Glover et al., 2014; Heron et al., 2012; Jarrett, 2016; McGrath et al., 2013; Moore et al., 2016; Nicolson, 1999; O'Mahen et al., 2015; Patel et al., 2013; Robertson & Lyons, 2003; Slade et al., 2010). However, a substantial number are Australian (Bilszta et al., 2010; Bultjens & Liamputtong, 2007; Chan et al., 2009; Highet et al., 2014; Holopainen, 2002; Myors et al., 2014; Nahas et al., 1999; Stone & Kokanovic, 2016). This is probably due to the Australian government focus on high instances of maternal suicide with the National Perinatal Depression Plan (NPDP) (Australian Government Department of Health and Ageing, 2008). This informed a robust system of training and education for health practitioners, a comprehensive system of psychosocial assessment and a robust care pathway system to offer treatment and follow-up support. The NPDP has led to increased research in Australia investigating all aspects of perinatal maternal health and care. In contrast, few articles came from North America, considering the population and size of this continent. The search found three articles from the USA (Abrams & Curran, 2009; Raymond et al., 2014; Ugarizza, 2002), and five articles from Canada (Ahmed et al., 2017; Bennett et al., 2007; Foulkes, 2014; Mauthner, 1999; O'Mahony et al., 2012). This was surprising, and may be due to the qualitative search criteria used. It is likely that the emphasis in North America is towards quantitative research methods,



**Figure 2.1** Flow chart showing search procedure for review of women's' experience of perinatal mental illness

particularly as there is currently a focus on evidence-based research in mental health. Five articles came from the African continent: with one article each from Nigeria (Adeponle et al., 2017), South Africa (Davies et al., 2016), Ethiopia (Hanlon et al., 2009), and two from Uganda (Nakku et al., 2016; Tole et al., 2018). Five articles came from Asia: with one article each from Vietnam (Abrams et al., 2016), Hong Kong (Chan & Levy, 2003), Bangladesh (Edhborg et al., 2014), China (Gao et al., 2010), and Taiwan, (Tseng et al., 2008). Excluding the UK, Europe yielded a paucity of studies, with only two articles from Sweden (Engqvist et al., 2011; Engqvist & Nilsson, 2013), and one from Norway (Haga et al., 2012). This was surprising and may be due to a focus on evidence-based practice.

Within this chapter the qualitative literature has been synthesised into the main research areas highlighted within the 43 studies included:

- help-seeking experiences
- help-seeking barriers
- help-seeking facilitators and barriers
- lived experiences
- women's experiences of psychosis
- Cultural experiences

### 2.2.1 Help-seeking experiences

Two articles explored women's help-seeking experiences (Holopainen, 2001; Tseng et al., 2008), both focusing on postnatal depression. Clearly, the research is currently limited and more similar, broad-based research is needed.

Holopainen (2001) interviewed seven women in Australia to explore their experiences of support and treatment for postnatal depression. This research discovered that women did not know where to go to seek help within the health provision in Australia. The support that was received was often incidental, such as from a midwife checking the baby's health noticing that the mother was also unwell. The study found that the women experienced dissatisfaction with their GP's, stating insufficient appointment time for the GPs to listen to them, and GPs preference to prescribe medication. While the women felt this may have alleviated their symptoms, it also reinforced a sense of inadequacy and stigma. This study is now quite old and it is possible, with the heightened awareness of perinatal mental illness in Australia, that a repeat study may produce different results.

Tseng et al. (2008) explored the experiences of 12 pregnant women with depression in Taiwan. They found these women had ambivalence and an

unbalanced commitment towards becoming mothers, specifically dissatisfaction with body image, emotional instability, lack of social support, future uncertainty and multiple conflicting roles. In particular, their research found that the transition to motherhood was one of excessive distress. The gender of the fetus was of importance, as the authors felt that there was still a cultural expectation of the male 'heir'. The women articulated the gap between expectations and the reality of motherhood. The article advocated the role of counselling and support groups to facilitate role transition.

### 2.2.2 Help-seeking barriers

Seven studies explored women's perceptions and experiences of help-seeking barriers in perinatal mental health (Bilszta et al., 2010; Boots Family Trust Alliance et al., 2013; Buultjens & Liamputtong, 2007; Jarrett, 2016; Myors et al., 2015; O'Mahen et al., 2015; Slade et al., 2010). Four focused on postnatal depression (Bilszta et al., 2010; Buultjens & Liamputtong, 2007; O'Mahen et al., 2015; Slade et al., 2010), and two on pregnancy (Jarrett, 2016; Myors et al., 2015). Jarrett (2016) investigated women with depression in pregnancy in the UK, while Myors et al. (2015) focused on pregnant women at risk of poor perinatal outcome and who had therefore been engaged into perinatal and infant mental health services in Australia. The Boots Family Trust Alliance et al. (2013) was the most comprehensive study, exploring both the women's experiences of accessing care and the health practitioners' experiences of treating women, to attempt integration of the two experiences to enhance services. This was the only study that looked at the entire perinatal period as well as mental illness, providing the broadest and most in-depth evidence.

As part of the PoNDER trial, Slade et al. (2010) researched the acceptability of health visitors giving psychologically informed sessions to women with postnatal depression. They interviewed 30 women and found that women's perceptions of their health visitors could be a significant barrier in seeking help. Although the study found that, when accepted, women's experiences of their health visitor giving psychologically-informed sessions was generally favourable, if women felt the health visitor had been unable to relate to their difficulties, it led them to decline psychological help. They also found that women struggled to admit needing help due to an implied sense of failure. Women would present an image of coping through fear of having their infant removed. This study highlights the need for health visitors to receive specific training in perinatal mental health and in interpersonal skills. A health visitor's job is to support women in this period, and yet this research appears to suggest that not all health visitors achieve this. The study also highlights the propensity for women to feel shame and the need for health visitors to adopt a non-judgemental approach, that is accepting of this illness and is facilitative.

Myors et al. (2015) researched 11 pregnant women who were at risk of poor perinatal outcomes who engaged with perinatal and infant mental health services in Australia. They found that a significant barrier was the length of time between a woman's first contact with health professionals and the antenatal assessment, citing a perceived suitable time lag for women as days, not weeks. Stigma was recognised as a barrier to engagement, as well as shame, especially for women from traumatic backgrounds. This research discovered that clinicians with a flexible attitude to delivery and mode of care, and a focus towards empowerment and enhancement of therapeutic relationship, were successful in promoting engagement with services. The importance of a clinician's flexible attitude to delivery and mode of care has been highlighted elsewhere (Chu & Kendall, 2009; Ghaderi, 2006; Perren et al., 2009). To keep women engaged, Myors et al. also emphasise the need to meet the women's actual needs, particularly for women who are marginalised in the perinatal period, in order to keep them engaged.

Bilszta et al. (2010) found barriers to treatment in Australia were maternal ignorance of postnatal depression, coupled with the stigma and shame of admitting illness to health professionals. They found an ambivalence towards seeking professional support due to a sense of being labelled 'patient' and the shame this produced as well as a fear of being considered an unfit mother. Their research found that having a diagnosis of postnatal depression could increase stigma. Families and partners were also identified as primarily helpful, yet could paradoxically enhance a woman's sense of stigma through well-meaning, but inappropriate help.

Jarrett's (2016) investigation into women's experiences of depression in pregnancy in the UK found that women did not disclose their symptoms to health professionals due to a lack of confidence in the expected response from GPs and midwives. She believed this was due to the women's belief that effective care was not available, or their fears that disclosing mental illness would mean losing custody of their infant.

The Boots Family Trust Alliance et al. (2013) report was a comprehensive mixed methods study integrating women's experiences of perinatal mental illness in the UK with those of health professionals caring for those women. The report highlighted barriers to accessing care as the perceived lack of time health professionals had for women, the lack of continuity in care received (women reported seeing a different health professional at each appointment), and the health professional simply not enquiring about the woman's mental health. The study found that over a third of women stated a fear of having their baby removed from their care as a reason for not admitting to a health professional

that they were unwell. The primary reason given for not asking for help was 'embarrassment'.

O'Mahen et al. (2015) conducted a mixed method study of 17 women who were offered internet-delivered self-help Behavioural Activation for postnatal depression. Initially this had a high up-take (910 women), just over a third initially complied with the treatment. Furthermore, views of the treatment substantially declined between treatments one and three, although it was not specified what those treatments were and why the compliance declined so rapidly. This implies that internet-delivered treatment, although initially intriguing, may not provide the one-to-one care that women say they want and need. Their interviews determined that this treatment led women to feel isolated, as they were completing the treatment on their own computer, with no outside intervention, which led to their disengagement. The study found six relevant barriers to treatment: unrealistic expectations of motherhood; lack of treatment content relevant to their needs; a sense of hopelessness about the treatment efficacy; disillusionment with the health providers (due to lack of efficacy of past psychological treatment, and time lags between diagnosis and treatment); inadequate support networks within family and friends; stigma attached to postnatal depression and the shame they felt, causing them to become secretive about their condition. The study found that women preferred individual, interactive engagement with more therapeutic support than that given with the internet-delivered treatment.

Buultjens & Liamputtong (2007) also found that some women did not know help was available for their postnatal depression symptoms. Findings showed that those women often felt isolated and alone in their illness. Their research used semi-structured, open-ended questioning and thematic analysis for their interviews of 10 mothers resident in an inpatient mother and baby psychiatric unit in Australia. The study highlights the sense of shame women felt about their symptoms. The study concluded that health practitioners were unaware that pregnancy could be a time of depression. They believed this was due to health practitioners' belief, at that time, that pregnancy was a protective factor against depression. This perception has changed with greater acknowledgement of the risk factors in pregnancy for mood disorders. Their research highlights the myths of motherhood, such as: 'normal' women will want to have children; parenthood is 'blissful'; and the 'perfect' mother exists, that are still relevant today, which serve only to stigmatise anxiety and depression after childbirth (Buultjens & Liamputtong, 2007).

### 2.2.3 Help-seeking barriers and facilitators

Four studies explored both barriers and facilitators to seeking help (Byatt et al., 2013; Foulkes, 2014; Nakku et al., 2016; O'Mahony et al., 2012). One study each investigated postnatal depression only (O'Mahony et al., 2012), perinatal depression (Byatt et al., 2013), postnatal mood disorders (Foulkes, 2014), and perinatal mental disorders (Nakku et al., 2016). Also included in this section are a systematic review on postnatal depression (Dennis & Chung-Lee, 2006), a literature review on postnatal depression (O'Mahony & Donnelly, 2010), and a meta-synthesis exploring perinatal distress (Button et al., 2017).

O'Mahony et al. (2012) researched immigrant and refugee women in Canada accessing care for postpartum depression. They interviewed 30 women to ascertain factors influencing their behaviour and decision-making process. Some barriers were similar to those described in 2.2.2 above, such as lack of knowledge and information about postnatal depression, and poor relationships with health practitioners. Other barriers were more specific to these women such as language barriers, lack of familiarity and knowledge of health care services and lack of knowledge about the existence of treatment.

Byatt et al. (2013) researched 27 women with perinatal depression in an outpatient obstetric setting in America using focus groups. This research found four barriers: stigma; loss of parental rights; negative experiences with health care professionals; and lack of knowledge and skill of professionals in depression management. Three facilitators were found: peer support; training for professionals and psychoeducation.

Foulkes (2011) interviewed ten women in Canada with a postnatal mood disorder and found four main barriers to seeking help: stigma; the continuous change of health care providers; lack of knowledge and training for health care providers; and the fear of pharmacotherapy. Enablers to care (not yet provided for) were: a truly comprehensive maternal health care system, which gave equal priority to a woman's mental health as well as her physical care; one should not preclude the other.

Nakku et al (2016) explored barriers, facilitators and needs of 48 perinatal women in Uganda, highlighting significant gaps in knowledge and negative attitudes towards maternal mental health as being barriers to care. Other contributory factors included stigma, lack of transport, poverty and poorly trained health care professionals, and a lack of properly resourced facilities. Poverty was considered to be a significant factor when designing treatment facilities for women with perinatal mental health care needs.



Dennis & Chung-Lee's (2006) qualitative systematic review on help-seeking barriers and treatment preferences for postnatal depression explored 40 articles from 1966 to 2005. They discovered that lack of knowledge about postnatal depression from where to seek help and the previously mentioned myths around motherhood were significant barriers to seeking help. Other barriers were the woman's own lack of proactivity, which may have been due to their perception of the role of health professionals as limited or inappropriate during this time. Their article was a thorough review in its time and is still cited often. However, it is now dated and would benefit from being replicated, as the articles used within it may be of limited relevance today.

O'Mahony & Donnelly's (2010) literature review and analysis of help-seeking experiences of immigrant and refugee women with postnatal depression found the cultural stigmatization of mental illness was a significant barrier to seeking help, as was the gendered role of women. They highlight the lack of research in cultural factors in postnatal depression, without which it is difficult to provide services that support women and address their specific needs.

Button et al.'s (2017) meta-synthesis on evidence from the UK only of help-seeking behaviours for perinatal psychological distress found three factors which affected a woman's ability to seek help: stigma; recognising a problem existed; and their health care experience. This research highlighted how women are not always aware they are mentally unwell, but that those who are unwell may misrepresent their symptoms and seek help only at the point at which they reach crisis. They also discovered that it was not simply a matter of women recognising ill-health, but that it also required them to want to consciously address their illness. The research again highlighted women's' needs to be perceived as a 'good mother' and how this, compounded with stigma and a fear of failure, leads to 'self-silencing'.

In general, the studies exploring help-seeking barriers, facilitators and preferences were of good quality. There was a lack of data on facilitators; which only Foulkes (2011) and Byatt et al. (2013) reported. There was also a lack of longitudinal data, therefore knowledge of changes in barriers and preferences over time is unknown, leaving scope for future research in this area. Longitudinal research to examine whether barriers and preferences change during the perinatal period, or with subsequent pregnancies would provide knowledge of a possible continuum and therefore be valuable. No studies investigate whether perinatal mental illness begins with one mood disorder, then changes to another disorder at a subsequent time point. Comparison with prior or subsequent pregnancies would also be useful. Longitudinal research would allow treatment to be focused and for knowledge and education to be disseminated appropriately.

#### 2.2.4 Women's lived experiences of perinatal mental illness

Twenty studies exploring women's lived experiences of perinatal mental illness were located (Abrams & Curran, 2009; Abrams et al., 2016; Adeponle et al., 2017; Bennett et al., 2007; Chan & Levy, 2003; Chan et al., 2009; Coates et al., 2014; Davies et al., 2016; Edwards & Timmons, 2005; Furber, 2009; Haga et al., 2012; Gao et al., 2010; Highet et al., 2014; Mauthner, 1999; Moore et al., 2016; Nicolson, 1999; Patel et al., 2013; Raymond et al., 2014; Stone & Kokanovic, 2016; Ugarizza, 2004). Two studies are relatively old (Mauthner, 1999; Nicolson, 1999), although both are included because they are still cited frequently and considered seminal articles. Ten of the studies focused on postnatal depression (Abrams & Curran, 2009; Chan et al., 2009; Chan & Levy, 2003; Gao et al., 2010; Haga et al., 2012; Mauthner, 1999; Nicolson, 1999; Patel et al., 2013; Stone & Kokanovic, 2016; Ugarizza, 2004), and one on postnatal mental health disorders (Edwards & Timmons, 2005). Six articles explored the perinatal period, four of which looked at depression (Adeponle et al., 2017; Davies et al., 2016; Moore et al., 2016; Raymond et al., 2014), one explored depression and anxiety (Highet et al., 2014), and one explored perinatal mental health disorders (Abrams et al., 2016). Only two articles researched the antenatal period, one of which investigated depression (Bennett et al., 2007) and the other specifically examined distress (Furber, 2009). Six meta-syntheses were also located (Beck, 2002; Knudsen-Knight & Silverstein, 2009; Mollard, 2014; Staneva et al., 2015; Tobin et al., 2018; Wittkowski et al., 2017), five of which investigated postnatal depression (Beck, 2002; Knudsen-Knight & Silverstein, 2009; Mollard, 2014; Tobin et al., 2018; Wittkowski et al., 2017). The sixth explored antenatal distress (stress, depression and anxiety) (Staneva et al., 2015).

The main, repeating themes throughout the 20 studies and the meta-syntheses are described below. Many of the themes overlap and contribute to each other. For example failure in breastfeeding could be perceived as 'failure as a mother', which could precipitate feelings of guilt and shame, and the need to isolate from family and healthcare professionals.

*Loneliness or isolation:* Many women talked about how lonely or isolated they felt with perinatal mental illness (Abrams & Curran, 2009; Bennett et al., 2007; Raymond et al., 2014; Stone & Kokanovic, 2016; Tobin et al., 2018) possibly because they felt they needed to hide their illness. In their meta-synthesis of nine studies, Knudson-Martin & Silverstein (2009) found it was isolation, and the inability to talk about or express themselves emotionally, within a context that women found validated their experiences, that maintained and supported their postnatal depression. This corroborates research by Jack (1991) about depression in women, that found women would silence themselves when in an

interpersonal or cultural process in which they were unable to express themselves fully.

*Unmet expectations:* three articles highlighted the pressure women felt to breastfeed, from their families, healthcare professionals and also from society (Coates et al., 2014; Gao et al., 2010; Haga et al., 2012). This compounded women's feelings of failure, through perceived inability to meet their high expectations of being the 'perfect mother' or the 'good mother' (Beck, 2002; Chan et al., 2009; Gao et al., 2010; Haga et al., 2012; Mauthner, 1999; Mollard, 2014; Patel et al., 2013; Staneva et al., 2015; Stone & Kokanovic, 2016). Mauthner (1999) also highlights the unrealistic and conflicting expectations of the mother that women thought they would be, which were then shattered by the reality of the mother they experienced themselves as being. This was concurrent with other research from Beck (2002), Choi et al. (2005), Mollard (2014) and Read et al. (2012). This often left women feeling overwhelmed (Abrams & Curran, 2009; Chan et al., 2003; Coates et al., 2014; Gao et al., 2010; Ugarizza, 2002) due to their continuous struggle and the lack of time they had to achieve everything (Patel et al., 2013), or feeling helpless (Chan & Levy, 2003; Chan et al., 2009).

*Guilt and shame* were felt by many women (Beck, 2002; Bennett et al., 2007; Chan et al., 2009; Coates et al., 2014; Knudson-Martin & Silverstein, 2009; Mollard, 2014; Stone & Kokanovic, 2016; Ugarizza, 2002), often due to their sense of the stigma of mental illness (Edwards & Timmons, 2005; Staneva et al., 2015; Tobin et al., 2018). This would lead women to hide their illness and to silence themselves (Coates et al., 2014) or to 'wear a mask' (Bennett et al., 2007; Chan et al., 2009; Patel et al., 2013;).

*Lack of knowledge* was also highlighted, both the woman's own lack of knowledge of perinatal mental health conditions (Raymond et al., 2014; Tobin et al., 2018; Ugarizza, 2002), her desire or need for more knowledge (Bennett et al., 2007; Raymond et al., 2014), and health professionals lack of knowledge (Abrams et al., 2016; Furber et al., 2009; Highet et al., 2014; Wittkowski et al., 2017;). Additionally, health professionals' lack of time, care and understanding caused women to struggle with their health care professionals and not divulge their illness fully (Coates et al., 2014; Tobin et al., 2018). Highet et al. (2014) also found a general lack of awareness and insufficient recognition of anxiety disorders in the perinatal period in comparison to postnatal depression. They felt this was due to the higher profile of postnatal depression. They believed this led to confusion among women with anxiety, as their symptoms did not correlate to the information they were being given, causing a greater sense of alienation.

*Loss in the transition to motherhood* is highlighted by Highet et al., (2014) who found that numerous changes in pregnancy and the postnatal period led to a

sense of loss and frustration in women, and reinforced their sense of dissatisfaction in pregnancy and the transition to motherhood. This research supports earlier research (Choi et al., 2005; Mauthner, 1999; Nicolson, 1999) which presented postnatal depression as a process of grieving this sense of loss. Similarly, a more recent meta-synthesis (Staneva et al., 2015) highlighted the strong sense of disconnection and dissociation women felt with themselves and their babies, which supports research by Abrams & Curran (2009), Chan & Levy (2003), Mollard (2014) and Stone & Kokanovic (2016).

One longitudinal research study was located. Nicolson (1999) studied postnatal depression experiences of 24 British women. Interestingly, although the women were interviewed in pregnancy, as well as at one, three and six months postnatally, such was the way in which mental illness in childbirth was determined at the time, that this study was still conceptualised as of being about postnatal depression only. Nicolson's conclusions are similar to a more recent qualitative research study (Highet et al., 2014), which highlights the significance of loss in the transition to motherhood. In 1999, this loss was contextualised as a paradox of loss and motherhood. Nicolson, however, argues that it is not a paradox at all due to the significant losses a woman experiences on becoming a mother, such as identity, work, time, relationships, the loss of their own body, and friendships. She argues that postpartum depression is not a pathological condition, yet that the myths of motherhood continue to frame it as such.

Many of the above studies confirm the dissonance between the expectations and reality of motherhood, and the part that the myths of motherhood can play in reinforcing the sense of failure and frustration women feel once they have given birth, leading to feelings of guilt, shame and stigma. Several of the articles highlighted the perceived need of women to grieve their sense of loss of the fantasy of motherhood (Choi et al., 2005; Highet et al., 2014; Mauthner, 1999; Nicolson, 1999; Staneva et al., 2015).

#### 2.2.5 Women's experiences of puerperal psychosis

Five studies explored women's experiences of puerperal (postpartum) psychosis (Engqvist & Nilsson, 2013; Engqvist et al., 2011; Glover et al., 2014; Heron et al., 2012; Robertson & Lyons, 2003).

Engqvist et al (2011) explored the experience of postpartum psychosis using women's narratives gained from specific internet sites offering information, support and assistance to women suffering from postnatal mental illness. The purpose of their study was to enhance the quality of care, and to decrease the suffering of women with psychosis. The narratives explored were those freely accessible on those specific sites. They found four main themes: unfulfilled

dreams (which encompassed disappointment with the delivery, pervasive guilt and paranoia, and inability to care for their infant); being enveloped by darkness (overwhelming fear, being in an 'unreal' world, being 'controlled' by someone or some thing, and confusion/disorganised thinking); disabling symptoms (sleeplessness, being unable to concentrate, feeling 'ill at ease', and self-destructive behaviour); and feeling abandoned (from infant, paranoia and distrust of everyone, detachment from the world and from their infant, dissatisfaction with care).

In a small-scale study, Engqvist and Nilsson (2013) explored the accounts of seven women, about their first few days of psychosis. The authors discovered five main themes: being in an unreal world; loss of sleep; infanticidal ideation; the transition from wanting their baby to not wanting their baby; and suicidal ideation. For women suffering it, puerperal psychosis was seen as a time of darkness and despair. Lack of sleep, particularly in the first days after giving birth, was considered of great significance as the first signs of psychosis, which is corroborated by Sharma et al., (2004). The study, although small, was useful in highlighting the importance of intimate support through partner or close family, and their role in early detection and recovery support.

In another small-scale study, Glover et al. (2014) interviewed seven women who had been diagnosed with psychosis. Their research discovered four main themes: the route to psychosis; the experience of unspeakable thoughts and an unacceptable self; a need to 'snap out of it'; and the women's perception of the causes of their psychosis. They discovered that women attributed their psychosis to physiological changes in pregnancy and childbirth, yet the narrative of their experiences often began prior to conception, with them citing life difficulties, distress and anxieties as part of their journey into psychosis. The study concurs with other studies (Doucet et al., 2012; Robertson & Lyons, 2003) that psychosis is a biomedical event. However, they also believe there is a need to continue to seek a more holistic, multi-dimensional explanation of psychosis, rather than to constrict it solely to the biomedical dimension.

Robertson and Lyons (2003) analysed women's experiences of psychosis and discovered three main themes: women separating their psychosis from other mental health disorders, believing that it was different; an over-riding sense of loss during this time, and post-psychosis; and how women had to negotiate their social roles and changes to their relationships with others during this time, and the difficulties these caused. The research highlighted the stigma and isolation women felt when going through psychosis, as well as the subsequent pathology placed upon their emotions, once the psychosis was over, which continued the stigmatisation. They highlighted the sense of anger and isolation these women felt suffering from such a rare condition. This caused women to direct their

anger towards health professionals due to the perceived lack of information and support for themselves and their families. More recently, Engqvist et al., (2011) reported similar findings, that women may still be experiencing a sense of abandonment when they go through psychosis.

Heron et al. (2012) interviewed five women on discharge from an in-patient mother and baby unit to address the risk of maternal suicide on discharge. They sought to understand the difficulties the women faced and their experiences of the illness, and to build a picture of support needs. Full recovery from psychosis was viewed as a long and difficult process. The emotional reactions women felt from an episode of psychosis were similar to those found by Robertson and Lyons (2003), particularly in relation to loss. Consistent with the research from Robertson and Lyons (2003), Heron et al. found the women reported a lack of knowledge, information and support from health professionals, and again this was equated with 'lack of power'. This research, although of a small sample size, was in-depth and rich with detail from the women's experiences.

All five studies highlight how women perceived their psychosis, where they believed it originated, how disabling their experiences were, their sense of the 'unspeakable thoughts' they experienced and how this led to them feeling unacceptable, and how isolated and abandoned they felt within their illness. The gap in knowledge both from a biomedical perspective on what causes this illness, and the minimal knowledge of women's experiences would benefit from much broader, deeper studies.

#### 2.2.6 Cultural aspects of perinatal mental illness

Five studies explored cultural aspects of depression (Ahmed et al., 2017; Edhborg et al., 2014; Hanlon et al., 2009; Nahas et al., 1999; Tol et al., 2018). Three focused specifically on postnatal depression (Edhborg et al., 2014; Hanlon et al., 2009; Nahas et al., 1999), while two explored perinatal depression (Ahmed et al., 2017; Tol et al., 2018). These articles also highlight differences in help-seeking barriers to care. However, several studies found cultural implications within their research, even though the research may not have been specifically about cultural aspects (Abrams et al., 2016; Adeponle et al., 2017; Chan & Levy, 2003; Chan et al., 2009; Davies et al., 2016; Gao et al., 2010; Tobin et al., 2018; Wittkowski et al., 2017). In particular, in rural areas within low-income countries such as Bangladesh, Vietnam and Uganda, the experiences of giving birth and mental illness is likely to be quite different to those from high-income countries such as the USA, UK and Canada, where most women give birth in a hospital environment and child birth is not a life-threatening event (Eberhard-Gran et al., 2010). Other aspects are also relevant, particularly for immigrant and refugee women, who have escaped what may have been deleterious conditions

due to war, economic privation, religion or cultural difficulties, and have had to adapt to possibly very different environments in first world countries in Europe, Canada or Australia. Three studies explore the experiences of immigrant or refugee women now living in first world countries (Ahmed et al., 2017; Nahas et al., 1999; O'Mahoney et al., 2012).

Ahmed et al. (2017) explored women's experiences of postnatal depression among Syrian refugees who had recently settled in Canada. Three themes emerged: the lack of understanding of maternal depression, with most of the women believing that this was less prevalent in Syria due to their love of children; the protective factors they believed in regarding their mental health, such as the social support they gained around the birth of the baby and afterwards; and barriers to mental health were stigma and privacy concerns. Almost two thirds of the women screened had symptoms of postnatal depression. However, the majority of women did not disclose symptoms within the study's focus groups, which the authors concluded was due to the negative perception of mental health in Syria. This concurs with research by Abrams et al. (2016), which explored the experiences of giving birth in Vietnam to gauge the relevance and need for a perinatal mental health system. Women in Vietnam did not seem to recognise illness in the same way, and there was a real lack of knowledge both socially and within the health care professionals, particularly as many Vietnamese thought that Western medicine was dangerous, and traditional medicine was an important resource.

Edhborg et al. (2014) explored the experiences of women with postpartum depression in rural Bangladesh. This is an important article, as few such South Asian studies exist. The study discovered that the prevalence of postnatal depression in women in rural Bangladesh is at least as high as in Western countries. This supports other research on the prevalence of postnatal depression, such as epidemiological studies conducted in Sub-Saharan Africa (Aderibigbe et al., 1993; Adewuya et al., 2005; Cooper et al., 1999; Nakku et al., 2006; Nhwatiwa et al., 1998). The experiences of the women in rural Bangladesh differ from those in Western countries because the women and their families were living at the limit of their survival. This caused women to be fearful of their economic and health (in)security, and fear of themselves or their infant dying in childbirth (one third of women in the study reported losing at least one infant in this way). Other factors included intimate partner violence, violence within the family, not being able to give birth in traditional ways, and family difficulties. Women living at the limits of survival were also researched by Davies et al. (2016) who found that the symptoms of depression in women from poor socio-economic conditions in South Africa were directly related to their life stressors (poverty, unemployment, lack of support, abuse, death of a

loved one), concurrent with research by Abrams & Curran (2009) investigating women living in poverty in the USA.

In their research on postnatal mental distress in Ethiopia, Hanlon et al. (2009) discovered the role of cultural dissonance (a difference in the cultural norms of childbirth and the woman's own beliefs and action) as a risk factor in postnatal distress. This was also highlighted by Dressler et al. (2007a; 2007b) and by Gao et al. (2010). Hanlon et al. found it was not considered to be an 'illness' in Ethiopia. This was particularly applied to women experiencing difficulties in participating in cultural 'practises' of childbirth, seen as protective rituals following birth. Other risk factors were poor marital relations, danger of physical harm (with high levels of intimate partner violence which increased during the pregnancy, and sexual violence), economic strain and poverty, and gender disadvantage of the newborn baby, again another area of cultural expectation. Hanlon and colleagues did caution whether there were any relationships between international diagnostic criteria and the distress experienced by postnatal women in Ethiopia.

Nahas et al. (1999) interviewed 45 Middle Eastern women living in Australia to explore their experiences of postnatal depression. They discovered five main themes: loneliness, due to isolation and lack of social support; fear of failure, and a sense of being a 'bad mother'; the inability to cope with the overwhelming cultural traditions of wife and mother; a lack of knowledge about mental illness; and coming to terms with their illness. The authors believed that greater sensitivity was needed from health professionals towards cultural differences, as well as more appropriate interventions, to meet their specific cultural needs. These findings were similar to those of Chan et al. (2009) who compared the differences in experiences of postnatal depression of Hong Kong Chinese women living in Australia, and Australian women. This research found that there was a cultural expectation on the Hong Kong Chinese women from their partner and their mother-in-law, which led to the women feeling trapped and helpless. The Hong Kong Chinese women, however, did not seek help for their perinatal mental illness, unlike the Australian women, who were more likely to ask for help.

Although more focused on experiences than cultural aspects, research in China by Gao et al. (2010) found that the gender of a baby, in addition to the one child policy played a part in a mother's sense of failure. If the baby was female the mother's mental health was likely to deteriorate. This research also identified a dissonance between cultural tradition around motherhood and giving birth, and modernity. In particular, they highlighted the cultural practice of 'doing the month', where mothers were expected to remain at home, lying in bed doing little, whilst others took over the role of looking after the house. Difficulties with



the mother-in-law seemed a common complaint, particularly around dissatisfaction of the baby's gender. Similarly, Adeponle et al. (2017) conducted research in Nigeria and also found that the child's gender caused difficulties and could lead to an increase in perinatal depression. They highlighted cultural aspects such as the gender role definition of women and a woman's position in the household as being contributory factors in a woman's mental health.

Again, limited data exists about cultural experiences of perinatal mental illness, and the part played by gender, religion, culture, spirituality and beliefs, as well as how women escaping from extreme poverty or deleterious conditions cope with their mental health in addition to all the other demands put upon them.

### 2.2.7 Summary

This review of the literature on women's experiences of perinatal mental illness shows there is a minimal amount of literature, much of which focuses on depression and the postnatal period. A large proportion of the literature comes from international studies and the quality of the literature is varied. The international studies are relevant, particularly those that give a more nuanced focus on cultural aspects of perinatal mental illness, which are applicable to the varied cultural and religious differences in the immigrant population within the UK, and in relation to women arriving with refugee status from countries such as Syria, Afghanistan, and north African nations.

Although there is some research on women's experiences of perinatal mental illness, only a limited amount investigates the antenatal period. The research study described in this thesis provides a broader scope, encompassing stress and anxiety, as well as depression over the entire perinatal period. The aim is to provide a greater understanding of how women perceive and experience their mental illness, the possible continuum of that illness, and the women's experiences of symptomatology. This understanding may help enhance treatment relevance and develop treatment procedures that women perceive as meeting their needs. More research is needed into all aspects of women's experiences, covering areas such as distress, stress, anxiety, culture, religion, spirituality, gender, immigration, refugee status, and puerperal psychosis. This research study cannot cover all these aspects of much needed research. In particular, research is needed to explore why so many women believe that mental illness would be a primary cause for health professionals to take their infant away (David et al., 2011; Diaz-Caneia & Johnson, 2004; Rampou et al., 2015; Thomson & Fudge, 2005), although there is evidence that custody loss can be frequent for women with severe mental ill health (Diaz-Caneia & Johnson, 2004; Dipple et al., 2002). In the UK a child protection order would be made if a

local authority deemed that a child was at risk of significant harm (Section 3 of the Children Act, 1989 - England & Wales).

### **2.3 The review on psychological treatment options**

This section of the literature review provides context for treatment options currently available to women experiencing perinatal distress. This review does not seek to report on effectiveness of treatment, although as the articles are predominantly of a quantitative nature, nearly all of them do report on their effectiveness, so this has been included within the table of literature in Appendix 3. The review aims to answer four main questions:

- a) What psychological therapies are currently used in the treatment of depression, stress and anxiety within the perinatal period?
- b) At what specific diagnoses are therapies aimed?
- c) Are therapies aimed at specific time periods (antenatal, postnatal)?
- d) How are these psychological treatments being delivered: by whom, with what training, for what length of time, and in what mode (group or individual).

A comprehensive, systematic approach to the literature review of research studies from 1998 to December 2017, was conducted using CINAHL, PsycINFO (Ovid), MEDLINE (EBSCO, OVID), Cochrane Library, PUBMED, Science Direct and Academic Search Premier databases. These databases are primary sources of research for counselling and psychotherapy and were chosen because of this. The keywords used in the search were: women, reduction, antenatal, postpartum, postnatal, perinatal, depression, stress, anxiety, treatment, intervention, counselling, psychotherapy, qualitative, quantitative, mixed method. Although the term “counselling” has not been used within this study, as it focuses on psychotherapy, counselling has been included within the keyword list. Regardless of the continued disagreement on the differences and similarities in psychotherapy and counselling, the terms can often be used interchangeably and therefore to remove counselling as a keyword may result in a limited and narrow literature review. More important is whether a woman received benefit from her interaction with her counsellor/therapist. Due to the initial lack of data found in the search criteria, reference lists from the articles searched were subsequently used to identify influential authors in the field of perinatal mental health. These authors were those who had written at length about the subject and whose work was often cited.

As the potential literature in this area is large, certain inclusion/exclusion criteria were used (see Table 2.1 below).

Pharmacotherapy treatments were excluded because this research study concentrates specifically on psychotherapeutic treatment. Articles on adolescent pregnancy and birth have been excluded because psychotherapists who would offer such treatment strategies would be specifically trained for such an age group, as stated within section 1.8 above.

**Table 2.1: Psychological Treatment Options - Inclusion and Exclusion Search Criteria**

<b><u>Inclusion Criteria</u></b>	<b><u>Exclusion Criteria</u></b>
Worldwide research	Diagnoses other than perinatal stress, anxiety and depression
Quantitative research	Studies published prior to 1998
Qualitative research	Pharmacotherapy treatments
Psychotherapy delivered by a professional psychotherapist or psychologist	Psychological intervention delivered by midwife, health visitor or nurse
Counselling delivered by a professional counsellor	Non peer reviewed research
Women’s experiences of psychotherapy or counselling for the treatment of depression, stress and/or anxiety	Adolescent pregnancy and birth
Peer reviewed research	Substance Abuse
Mental health conditions in the perinatal period (apart from puerperal psychosis)	Birth trauma
Systematic Reviews	
Meta-analyses	

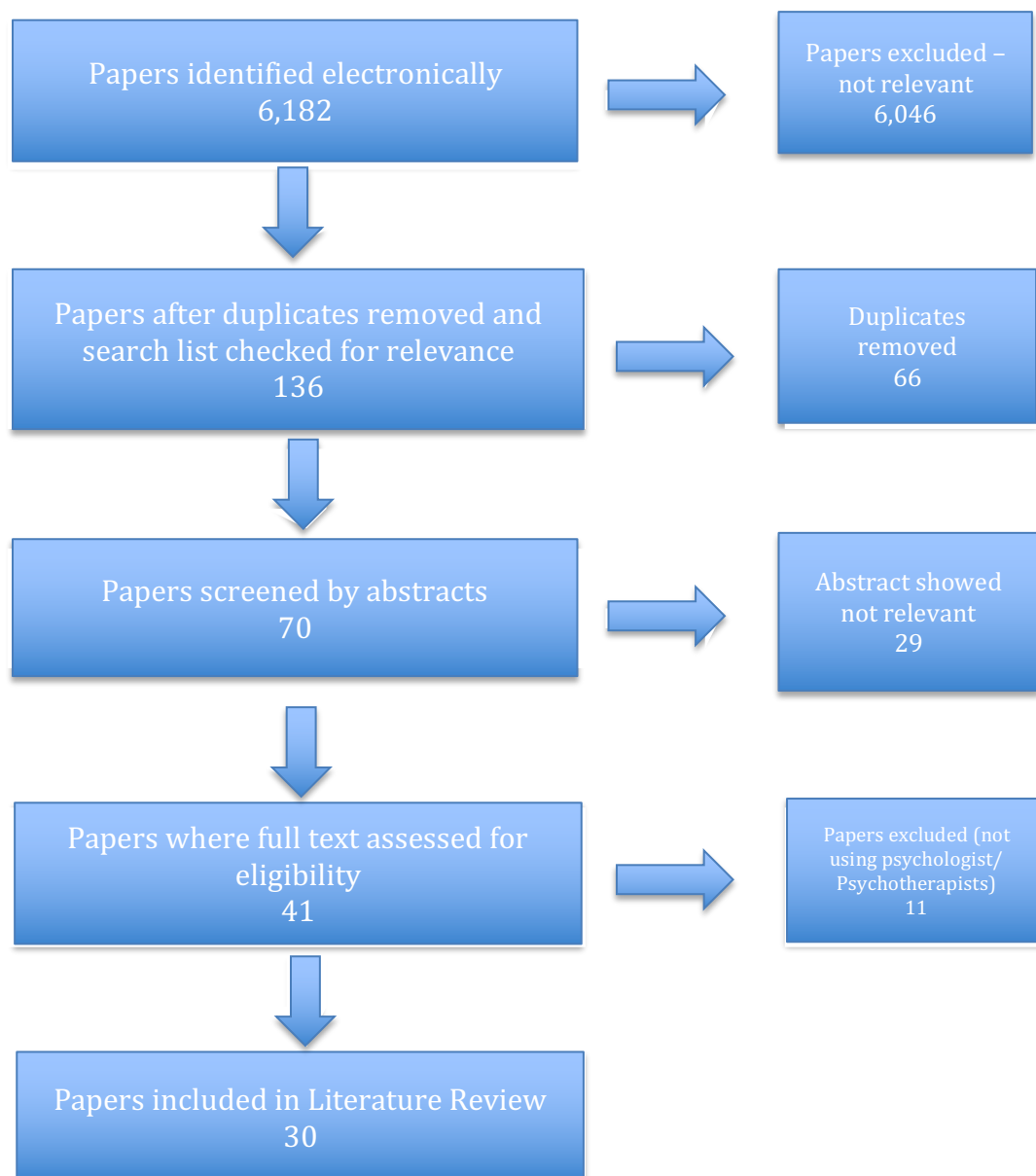


Figure 2.2 Flow chart showing search procedure for psychological treatment options

### 2.3.1 Results

The search resulted in 6,182 articles from the eight databases. Duplicated articles were excluded, and inclusion criteria applied leaving 30 articles. The flow chart for the search procedure is outlined in Table 2.2. Studies were only included if the treatment was delivered by professional psychotherapists, or counsellors. Some qualitative research studies were found, but were omitted

because the therapy was given by doctors, nurses, health visitors or midwives and as such would be seen as having 'listening skills'. However, the papers were searched in case those health practitioners had a professional qualification in counselling or psychotherapy, in which case the study was included. Counselling and psychotherapy are professional qualifications, and it was not viewed as an appropriate comparison to include studies whereby the treatment provider was not professionally qualified.

The 30 articles reviewed were all quantitative in design. This shows a lack of qualitative research on psychotherapy for the treatment of perinatal depression, stress and anxiety and clarifies the importance and uniqueness of the present study. Two qualitative articles were found (O'Mahen et al., 2012; Scope et al., 2012), but only one fitted the inclusion (O'Mahen et al., 2012). Scope et al. (2012) performed a systematic review on women's perceptions and experiences of group CBT and other group interventions for postnatal depression. However, as all the interventions in their systematic review were support groups led by health practitioners, such as nurses, or health visitors, this review was excluded. O'Mahen et al. (2012) sought to gain women's views on ideal treatment for CBT. This research is included within the section on CBT.

Of the 30 included articles (see Appendix 3) 18 looked solely at treatment in the postnatal period, and of these, 13 investigated the treatment of postnatal depression only. None of the articles stipulated stress within their research criteria, although one article (Fonagy et al., 2016) used the term 'mental health conditions' within their criteria. Seven articles (Bittner et al., 2014; Bowen et al., 2014; Burns et al., 2013; Dornelas et al., 2010; Milgrom et al., 2015; Spinelli et al., 1997; Weidner et al., 2010) looked at treatment in the antenatal period, of which three were solely on depression (Burns et al., 2013; Dornelas et al., 2010; Spinelli et al., 1997). Five articles explored the perinatal period (Green et al., 2015; Grote et al., 2009; Moayedoddin et al., 2013; Nanzer et al., 2012; O'Mahen et al., 2013), three of which were interested only in depression (Grote et al., 2009; Nanzer et al., 2012; O'Mahen et al., 2013). This shows that a substantial proportion of research into psychotherapy or counselling as a treatment option for perinatal mental health conditions is focused on the postnatal period, and mainly on depression. This highlights the substantial gaps in research into stress, regardless of the time period in which it occurred. It also shows gaps within the research of depression and anxiety, in a co-morbid existence, in the perinatal period. This demonstrates a need for research to include the whole perinatal period as well as the wider range of conditions, including stress, as is the focus within this study.

Several of the included studies showed mixed results regarding the effectiveness and usefulness of counselling and psychotherapy in the perinatal period. The research into CBT showed that either it was not efficacious (Bittner, et al., 2014),

showed inconclusive results (Austin et al., 2007; Barlow et al., 2015; Burns et al., 2013), or at very best was found to be 'feasible' (O'Mahen et al., 2012). This is important and provides a rationale for searching for alternative psychotherapeutic treatments. There was also clear agreement, even with limitations such as publication bias of several studies, that there was a dearth in the literature about pregnancy or stress and anxiety. Clearly, more research is needed regarding treatment of all types. This study will make a significant contribution.

The evidence in this review has been synthesised according to psychological therapy, presenting information on the mode of delivery, specific time period of the treatment (antenatal, postnatal or perinatal), target illness (stress, anxiety and/or depression) and its effectiveness, as well as the treatment delivery format (group or individual). The purpose of this part of the review was to determine what research exists, and what therapies have been investigated. As all the studies were quantitative and therefore different in design compared to this research study a full critical appraisal of each study was not undertaken. Study design (such as meta-analysis or randomised trial) was used as an indicator of the quality of the study.

### 2.3.2 Counselling and psychotherapy treatment modalities

Eight distinct treatment modalities of psychotherapy have been researched for postnatal depression primarily. The four most commonly-researched modalities, CBT, Interpersonal Therapy, Psychodynamic/Psycho-analytic Therapy, and Parent-Infant Psychotherapy, are detailed below. The other four modalities were the subject of single research studies or pilot trials and their evidence base is limited. They have been grouped together in a paragraph at the end of this section.

#### Cognitive Behavioural Therapy

CBT is primarily a treatment for depression. It is based on the premise that how you think (about yourself, the world, and others) directly affects how you behave. By modifying these distorted thinking patterns, clinicians believe they can help patients to make behavioural changes to reduce stress and depression. However, evidence for the efficacy of CBT for depression during the perinatal period is mixed. Two systematic reviews (Dennis & Hodnett, 2007; Scope et al., 2012) and a meta-analysis (Cuijpers et al., 2008) on CBT have been completed. Dennis & Hodnett (2007), and Cuijpers et al. (2008) report mixed evidence of efficacy, while Scope et al. (2012), in their systematic review of six studies of group CBT, concluded it is effective despite the evidence being limited and of poor quality. These studies' conclusions make it difficult to determine whether

CBT is helpful or not. Ten articles (other than the three reviews described above) were identified. Seven articles investigate CBT as a standalone treatment option (Austin et al., 2007; Bittner et al., 2014; Burns et al., 2013; Green et al., 2015; Milgrom et al., 2005; Milgrom et al., 2015; O'Mahen et al., 2012). Two articles examine CBT in comparison with other types of psychotherapy or counselling (Cooper et al., 2003; Pinheiro et al., 2014). One article combines CBT with systemic family therapy (Hou et al., 2014). Austin et al. (2007) and Bittner et al. (2014) found that CBT was not efficacious (Austin et al., 2007), or was no more effective than a control group (Bittner et al., 2014).

CBT is often given in a group therapy format, although this is not recommended in CBT guidelines. Bittner et al. (2014) evaluated a group CBT programme specifically for antenatal women. Although their results showed the group programme did not have an impact on the total sample of pregnant women, they did find an effect three months postpartum for those women whom had significantly greater symptoms of depression in their first trimester of pregnancy. They concluded the participants could have learned strategies during pregnancy that might have been applicable postpartum. However, the results did not show general efficacy of a CBT group programme for pregnant women with low levels of anxiety and depression. Cooper et al. (2003) completed a study on the efficacy of CBT, psychodynamic therapy, and non-directive counselling against routine primary care. CBT was found to be slightly more effective than routine primary care in reducing postpartum depression, but not as effective as psychodynamic psychotherapy. Pinheiro et al. (2014) looked at the maintenance of the effects of manualised CBT and relational constructivist psychotherapy for postpartum depression. They found that there was a significant reduction in depression for both therapies and that this was maintained for 12 months post-intervention (Pinheiro et al., 2014).

CBT has been used in conjunction with other therapies, and one study has been included in this literature review (Hou et al., 2014). Hou et al. researched the efficacy of combining CBT with systemic family therapy as a treatment for mild to moderate postpartum depression, finding that short-term (three-month) therapy improved depression symptoms.

Evidence from the articles reviewed demonstrates CBT is not being used to treat women with stress in the perinatal period, although three separate articles reported on CBT as a treatment for anxiety (Austin et al., 2007; Bittner et al., 2014; Green et al., 2015). Of these, one investigated group CBT as a suitable treatment for postnatal depression with anxiety (Austin et al., 2007), one article researched group CBT for antenatal depression with anxiety (Bittner et al., 2014), and one reviewed group CBT for the treatment of perinatal anxiety (Green et al., 2015). Both Austin et al. (2007) and Green et al. (2015) found a

significant improvement in anxiety after CBT. Bittner et al. (2014), however, found no intervention effects on anxiety.

O'Mahen et al. (2012) qualitatively investigated CBT as a treatment for perinatal depression. The authors asked 23 pregnant women in the United States how CBT could be enhanced to make it more relevant and acceptable by eliciting their desired content of the treatment (O'Mahen et al., 2012). The three dominant themes were self, motherhood and interpersonal. The authors wanted to integrate these themes into CBT to make it more relevant, as previous research showed sub-optimal outcomes for CBT (Cuijpers et al., 2008; 2010). The research highlighted areas not present within CBT, such as the role of interpersonal strategies, the rigid views held about motherhood, and facilitators to enhance women's ability to seek help and support.

### Interpersonal psychotherapy

Evidence on the efficacy of interpersonal psychotherapy (IPT) is most prevalent in studies about perinatal depression. Three recent meta-analyses confirm this (Bledsoe and Grote, 2006; Sockol et al., 2011; Claridge, 2014).

Bledsoe and Grote (2006), and Sockol et al. (2011) looked specifically at IPT, whereas Claridge (2014) included systemically oriented psychotherapy as well as IPT within her synthesis. Bledsoe and Grote (2006), and Sockol et al. (2011) both conclude their findings indicate the superiority of IPT over CBT as a treatment for perinatal depression. However, Claridge (2014) found that results of combined IPT and relational interventions were the same as treatment by medication or by CBT alone. These meta-analyses have been marked blue within the table in Appendix 3.

As both CBT and IPT are short-term, time-limited therapies it is appropriate to compare and contrast them. However, IPT does not address the cause of psychiatric illness, it only addresses the symptoms, therefore its effectiveness for alleviating subsequent mental illness in future pregnancies is unknown. The long-term effectiveness is also not clear. There is data supporting its use as a group therapy (Klier, et al., 2001; Reay et al., 2006; Mulcahy et al., 2010). However, Klier et al. (2001) and Reay et al. (2006) reported high attrition rates in group therapy, particularly with those women who reported higher initial levels of symptoms. IPT as a group therapy may have advantages such as cost, increased social support, a reduction in stigma, and a normalising effect for the group participants. It may actively enhance interpersonal skills within the group due to modelling, and can include partners in the therapy as it is an interpersonal therapy. Therefore, it could be an effective method for treating depression in the postpartum period (Stuart, 2012). However, caution is needed,



as all the group IPT studies included here used only self-report questionnaires, or objective measures to determine treatment efficacy. No long-term research was performed and group IPT showed high levels of attrition.

Eight IPT studies fitted the inclusion criteria (Beeber et al., 2013; Bowen et al., 2014; Dennis et al., 2007; Grote et al., 2009; Klier et al., 2001; Mulcahy et al., 2010; O'Hara et al., 2000; Reay et al., 2012). All eight examined depression with two also including anxiety (Beeber et al., 2013; Bowen et al., 2014). Two articles researched depression only in either the antenatal period (Dennis et al., 2007) or the perinatal period (Grote et al., 2009). The other six articles researched postnatal depression. IPT was deemed to be efficacious at treating depression in all articles apart from Dennis et al. (2007), which stated the results as inconclusive.

### Psychodynamic/psychoanalytic therapies

Three studies on psychodynamic/psychoanalytic therapy were included in this review (Cooper et al., 2003; Kurzweil 2008; Kurzweil, 2012). Kurzweil (2008) researched group psychotherapy for postnatal depression, and compared outcomes of group, individual and a combination of the two for postnatal depression (2012). They found significant improvements after treatment for all client groups. Cooper et al. (2003) conducted a controlled trial on routine primary care compared to CBT, non-directive counselling or psychodynamic therapy for postpartum depression. In this study only psychodynamic therapy showed a rate of reduction significantly superior to routine primary care (Cooper et al., 2003). The conclusion from these studies is that psychodynamic/psychoanalytic therapy is suitable for this client group and efficacious, particularly when provided on an individual basis.

Psychotherapy centred on parenthood, a brief intervention delivered by highly trained and experienced psychoanalytic psychiatrists or psychologists in a psychiatric setting, is also relevant in this section. This intervention has been developed and based on the Geneva mother-infant psychotherapeutic model (Cramer, 1998). There are two studies on this type of psychotherapy, a pilot study (Nanzer et al., 2012) and a follow up study to assess the effect of psychotherapy on the mothers' symptoms of depression and anxiety (Moayedoddin, et al., 2013). Both studies, although small (Nanzer studied 40 women, Moayedoddin studied 23) suggest psychotherapy resulted in a high rate of clinical and functioning improvement. Also relevant in this section is research on mother-infant group psychotherapy (de Camps Meschino et al., 2016), which showed promising preliminary results. However, this used a small sample (13 women).

All the studies based on parenthood appear similar to Parent Infant Psychotherapy (see below), and may indeed be the same phenomenon, delivered in a different country, and translated slightly differently.

### Parent-Infant psychotherapy

Parent-Infant psychotherapy (PIP) is a psychodynamic intervention designed to enhance the parent-infant relationship and improve infant attachment security. It was designed by Selma Fraiberg (Fraiberg, 1980) as a response to the recognition of how common parent-infant relationship difficulties were. PIP has been developed by Lieberman et al. (1991) and by Toth et al. (2006). The intervention lasts between five and 20 weeks and is designed specifically for infants under two years. PIP is not specifically designed for the treatment of perinatal mental illness. However, a Cochrane review assessed the effectiveness of PIP in improving both parent and infant mental health among other outcomes (Barlow et al, 2015) and found no significant difference between PIP and the control groups when assessing a) parent mental health, namely depression, b) parent-infant interaction.

In contrast, a more recent randomized controlled trial (RCT) by Fonagy et al. (2016) concluded the opposite, finding PIP to be potentially beneficial at reducing maternal mental health and parenting stress at the end of treatment and at six and 12 month follow up. In this RCT, 'mental health' included depression, stress and anxiety (Fonagy et al., 2016) and suggests that PIP impacts the emotional well-being of mothers.

### Other therapies

A small number of other therapeutic approaches have also been researched, but the evidence base to date is limited. They have been included in the table in Appendix 3. These therapies were psychosomatic therapy (Weidner et al., 2010), meta-cognitive therapy (Bevan et al., 2013), relational constructivist psychotherapy (Pinheiro et al., 2014), and eclectic mixes of different styles of psychotherapy (Clark et al., 2008, Muzik et al., 2015). These studies used small samples, or were pilot trials. None of these different approaches have had more than one research study to assess their efficacy or their acceptability.

### 2.3.3 Discussion

The literature currently available shows that the majority of research has been targeted towards postnatal depression. Although there is not extensive research into psychotherapy treatment for mental health conditions in the perinatal period, the existing research shows that psychotherapy, of any type, offers a

form of treatment that could be perceived by women as preferable, particularly during pregnancy and with breast-feeding mothers. It also shows that the type of therapy is not necessarily important, as all types seem to be efficacious when researched against treatment as usual/pharmacotherapy. This agrees with research showing that the modality of treatment is not necessarily important in the outcome for depression in adult mental health (Barth et al., 2013; Linde et al., 2015). Interventions found most effective are either psychodynamic or psychoanalytic psychotherapy, and IPT, as well as other models that address relationship issues as a primary part of their intervention model. In particular, one-to-one psychotherapy rather than group therapy is shown to be more preferable to women, as well as being more effective. This has economic implications for treatment delivery, as one-to-one psychotherapy is more costly than group psychotherapy.

There is a significant gap in the research on psychotherapy and counselling as a treatment option for perinatal stress, anxiety and depression. A substantial gap exists in qualitative research on psychotherapy as a treatment option, as there was only one article available. To date much of the existing research has focused on the postnatal period and on depression only. This leaves a gap in the antenatal period, and also ignores the conditions of stress and anxiety. Yet, research shows that anxiety is more prevalent than depression (Britton, 2008; Faisal-Curry & Menzes, 2007; Rubertsson et al., 2014). A great deal of the literature so far is based only upon quantitative research. This quantitative data comes mainly from data gathered from medical-type questionnaires such as the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987) or Generalised Anxiety Disorder Scale (GAD-7) (Spitzer et al., 2006) that are able to give a snapshot view of a particular woman at a particular time. Quantitative techniques can test the outcome of the treatment option, i.e. does it work, and by what percentage. This type of research is from a bio-medical perspective, measuring incidence, risk, and objective treatment outcomes. However, although useful, this evidence could be enhanced and supplemented by qualitative data to provide the depth of understanding and information gained through the subjectivity of women who are experiencing this condition and are also experiencing psychotherapy as a treatment intervention.

The lack of qualitative research into psychotherapy as a suitable intervention is striking. Psychotherapy is relational, the relationship between therapist and client being fundamental to the success of psychotherapeutic treatment. It is also a narrative relationship, meaning that it is formed dialogically. Maternal mental health occurs within a relational paradigm, mother and fetus/infant. Yet quantitative research effectively eradicates the breadth and depth and the awareness of the voices of the mother, infant and therapist. Those voices are fundamental, if treatment options are to be constructive, effective and acceptable

to the client, rather than only to the medical profession. Quantitative research might inform whether a treatment does or does not work, however it removes the patient voice, silencing their experiences of the treatment, relying instead on a set of finite questions to elicit categorized, forced-choice responses with little room for open-ended replies to questions (Jackson et al., 2007). One possible reason for the dearth of qualitative studies in favour of quantitative studies could be the dominance of psychology rather than psychotherapy and counselling.

The prevalence of stress in the UK is reported as between 14% and 17% (Craig et al., 2009). Psychotherapeutic treatment for stress during the perinatal period is rarely researched either in its own right, or as part of a wider research agenda including depression and/or anxiety. This could be explained by the lack of recognition of and breadth of perinatal mental health conditions, which in turn would have an impact on research in this area. Yet, it is also well-established that pregnancy and motherhood can be a time of considerable stress for some women (Buist, et al., 2006; Miller et al., 2006). Therefore, research into psychotherapy as a suitable treatment for stress in the perinatal period is urgently needed. Further research would help pinpoint which condition - depression, stress or anxiety - seems to have the earliest onset. Furthermore, it could provide insight as to whether these conditions are on a continuum of symptoms, and whether any are a precursor to puerperal psychosis. Such investigations are outside the scope of this thesis. However, such research would help clinicians to target specific conditions at specific time-points within the perinatal period.

#### **2.4 Review on TA psychotherapy for depression and anxiety**

There is no data available on TA psychotherapy as a treatment for perinatal depression, stress and/or anxiety. As perinatal mental illness is such an impactful and prevalent condition, it is important that treatment addresses the particular needs of these vulnerable women. It is also important to recognise that the psychotherapeutic treatment already benefits from a body of evidence for its use for depression, stress and anxiety within adult mental health. Additionally, the small but recent literature on the use of TA psychotherapy is expanding, both as a treatment option for depression (see: Benelli et al., 2016; 2017; van Rijn, & Wild, 2013; 2016; van Rijn, Wild, & Moran 2011; Widdowson, 2011; 2012; 2013; 2014; 2015) and for anxiety and depression (van Rijn & Wild, 2016; van Rijn, Wild & Moran, 2011; Widdowson, 2014). This provides a prima facie case to suggest TA may also be effective for perinatal distress. TA also has an archive of research covering its usage to treat a wide variety of mental health conditions, such as schizophrenia (Golovan, 2015), attachment disorders (Baba Neal, 2017; Perret, 2017) addiction (Dmitri et al., 2016; Shorrocks, 2015) and

Post Traumatic Stress Disorder (PTSD) (Harford, 2013; Harford & Widdowson, 2014).

The purpose of this review is to determine the research that already exists within TA Psychotherapy for the treatment of depression, stress and anxiety. The evidence was searched in two separate ways:

- i) manual search of two separate publications, both primary sources of published research material on TA, the Transactional Analysis Journal (TAJ) and the International Journal of Transactional Analysis Research & Practice (IJTARP). Fourteen articles were located using this search, shown in Table 2.4.
- ii) database search using the terms ‘transactional’, ‘analysis’, ‘depression’, ‘stress’, ‘anxiety’, ‘treatment’, ‘psychotherapy’, ‘counselling’, through the databases CINAHL, PsycINFO (Ovid), MEDLINE (EBSCO, OVID), Cochrane Library, PUBMED, Science Direct and Academic Search Premier databases. No articles were located in this search.

All research article abstracts were read thoroughly to determine whether the article was about TA psychotherapy or something different.

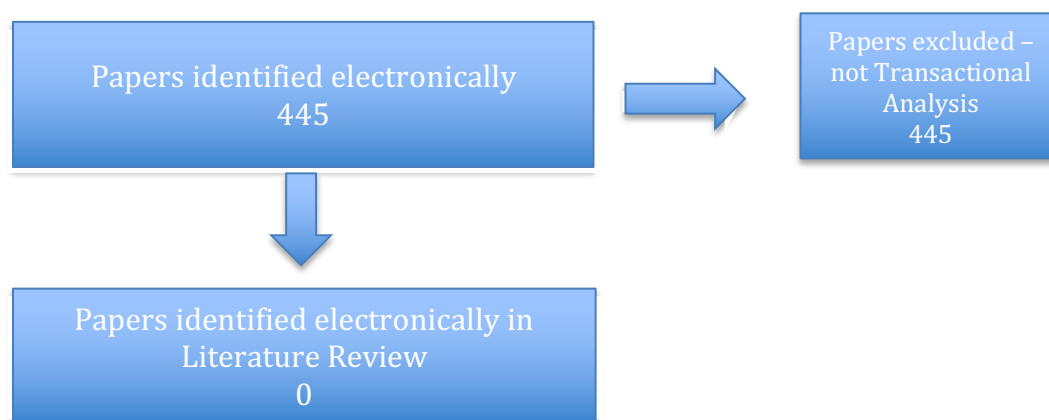


Figure 2.3 Flow chart showing search criteria used for TA research articles

The earliest research study located is from 2011, indicating the literature into TA as a treatment for depression, stress, and/or anxiety is relatively recent. Of the 14 studies included, one studied anxiety alone (Gentelet & Widdowson, 2016). No studies focused on using TA psychotherapy as a treatment for stress. All the studies investigated treatment for depression. Four investigated treatment for anxiety and depression. Of the 14 studies, 11 studies used a single case study design while three used a naturalistic enquiry style. The end-date of this review was December 2018.

Of the 11 single case studies, all apart from one (Widdowson, 2013) found TA to be a successful treatment. This one study was considered a ‘mixed outcome’ case, meaning that the client showed improvement over the course of therapy, but this was not sustained when they faced a stressful life event at follow up.

Table 2.2 TA research studies on the treatment of depression and/or anxiety

Publication	Author(s)	Style of Research	Year	Depression, Stress or Anxiety
IJTAR	Benelli et al.	Hermeneutic Single-Case Efficacy Design (HSCED) – Anna	2017	Depression
IJTAR	Benelli et al.	HSCED – Caterina	2017	Depression
IJTAR	Benelli et al	HSCED - Deborah	2017	Depression
IJTAR	Benelli et al.	HSCED - Penelope	2016	Depression
TAJ	Gentelet & Widdowson	A Systematic Adjudicated Case Study	2016	Anxiety
IJTAR	Benelli et al.	HSCED - Luisa	2016	Depression
TAJ	Van Rijn & Wild	Naturalistic Enquiry	2016	Anxiety & Depression
IJTAR	Widdowson	Pragmatic Adjudicated Case Study - Alastair	2014	Anxiety & Depression
TAJ	Van Rijn & Wild	Naturalistic Enquiry	2013	Anxiety & Depression
IJTAR	Widdowson	HSCED - Linda	2013	Depression
IJTAR	Widdowson	HSCED - Denise	2012	Depression
IJTAR	Widdowson	HSCED - Tom	2012	Depression
IJTAR	Widdowson	HSCED - Peter	2012	Depression
IJTAR	Van Rijn, Wild & Moran	Naturalistic Enquiry	2011	Depression & Anxiety

#### 2.4.1 A critique of the research into TA psychotherapy for depression and anxiety

Of the articles listed in Table 2.2, nine used Hermeneutic Single Case Efficacy Design (HSCED). This is a style of mixed method study designed by Robert Elliott (2001; 2002; Elliott et al., 2009) which integrates both quantitative and qualitative research in a comprehensive way. HSCED uses a variety of data collection and monitoring tools, to monitor the participant's progress throughout the course of therapy. A systematic case study is then formed which is adjudicated by an independent panel of judges cross-examining the data, developing an argument for any change in the participant, resulting from psychotherapy treatment. This use of an independent panel enhances rigour and reduces the potential for researcher allegiance. Although each study examines only one therapy, each goes to considerable depth and breadth in its use of data collection tools at specific time points both within the therapy, and afterwards. Therefore, this type of case-study research is argued by Elliott and co authors to be able to meet criteria for being an established, empirically-supported, rigorous and efficacious therapy. This style of research accounts for all aspects of the therapy including the context of the client, the therapy and a range of other factors, which might impact upon the outcome of a case. Its use of an independent panel of judges to adjudicate the outcome in a team-based approach allows for a conclusion of 'mixed outcome' (Widdowson, 2013) to be reported. This helps to enhance understanding of why therapy may have been less successful within a particular area, but also gives a detailed analysis of the entire therapy. This is a useful and positive outcome of the research that could deepen the interpretation of the case, as well as enhance the knowledge and skillset of practitioners.

The system of adjudication with a panel of non-TA experts was also used in Gentelet & Widdowson (2016), and Widdowson (2014). This research was not HSCED. However, one was a systematic case study review (Gentelet & Widdowson, 2016), the other a pragmatic adjudicated case study (Widdowson, 2014). Both were based on pragmatic case study designs (McCleod, 2010). This research used a number of assessment instruments throughout the therapy, as well as at three, six, nine months and 12 months follow up. In this respect the research used a process similar to HSCED.

Three studies were based on a naturalistic enquiry style (van Rijn, Wild & Moran, 2011; van Rijn & Wild, 2013; 2016). One of the studies (van Rijn, Wild & Moran, 2011) replicated a Routine Outcomes Evaluation study which evaluated the design associated with the UK NHS IAPT initiative (CSIP 2008, NHS 2011) used to assess CBT in primary care. This study used standard outcome measures (e.g. CORE 10 and 34; CORE 2007) as well as measurements of the working alliance

(WAI Horvath, 1986) and an additional depression inventory, BDI-II (Beck, 1996). Another of the studies (van Rijn & Wild, 2016) compared TA group and individual psychotherapy for the treatment of anxiety and depression. This was a Routine Outcomes open-label trial in a clinical setting, with limited randomization and no control group to evaluate the effectiveness of group compared to one-to-one therapy. The results found a reduction with a significant effect in both depression and anxiety. No significant differences were found between group and one-to-one therapy. The final naturalistic enquiry (van Rijn & Wild, 2013) was again focused on the treatment of depression and anxiety, evaluating different types of humanistic and integrative therapies including TA and Gestalt psychotherapy, and Integrative Counselling Psychology, and Person-Centred Counselling. Routine outcome evaluation with standardized measures was used to assess treatment outcomes and working alliance. The research determined a high rate of improvement in all clients engaging in a particular treatment style. Outcomes showed no difference in effectiveness between theoretical approaches, which is supported by the evidence of common factors research and meta-analytic research (Lambert & Ogles, 2004; Wampold, 2001).

TA research appears to focus heavily on a unique style of research, HSCED. This may be because research in TA is in its infancy, and with time a broader range of study design may be forthcoming. The predominance of HSCED could also be due to the emphasis on evidence-based research within the NHS, and the recognition that without some research basis TA will struggle to survive as a professional psychotherapy style anywhere other than within the private sector.

## **2.5 Conclusion**

The literature presented in this chapter shows that many women still say they are remaining silent about their mental ill health and are not asking for help in the perinatal period. Unfortunately, as yet we do not know the proportion of women who remain silent. Also, women who do ask for help do not seem to remain engaged with their treatment. There is also little research into suitable therapies for women with mental illness in the perinatal period, conceivably due to protectionist policies leading to the exclusion of 'the vulnerable' from research (Rogers, 2014). This lack of research into treatments in pregnancy is recognised, as are the consequences: undertreatment or unknown or possibly unsafe treatments (Lyerly et al., 2008). It is possible that barriers to treatment hold the key to firstly engaging women to ask for help, and keeping them engaged within treatment. This will be one of the objectives of this study.

This review demonstrates there is some qualitative research on women's experiences of perinatal mental illness. However, there is a paucity of qualitative



research on psychotherapy as a treatment for perinatal mental illness, although a small amount of quantitative research exists. Women say they would prefer psychotherapy as a treatment, yet it would appear that no research has sought to hear women's views on this type of treatment, its acceptability to them and their sense of its efficacy. This literature review highlights that the majority of the existing research on psychological therapy as a treatment is quantitative in nature and often focuses on postnatal depression; only a small section of the research includes treatment for anxiety as well as depression. This confirms that the majority of research, regardless of the research topic, is aimed at depression and only in the postnatal period. A small amount of research exists about the antenatal period, and even less research covers the entire perinatal period. There is virtually no research on stress, neither the prevalence of it nor the treatment of it within the perinatal period. Arguments for including stress as a condition within this period were explored in section 1.2. This review confirms that women perceive stigma and shame as significant barriers to treatment, which lead women to silence themselves, or to feel silenced, constricting their help-seeking behaviours. Another primary barrier to treatment is shown to be the women's perception of the treatment's relevance. These barriers will be explored more fully within this study. This study also seeks to widen the scope of knowledge, by seeking to hear women's experiences about perinatal distress, not only postnatal depression.

This study seeks to begin to fill the gap in research for TA for perinatal mental illness. It is difficult to use a style of psychotherapy that has little or no research on its efficacy, and it may be considered by some to be unethical. Yet, TA has been used as a treatment for mental disorders for many years, and to treat perinatal mental illness by some clinicians for several years, albeit with no supporting research. The research base needs to begin somewhere, and this study aims to add to the small base that is beginning to accumulate, and aims to extend the breadth of TA usage.

There is little literature available on qualitative research into psychotherapy as a treatment for any kind of antenatal or postnatal mental illness. Neither is there research on TA psychotherapy as a treatment option, and little research covers the entire perinatal period, yet it is well-established that psychotherapy treatments have positive effects for depression in pregnancy and the postpartum (Claridge, 2013).

Therefore, this study seeks to provide qualitative evidence by listening to the perceptions of women, regarding their illness and its treatment. It extends the scope of research to include the entire perinatal period, and includes stress and puerperal psychosis, as well as depression and anxiety within its criteria. The research seeks to give women an opportunity to express their individual

experiences of this particular type of psychotherapeutic treatment, where previously there has been little or no client voice.

The objective is to address these gaps in research by:

- Including the entire perinatal period
- Including mental health conditions such as stress and anxiety as well as depression and puerperal psychosis
- Addressing the lack of qualitative research
- Addressing the gap in TA research
- Addressing the gap in research reporting on women's experiences and perceptions of psychotherapeutic treatment
- Adding to knowledge of prior mental health conditions in relation to perinatal mental health

## **2.6 Aims and Objectives**

This qualitative narrative research will explore the client's experiences of their perinatal mental illness and their TA psychotherapy treatment. The primary aim is to gather qualitative evidence about clients' experiences of TA psychotherapy treatment, where previously the client's voice has been missing. Exploring the experiences of their perinatal mental illness will give context to the exploration of their psychotherapy.

The objectives are:

- to ascertain women's experiences of the treatment
- to increase understanding of the barriers to treatment
- to explore the factors which women express as facilitative in their engagement and compliance with treatment, particularly in relation to different time points
- to gain greater understanding about prior mental health conditions and what part these play a part in a woman's perinatal mental ill health

## CHAPTER 3 Methodology

### 3.1 Research Paradigm

Guba & Lincoln (1994) define a paradigm as *“the basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways”* (p 105). Schwandt (2001) states that a paradigm represents the *“commitments, beliefs, values, methods, outlooks and so forth shared across a discipline”* (p 183).

Guba (1990) states that research paradigms can be characterised by:

Ontology - the nature of reality  
Epistemology - the ways of knowing

leading to the appropriate:

Methodology - the way of finding this out

This research study is qualitative, involving human subjects and axiology (ethics and value systems). The ethical principles of the study are presented in section 4.9.

A qualitative pluralistic methodology has been used to address the aims and objectives of this study (Section 2.6). In this instance, qualitative research facilitates an exploration of the experiences of women, from their personal perspective. The research paradigm is constructivist/interpretive, with an inductive approach, and an ontological assumption of multiple competing realities that need interpretation, with no single reality or truth to be measured or known. The epistemology is multi-faceted: reality needs to be interpreted, and knowledge is constructed subjectively by people and groups; women are socially constructed within cultural and historical discursive practices (Bloom, 1998); and women’s lives can be the primary sources of data. The philosophies underpinning the research are therefore Feminism and Social Constructionism. These will be explored in more detail from section 3.3 onwards.

### 3.2 The value of qualitative research for psychotherapy

Qualitative research does not rely on numeric data, rather it is an exploration of meaning as data, in its many and varied forms (texts, narrative, visual, conversation, discourse, nature, creativity). The aim and function of this type of research is to understand the meaning of human ‘being’ and ‘action’

[apostrophes my own] by describing the essential characteristics of human experience (Denzin & Lincoln, 2000). Slife and Gantt (1999) recommend this type of research because '*Qualitative methods are a highly rigorous defensible means of gaining insight into psychology generally and psychotherapy specifically*' (p 1458).

Quality and outcome of psychotherapy is, in its very nature, subjective and may be difficult to evaluate by using purely quantitative methods. Quantitative research is useful to psychotherapy as a means of measuring effectiveness, through outcome and process studies, or for comparing different modalities of therapy. This can be seen with the continuing research on comparing and contrasting therapies, particularly CBT and Interpersonal therapy, combined often with antidepressant medication (see the National Institute of Mental Health Treatment of Depression Collaboration Research - Elkin, 1994; Elkin et al., 1985; 1989; Shea et al., 1992). Similar studies also exist in the treatment of perinatal mental illness, reported in Chapter 2 (Bowen et al., 2014; Cooper et al., 2003; Pinheiro et al., 2014), and particularly two meta-analyses, (Bledsoe & Grote, 2006; Sockol et al., 2011).

As the aim of this research was to hear the voices of women, it was clear that quantitative research would provide limited evidence and could effectively silence women (Buultjens & Liamputtong, 2007), by not allowing for the voices of women to be heard. Cresswell (2003) states that quantitative techniques produce generalisations, made by a sample of people as a representation of a particular population. Generalisations were the antithesis of the research aim, as the research was actively seeking out difference within women's voices. Quantitative methods also rely on tests and measures that may ask limiting questions and seek to establish causal relationships or quantify the size or extent of the problem (Harper & Thompson, 2012). Comparing and contrasting modalities, searching for evidence of effectiveness, or a quantification of TA was not the aim of this research.

Qualitative research is "*particularly valuable for investigating the personal meanings that people attach to their experiences*" (Pistrang & Barker, 2010, p67). Stake (1995) describes three major differences between quantitative and qualitative research, all three of which informed the choice of qualitative research within this study:

1. A difference in the purpose of a research inquiry, between explanation (quantitative) and understanding (qualitative)
2. The role of the researcher - a personal (qualitative) or impersonal (quantitative) role

3. The difference in knowledge (qualitative - constructed), (quantitative - discovered) (p. 37)

Slife and Gantt (1999) discuss the uniqueness of psychotherapy and the way in which traditional scientific research, due to its assumptions, restricts the researcher by confining both the questions they can ask, and the variables testable. They point to empiricism, quantification, universalism, and naturalism in traditional quantitative scientific research and their limitations on psychotherapy research, advocating that true research into psychotherapy needs to use pluralism and a more pluralistic approach to methodology. However, although aspects of their argument fit the premise of this research study, such as the advocating of creativity within psychotherapy research, methodological pluralism does not fit.

### 3.3 Feminism

*“Childbirth stands uncomfortably at the junction of the two worlds of nature and culture”* (Oakley, 1980, p 7).

By its very nature, this thesis focuses predominantly on women who have mental illness and who are vulnerable. In this instance, vulnerable means *“more or much more susceptible than others to certain harms, injuries, failures, or misuses”* (Schroeder & Gefnas, 2009). This thesis explores women who can find themselves on the margins of society, with mental illness. The biomedical model of perinatal mental illness portrays women as passive ‘victims’ of their own biology, their own social context or their own psychology (Mauthner, 2002). Yet feminists view this illness differently: *“[Women] could see no way of enacting or voicing their thoughts and feelings within interpersonal and cultural contexts ... this move into silence ... protected mothers from what they experienced as a cultural and interpersonal invalidation and dismissal of their feelings”* (Mauthner, 2002, p459). Therefore, it can be argued that an examination of the nature and presence of oppression and how it manifests in the lives of the participants is also intrinsic within this study. Feminism is suitable as an epistemology and methodology to underpin this research. Feminist methodology also offers a more personal, reciprocal and interpersonal relationship between researcher and participant, whereby the lives of the women participants are the focus of the research (Bloom, 1998).

Bloom (1998) in her book ‘Under The Sign of Hope’, identifies multiple feminist methodologies that could be used to underpin this research. Reinhartz (1992) also suggests there are many feminist perspectives on research methods in the social sciences. For this study, it is useful to use the five concepts identified by

Bloom (1998) as critical to her work, which are embedded within this study and underline the rationale for choosing feminism to underpin it:

- the social construction of gender
- the study of women's diverse lives and personal narratives
- the context of the research question
- the critical self-reflections of the researcher
- feminist research relationships

Feminism has a view on postpartum depression. Mauthner (1999) states that this view involves a different way to research, prioritizing and legitimising women's own accounts, and linking women's 'private' lives and 'public' conditions and constraints. Feminism sees perinatal mental illness as much wider than its traditional medical determinants, and would include cultural, social, psychological and biological considerations as part of the characteristics of the illness. As this study seeks to understand more fully the way in which women themselves perceive their illness, this widening of determinants is helpful. Blooms's five concepts and the part they play within this study are explored below.

### 3.3.1 The social construction of gender

The critique of the binary system in which men are hierarchically placed above women is one of the most defining characteristics of feminist ideology. Lugones and Spelman (1983) state that feminist research is "*a response to the fact that women have either been left out of, or included in demeaning and disfiguring ways in what has been an almost exclusively male account of the world*" (p 573). Throughout history and within different cultures, reproduction has always been a female concern. Currently, only women can bear children and society is structured in a way that means women continue to dominate the rearing of children.

The male domination of childbirth became the 'norm' in the 20<sup>th</sup> century, particularly within the Western world, with the introduction of men and the medicalization of childbirth, transforming it from what was traditionally a female-controlled community-based management to a male-controlled medical management (Oakley, 1980). This seems to have oppressed women and promoted a sense of anxiety and fear within women around giving birth (Ayers, 2013; Dahlen, 2010; Dahlen & Gutteridge, 2015; Morris & McInerney, 2010; Nieminen et al., 2009; Rouhe et al., 2012). It is also argued that there is now a prevailing sense of fear within midwifery and obstetrics, which contributes to a more defensive style of practice (Symon, 2000), over-regulation and control of childbirth (Byrom & Downe, 2015). Gender plays a primary role in the culture

of abuse and disrespect of pregnant women in low- and middle-income countries, which is having an impact on morbidity and mortality in newborn infants and in women giving birth (Bowser & Hill, 2010).

However, gender is only a part of feminist methodology and to focus primarily on this aspect may be to leave out other areas in which women are also marginalised such as race, culture, ethnicity, religion, class, and sexual orientation (Bloom, 1998). Bloom (1998) highlights that "*it may give a false promise of universality among women or essentialize women*" (p141). Within this study, though "*The experiences of men are not the experiences of women, nor are the experiences of women homogeneous*" (Kralik et al., 2008, p. 38). It is these individual, personal, different female experiences that are sought in this study.

### 3.3.2 The study of women's diverse lives and personal narratives

Using women's diverse lives as a primary data source is "feminist standpoint" research (Bloom, 1998). This study wishes to hear the individual's standpoint, the way in which her illness manifested for her, and to honour her experience and perception of it and the treatment received. The study wishes to prevent the voice of the individual subject disappearing within the common voice. It seeks to prioritise individuality, acknowledging that each person will have different experiences, perceptions, knowledge and realities. Harding (1991) believes that the world "*systematically silences and devalues*" (p7) women's voices and that feminists have a duty to validate their diverse voices and to publicise them. This study seeks to hear each and every woman, in all of her diversity. This is in stark contrast to generalising their experience, stereotyping women and attempting to fit all women into the same [medicalised] bracket (Hill Collins, 1990; Harding, 1987). In particular, feminist research has extensively discussed the importance of using women's personal narratives as a primary data source.

### 3.3.3 The context of the research question

In this research study the need to know about women's lives is inherent within the title of the project. The project is designed to "*understand the forces that shape women's lives and a need to discover ways for women to transform and have authority over their own lives*" (Bloom, 1998, p 147). Within perinatal mental illness this knowing and understanding is an important aspect for women, as many women in therapy speak of being lost, struggling with their health, the transition to motherhood, relationships and many other demands on their daily lives (Haynes, 2017).

Reinharz (1992) asserts that many feminist research projects come from a researcher's own personal experience that frames their research question.

Fonow and Cook (1991) agree with this, underlining the part the researcher's own experience plays within the research. Accordingly, the researcher's own experience of working with women with perinatal mental illness is a fundamental and integral part of this research.

### 3.3.4 The critical self-reflections of the researcher

Harding (1987; 1991) asserts the need for the researcher to locate herself within the research, for personal, critical scrutiny. It is impossible to hear only the voices of the participants, with the exclusion of the researcher, as there is not a vacuum within this research. However, the researcher's voice is one of reflection and of reflexivity, acknowledging her impact on the research (Fox et al., 2007) and acknowledging how her biases and actions have shaped the research question, the type of research and the choices in data collection and analysis. Reflexivity is a skill developed within psychotherapy, acknowledging our selves within the therapeutic process, our responses to our clients, and their circumstances, and understanding how allowing awareness of our own circumstances, culture, religion, and class impact our own interpretations of the world. Throughout this study, reflection and reflexivity is intrinsic and forms a chapter in itself (Chapter 10). This allows for the reflections and reflexivity of the researcher, but also inhibits it from dominating the thesis, as it would if it was a thread throughout the thesis.

### 3.3.5 Feminist research relationships

Feminist research is dependent upon women's narratives as a primary data source, so it is important to develop a good relationship between the researcher and participant, to facilitate the participant's narrative and interpret it authentically. Bloom (1998) highlights how researching women and their lives can be a journey for the researcher and participant, allowing both the possibility of critical self-evaluation and understanding. Bloom also recognises the belief within feminist methodology that a researcher's interpretive abilities can improve by the identification the researcher has with her participants' experiences and lives. However, this should not be done to the point of "blindness" to difference, with a lack of critique of power imbalances within women (Mies, 1991). Reinharz (1991), also argues for women not to over-romanticise research relationships, by looking for a "sisterly" rapport between researcher and researched. The relationship exists for the purpose of the research. Once the research is over, the relationship, as it is, ends (Cotterill, 1992).



### 3.4 Social Constructionism

*“What we take to be the truth about the world importantly depends on the social relationships we are a part” (Gergen, 2015, p3).*

Social constructionism is not one single philosophy, book or idea. It is multiple views, multiple accounts, multiple proposals, and as such there is tension as well as dialogue within it, which is on-going and may continue to be on-going (Gergen, 2015). Each individual constructs a view of the world. This does not occur in isolation, but does occur within the context of social relationships. Within these relationships individuals make sense of the world around them. Each individual constructs their story of their world from their own particular relational standpoint. Co-creative TA fits with this theory, co-creating in order to make sense of the world and each individual’s place within that world. Social constructionism also fits with co-creating meaning with participants about their story, using dialogue to address content, as well as structure and context (Wetherell, 1998).

Social constructionism brings awareness that knowledge is not value-neutral, that all research is based on assumptions or understandings that are formed within relationships (Gergen, 2015). No matter what is heard within this research, no matter if it comes first-hand, the values of the participants, as well as the researcher’s values will lead us both to narrate our stories in a particular way, co-constructed together. Social constructionism engenders a desire to listen to and critique the narrative that is formed, the explicit and implicit messages embedded within the narrative, the subtleties of language and the consequent power relations and cultural ideologies inherent within that narrative. Using the ideas of social constructionism enables the researcher to attend to the voices within their participant’s narratives and the way those voices might interplay, as well as to attend to the cultural context of the interview, and the dynamics of the research relationship. This grounds the inquiry within a physical and cultural context, and allows for the inner and outer worlds of the participant to become visible and to be paid attention to.

This research could not be underpinned by one philosophy or methodology. Instead it uses a holistic approach, moving between and synthesizing both feminism and social constructionism. This parallels the psychotherapeutic process with the psychotherapist continually moving between and engaging with those spaces between: what is known, what is not yet known, and what is unknown. This is an area for self-reflection and self-contemplation, as well as an area for continual questioning of self and other. Foucault sees this area between as within a space of power relations, where aesthetics and ethics join together and where we are continually creating and re-creating self (Foucault, 1988).

This study involves human subject research and these subjects should be seen as subjects, not as objects, with their own identities. These identities are both common to all human beings, but also different, distinguishing each individual from one another, therefore making each individual unique. This individuality is key to the research design, methodology, fieldwork and discussion. As a result of choosing the constructivist/interpretivist paradigm, the methodology that fitted the need to highlight difference in voice and story, rather than similarity, was narrative research, "*noticing the differences and diversity of people's behaviour*" (Polkinghorne, 1995, p 11). Narrative research would enable a deep understanding of the uniqueness of the participants' stories. Grounded theory (Glaser & Strauss, 1968) was explored and rejected due to its focus on commonality and the way in which it advocated mining the data for particular categories and themes, as well as the depersonalisation of the research participants within the coding process. Narrative research allows the researcher an immersion in the multi-layered 'voices' of the participants, as well as the "*sometimes contradictory layers of meaning*" (Squire et al., 2013) rather than in the more generalisable categories found in Grounded Theory and other thematic styles.

### **3.5 A narrative approach**

Narrative is not new. It has been a part of human behaviour for centuries, as has narrative theory (Riessman, 2008). Squire (2013), states that historically, narrative social research is most often located in two distinct yet parallel academic movements:

- The rise of humanist approaches in Western psychology and sociology, which occurred after the second world war, such as case studies, life-histories and biographies (Bertaux, 1981; Bruner, 1990; Polkinghorne, 1988; Sarbin, 1986)
- The Russian structuralist, the French poststructuralist (Barthes, 1977; Culler, 2002; Genette, 1979; Todorov, 1990), the postmodern (Foucault, 1972; Lyotard, 1984), the psychoanalytic (Lacan, 1977) and the deconstructionist (Derrida, 1977) movements.

Riessman (2008) goes back further and situates the narrative form as starting with Aristotle, whom she believes understood the need for a moral element, as well as an interpretive element within stories, mirroring the world. Such tales have a beginning, middle, and an end, and are therefore considered whole, with a linear, temporally structured plot (Loots et al., 2013). Narrative as a research methodology has become popular over the last three decades, with many competing styles and aspects, forming a broad and diverse group under the title

'narrative'. Although it began as a way of examining literary texts, narrative research now covers many diverse sources of narrative. It is often synonymous with the word "story", and has many meanings. It is used by many disciplines, in many ways (Riessman, 2008). Because of this, Riessman (2008) believes the concept of narrative has now lost its specificity, and argues that "*all talk and text is not narrative*" (p5).

In narrative research there are few debates on the different, often conflicting styles and approaches, as is common in other areas of research such as Discourse Analysis (Squire et al., 2013). This does not help to delineate narrative research. It does not offer a particular way of analysing data such as Interpretive Phenomenological Analysis (IPA) (Squire et al., 2013), nor are there clear, simple definitions, covering all aspects of narrative (Riessman, 2008). Narrative research is a process of systematically gathering human stories, analysing those stories, then representing them in a way that keeps the authenticity of the story as told by the person. It is a reciprocal process, and therefore power relations within the process are unavoidable (Clandinin & Connolly, 2002; Josselson & Lieblich, 1993, 1995, 1999; Josselson et al., 2003; Langellier & Peterson, 2004; McAdams et al., 2001; Riessman, 1993). It is an approach that "*combines a discursive emphasis on the construction of meaning through talk and language, alongside a humanistic image of the person as a self-aware agent striving to achieve meaning, control and fulfilment in life*" (McLeod, 2011, p 191).

In the context of this research project, narrative research is experience-centred, as opposed to event-centred, (Labov & Waletzky, 1967; Patterson, 2013) and is focused on allowing women to tell their individual stories about their everyday experiences of perinatal mental illness, and how they live their lives. It is about listening in a way that could bring new, contradictory, multi-faceted, multi-layered meaning. It provides a means of accessing the rich and compelling stories women produce, and to allow access to those aspects that may be silenced, ignored, challenged or accepted (Squire et al., 2013).

Narrative analysis is "*grounded in close study of the particular*" (Riessman, 2008, p 18). What interests a researcher is how or why the narrator tells the story in the way they do, the sequencing of events, the language used and any visual images or objects used to communicate meaning. Also of interest is the audience the story is arranged for, and the purpose of the story-telling. Each story, for each audience will be different, and may be configured differently. Attention is drawn to the details of the story: the cultural resources that the story teller draws upon, the plots the story summons up, the purpose of the story, all are of relevance to the interpreter. The sequential nature of long accounts of narrative is adhered to. This is different to other research methods, where such accounts are carved into sections, often taken out of context, and are then coded as units.

No method is right or wrong, each method will bring forth different ways of knowing, each with its own merits. In this study a particular definition of narrative is used: “*a bounded segment of talk that is temporally ordered and recapitulates a sequence of events*” (Riessman, 2008, p116).

This research used two methods to collect narrative. The first was Free Association Narrative Interviewing (Hollway & Jefferson, 2000). The second was a creative methodology of visual form: the participants brought an object which gave meaning to the participant’s experience of perinatal mental illness and the treatment received. The method of data analysis was the Listening Guide method (Gilligan et al., 2003; Gilligan, 2015), a qualitative, relational, voice-centred, feminist methodology, which places emphasis on the participant’s voice as a means of unpacking the human psychological complexities (Woodcock, 2016).

### 3.5.1 Data collection - Free Association Narrative Interviewing

This style of data collection was chosen to give women the chance to describe their experiences. This may empower them and give their voices an increased emphasis. Many women with perinatal mental health conditions say they feel silenced (Dennis and Chung-Lee, 2006; Mauthner, 2002; McLoughlin, 2013; Staneva et al., 2015), stigmatised (Bilszta et al., 2017; Davies & Allen, 2007; Edwards & Timmons, 2005; Goodman, 2009; Krumm & Becker, 2006; Mantle, 2002; Mauthner, 2002; McLoughlin, 2013; O’Mahen & Flynn, 2008; Staneva et al., 2015) and ashamed (Buultjens & Liamputtong, 2006; Cheng et al., 1994; McIntosh, 1993; Holpainen, 2002) due to their illness. Therefore, hearing these women’s experiences and listening to their voices became an important part of this research. These voices may not have been listened to or heard before, other than within the psychotherapeutic process. Women with perinatal mental illness talk about not being able to tell anyone how unwell they feel, often because of fear: of losing their babies; of being labelled a ‘bad’ mother; or of not being able to care for their babies well enough (Boots Family Trust Alliance, 2013; Kennedy, et al., 2002); fearful of themselves and their illness, and whether they may harm their babies (Choi et al., 2010). In psychoanalytic theory, anxiety might bring defensiveness (Hollway & Jefferson, 2000). Free Association Narrative Interviewing (FANI)(Hollway & Jefferson, 2000) acknowledges the defensiveness of participants, who may have defended themselves against anxieties they have from the questions which arise from a research project. These defence mechanisms are an automatic, unconscious reaction to a perceived threat, such as an unpleasant experience or feeling. Within their defended stance the participants may become inconsistent and contradictory and researchers could often think they know what to conclude, yet it is unclear

how they actually do know. As FANI is also a psychoanalytic style of interview technique it could also provide a different narrative to that of the normative discourse. It is different because there is no interview format as such. This allows the researcher and the interviewee freedom to go where the narrative leads. It also enables researchers to focus on the narrative form, and not be fooled into thinking that people and their accounts are transparent and accurate:

*'Treating people's accounts as unproblematic flies in the face of what is known about people's less clear-cut, more confused and contradictory relationship to knowing and telling about themselves. In everyday informal dealings with each other, we do not take each other's accounts at face value, unless we are totally naïve; we question, disagree, bring in counter-examples, interpret, notice hidden agendas. Research is only a more formalised and systematic way of knowing about people, but in the process it seems to have lost much of the subtlety and complexity that we use, often as a matter of course, in everyday knowing. We need to bring some of this everyday subtlety into the research process.'* (Hollway and Jefferson, 2000, p3).

The women participants within this research project may well be defended due to their experience of mental illness and the stigma attached to it. It is also certain that their experiences will be reliant upon context. Mishler (1986) raises the importance of keeping the connection between interviewee and their socio-cultural meanings, and the way that people contextualise their experiences. To allow these women to contextualise their own experiences, it was important the interviews were not structured in any way, that the women were not answering a set of questions with a set of 'assumed' answers or a binary yes/no answering system. This would not add to knowledge. It would simply be a reiteration of what we already know. More important is that these women are all different. They are different culturally, geographically, experientially, in their relationships and their experience of employment. They all have experience of a similar illness, within a similar time frame, but this may be the only part of their experience that is similar. Using FANI provided an opportunity to allow the differences to come to the fore, to take account of the possibility of defence, and to allow the women to tell their story, in their way. All questions asked were open or clarifying questions. The initial question asked the participants to tell their story and what brought them into psychotherapy. From that point the interview was not structured. The FANI procedure is stated in depth in Section 4.7.

### 3.5.2 Data collection using a creative methodology

The goal of this part of the research was to bring forth new information by using the visual, rather than relying solely on the spoken narrative, as the visual might

offer a voice for those parts that are often left unspoken. Geer (1964) originally highlighted the common barrier of familiarity. Bringing a creative element into the research was designed to 'fight familiarity' (Mannay, 2016, p41) within the research and bring something new, making the familiar strange (see Delamont & Atkinson, 1995; Deleuze, 2000; Sikes, 2003; Thorne, 1993). Deleuze (2000) stated that abandoning the constraints inherent within language would allow freedom to make new connections and open up experience, again something this study was attempting to achieve. The use of this creative visual approach was aimed at overcoming the 'discipline of words' (Mead, 1995) that is a sense of social sciences research. The visual form is "*an immediate and authentic form, from which verbal accounts are unable to fully encompass*" (Spencer, 2011, p32). Mannay (2010) argues that creative visual approaches are powerful media with which to fight familiarity and engender de-familiarisation. It was hoped this creative element would 'speak out' visually (Mannay, 2016). The approach was designed to be flexible, and would be participant-initiated, as each participant could choose whether to participate prior to the interview stage.

The visual form chosen was the incorporation of an 'object' of the participant's choice, brought to the interview. The 'object' would then be explored co-creatively in a dialogic form, creating an active 'participatory process' (Mannay, 2016), with the researcher and the participant creating research material together. The object, therefore, was to become an active part of the research process and would be photographed for inclusion within this thesis, if the participant granted their permission.

### 3.5.3 Merging the two data collection styles

Both the narrative and visual forms are inclusive and exclusive, and using both forms may help each complement the other. The photographs of the objects the participants chose will engender a response, an interpretation and a meaning (Luttrell & Chalfen, 2010), which will probably be different for each reader. Luttrell and Chalfen (2010) also speak of the 'serendipity' that is a recurrent feature within visual research, and the uncertainty and complexity of analysing and interpreting images. It is unlikely all readers will agree with the researcher's interpretations.

This study aimed to use the two techniques as a co-creative construction to form a deeper, richer understanding which neither form can achieve in its own right. The aim was not to be 'ocularcentric' (Mitchel, 1994), nor to be simply storied, but to be both/and, allowing the one style to complement the other, and together to form a co-created space within which original data could emerge. Arnot and Reay (2007) highlight how researchers will use a method to suit their theoretical aims, therefore highlighting the power that the researcher has in these

relationships:

*'Most contemporary voice research recognises the power of research relationships and methods in framing particular voices, eliciting some and not others. Therefore most researchers accept that there is not one authentic voice of a single social category – they appreciate that voices, for example, are internally differentiated by space, time, relation and place'* (Arnot & Reay, 2007, p313).

#### 3.5.4 Data Analysis - The Listening Guide Method

The Listening Guide method (Brown & Gilligan, 1992; Gilligan et al., 2003; Taylor, Gilligan and Sullivan, 1995; Gilligan, 2015) is a voice-centred, relational, feminist method of analysis, which allows a researcher to tune into the multiple different voices within the narrative of one person. Themes, repeated metaphors, contradictions, emotions and images emerge from the data in this style of analysis. It also offers, and actively calls for, an attendance to those themes, contradictions, people, and relationships that remain silent within the data. This style of analysis allows for concentration on who is speaking, and to whom, as well as the context (Brown & Gilligan, 1992). This creates a richer description of the data set. Woodcock (2016), another advocate of the Listening Guide's use as a data analysis tool, states the way it *"honors the role of the researcher-researched relationship, the intricacies of voice and silence, and perhaps most importantly, unearthing trends which may have gone unnoticed"* as its value to narrative methods. Gilligan (2015) argues that often people do not actually listen actively to what they are hearing, and she advocates a deeper way of listening, a poetic listening, that she believes is more honouring to the voice of the participant.

The Listening Guide method was chosen to allow for the different voices of each participant to be present and noisy within the data, and to allow for the temporal movement to be noticed within the interviews. It keeps the chronological order of the data through time. Gilligan's three separate listenings were closely used, and some of the details were enhanced within each of these separate listenings from Woodcock's more explicit method (2016). This style of analysis would be included within Riessman's (2008) dialogic/performance style of analysis. As such this type of analysis draws on parts of both thematic and structural analysis but 'folds' them into a much broader style of inquiry with a different determination of meaning. It actively promotes the need for the researcher to keep reading the narrative over and over, to bring the text to life, obtaining a different impression and meaning with each reading. The style is quite new, therefore it could bring something new to the research process and the data. A fuller exploration of the Listening Guide process is given in Chapter 4.

### 3.6 A critique of narrative research

Using this type of research requires a level of assumed interpretive authority on behalf of the researcher and positions the researcher within it. Those who support and use more objective, deterministic styles of research, which constitute paradigmatic knowledge (McLeod, 2011) may consider narrative research a nebulous way of providing a credible research project, too subjective and interpretive on the one hand, and unscientific on the other. Post-structuralists such as Derrida may object to the assumption that participant voices and also those of the researcher are identical to, authentic of, and directly correspond to their narrative identities (Grant, 2013). Narrative identities naturally evolve and serve as a way for a person to gain purpose and meaning. These stories are synthesized versions of particular events, combined with 'envisioned goals' (McAdams & McLean, 2013) which people internalise as a way of conveying to themselves and others who they are, where they have come from, and where they are heading towards in the future. Post-structuralists could argue that narrative identity and participant voice are and will be different, due to the constant evolution of narrative identity, and the 'fixed' transcript of a participant 'voice'.

There may also be an element of the story that is difficult for others to comprehend, particularly as the narrative may not be applicable across all social, historical or cultural contexts. It may not fit with the dominant social and cultural narrative, and, particularly within narrative research such as this, there may be an expectation by readers of a participant 'getting better' within the research. However, this may not be the experience that is told. This sense of 'getting better, or not getting better' is explored within the data analysis, particularly of the participant Jane (Chapter 7).

There is also the question of why the story should be believed, bringing with it two component parts to validity and trustworthiness: the story told by the research participant and the story told by the researcher (Riessman, 2008). Bruner (1991) believes that verifying narrative is of limited use and application as "*the distinction between narrative fiction and narrative truth is nowhere nearly as obvious as common sense and usage would have us believe*" (p 13). Within this research, verification of the facts is less important than hearing the meaning that women ascribe to this time in their lives. The women tell their version of their story; the participant will have interpreted the story and it will not necessarily be reproduced as it actually occurred (Riessman, 2008). Denzin and Lincoln (2000) stress that it is the researcher performing the analysis of the narrative and their interpretation of that narrative that can be interrogated, rather than the story itself. Even more important is for the researcher to be explicit about how they performed the research, how the materials were gathered, how the



narrative was transformed into text, how the inquiry was focused and how each unit of analysis was chosen, with final attention being paid to the local and societal context.

A further criticism of narrative research is that it disembodies the story-teller, by leaving the physical body out of the research (Hydén, 2013). Hydén argues that this is a problem when the storyteller has an illness or dysfunction, as the body may be a primary part of the story. As this research is about illness and treatment of illness, the body needs to become a part of the narrative element of the research. The participants describe bodily functions inherent within their illness. There is also an element of my own embodied reflexivity, where I pay particular attention to my bodily experience of the participant and my own counter-transference. As I am a psychotherapist, and an analyst, with knowledge of bodily affect and unconscious processes, these aspects of the interview are attended to and narrated within the reflexive part of the story of each participant.

## CHAPTER 4

### Methods

#### 4.1 Methods

This study used in-depth, one-to-one interviews, which were tape-recorded and transcribed for analysis. To avoid the restrictions imposed by pre-set questions, interviews were based on, but not rigorously adhered to, Free Association Narrative Interviewing (FANI). FANI uses a pro-forma for biographical details only (see Appendix 5). Data analysis was conducted using The Listening Guide method (Brown & Gilligan, 1992; Gilligan, 2013; 2015) a voice-centred, relational, feminist method of analysis. The remainder of this section explains the methods and research procedure in more detail.

#### 4.2 Sampling and Recruitment

To determine, sample size can be based on whether there is sufficient qualitative material data to transfer that body of knowledge to another group of similar people. Therefore, the purpose of the research is a deciding factor in appropriate sample size. Kitson et al. (1982) state that a detailed description of sampling is needed in order to interpret findings and replicate search strategies. Qualitative research requires deliberate choice of sampling, 'purposive sampling' (Yin, 2011), with a goal to yield the maximum amount of data relevant to the study topic. Kuzel (1992) highlights the importance of selection to "*obtain the broadest range of information and perspectives on the subject of the study*" (p 37). It is important to remove as much bias as possible from a sample, therefore choosing only those participants who would confirm the preconceptions of the study would not be suitable. Marshall (1996) suggests three different approaches to sampling for a qualitative study:

- convenience sample: this approach lacks credibility, as the researcher may choose participants likely to be easily accessible, therefore reducing costs in terms of time and money in recruitment. This type of sampling is not preferred, because the most readily-available data sources may not be the most informative. It is therefore likely to produce incomplete data sets and unwarranted bias.
- judgement sample: a researcher purposely selects the number of participants needed to answer the research question. This style of sampling is more like purposive sampling, which allows for samples to be chosen in a deliberate manner, yielding the most relevant data

- theoretical sample: this requires building interpretive theories from the data and selecting different samples to examine, then new samples to further enhance the theory. This type of sampling is the primary strategy found within the Grounded Theory approach, but is also used in many other qualitative projects.

The approach to sampling chosen for this study was judgment sampling. The original goal was to recruit a total of ten participants, which was a maximum amount thought to be possible to interview and analyse, within the timescale of the thesis. The actual number was reduced to five, due to the difficulties in recruitment, as it took six months from ethical approval to gain the first participant interview. Initially, five seemed to be a small sample. Yet, it became clear there would be sufficient data from a more restricted number of participants, due to the volume of rich, detailed data provided in each interview. At the broader level of sampling, some studies have only one data collection unit (Yin, 2011). These types of study would include HSCED studies (Elliott, 2001, 2002; Elliott et al., 2009). Yin (2011) also suggests that broader level studies can include two or more units, particularly if they are of contrasting instances. In this sense this research study is of five separate case studies. Each case study has its own chapter and within those chapters there is no comparison between the participants. Comparisons are made within the discussion and conclusion only. This is different to a thematic style of analysis, whereby the themes across all participant's stories are collectively highlighted.

### **4.3 Inclusion – exclusion criteria**

Inclusion criteria specified that every woman had experienced anxiety, stress, and/or depression during pregnancy or in the postnatal period and had received TA psychotherapy for this reason. Perinatal mental health issues must have been addressed explicitly during psychotherapy but success of treatment was not a pre-requisite.

The psychotherapist had to be a professional TA psychotherapist, qualified to Certified Transactional Analyst (CTA) level as a minimum, with TA the psychotherapist's primary theoretical and methodological stance. Setting a minimum standard of training at CTA as a requirement was to ensure that all TA psychotherapy received had a high level of consistency in methodology and process.

Initially, it seemed that the exclusion criteria should be the extremes of mental illness, such as puerperal psychosis, which is defined by the Royal College of Psychiatrists as:

*“a severe episode of mental illness which begins suddenly in the days or weeks after having a baby. Symptoms vary and can change rapidly. They can include high mood (mania), depression, confusion, hallucinations and delusions. Postpartum psychosis is a psychiatric emergency” RCPsych (2017)*

In the majority of research about any form of perinatal mental illness, one of the excluding factors is almost always puerperal psychosis, although there is a small body of research which has been undertaken recently that included puerperal psychosis (see Doucet et al., 2012; Engqvist et al., 2011; Glover et al., 2014; Heron et al, 2007; 2012; Robertson & Lyons, 2003). However, part way through the recruitment stage this changed. A woman who had experienced puerperal psychosis was suggested as a possible participant. On initial contact both parties were hesitant. However, this participant offered a unique insight into how psychotherapy might or might not work with this particular client group. Psychosis has been treated with psychotherapy prior to this study (Alanen et al., 1986; 1994; Jackson, 2001; Rosenfeld, 1987; Rosenfeld et al., 2012) yet it does not seem that this particular type of psychosis has research into psychotherapy as a possible form of treatment.

Puerperal psychosis can be misunderstood, and it may evoke fear in a woman. It often requires a stay in an inpatient psychiatric mother and baby unit, which could mean being away from family and friends, and it will almost certainly mean taking medication or undergoing ECT which many women fear doing, due to anxiety around harm to the baby from medication, or to themselves from Electroconvulsive therapy (ECT). It felt important to include this participant's experience, to preclude shying away from the possibility that psychotherapy may not work with this condition. It would be easy to try to claim that psychotherapy works for all types of mental illness. It might also be tempting to suggest that TA psychotherapy could work for puerperal psychosis. This would not be accurate and would be a misrepresentation of both the severity of puerperal psychosis and also the efficacy of TA psychotherapy. However, exploring and listening to the experiences of this woman would make it possible to give an accurate representation of her illness and her treatment, and enable her to be heard. Judgement of whether it worked has been left to individual readers, each of whom may have a differing opinion.

Finally, there was no time limit regarding when the psychotherapy had occurred. One participant had TA psychotherapy for this condition many years ago, but had been so affected by her experience of the psychotherapy that she contacted me about my research to offer her support and participation.

## 4.4 The Recruitment Process

After receiving ethical approval (see Appendix 5), the recruitment strategy was to recruit participants through their TA psychotherapists. Advertisements were placed for suitable therapists through the European Association of Transactional Analysts, the International Transactional Analysis Association and also through the International Association of Relational Transactional Analysis. An article in the Transactional Analysis Journal described the project and called for suitable therapists. The research was presented at several conferences, for networking and to increase awareness. Unfortunately few therapists in the UK had relevant experience. A peer offered a Romanian participant, but this proved too difficult to organise, due to legal difficulties with research participation in Romania. After 18 months five women had come forward and were able to engage in the interview process. All five participants received the Participant Information Sheet and signed the Consent Form. The interviews were completed by May 2017.

### 4.4.1 The five participants

The first participant came through a peer who knew her and had asked her if she would participate. The second participant came through a psychotherapist participating in a worldwide conference for TA, who attended a workshop I ran about perinatal mental health. The third participant came through the first participant, in a snowballing process, as they had been through perinatal mental illness together and had discovered that they both had undergone TA psychotherapy. The fourth participant came through a TA psychotherapist in Eastern Europe and had heard about my research project through her psychotherapist. The final participant read an article about the study and asked if she could participate.

Table 4.1 lists the participants. Each participant has been given a pseudonym to retain confidentiality.

Each participant initially sought help from their GP, midwife or health visitor. Each was offered medication as the main form of treatment. Three were offered psychological therapy, based on CBT, or a mixture of CBT and mindfulness. All participants accessed TA psychotherapy privately. One participant, Jane, was

Table 4.1 The five participants

<b>Participant Number</b>	<b>Name</b>	<b>Interview Date</b>	<b>Locality</b>	<b>Setting</b>
One	Lucy	October 2016	North of England	Own Home
Two	Shoshana	November 2016	Scotland	Rented Office
Three	Jane	February 2017	North of England	Own Home
Four	Julija	March 2017	Eastern Europe	Rented Office
Five	Sarah	May 2017	South of England	Own Home

already undergoing TA psychotherapy when she experienced puerperal psychosis. One participant was already in couples TA therapy with her husband after suffering an ectopic pregnancy. Some participants continued to take medication throughout psychotherapy so the two effects combined. Whether this had any advantage is unknown and was not explored.

#### 4.4.2 Biographical information and diversity

I set out to recruit a diverse sample of participants. There is a contrast within the sample as one participant, experiencing puerperal psychosis, provided a different perspective on treatment to the other four. It could also be argued that two participants provided a cultural contrast from the other three English participants, as one came from Scotland and the other from Eastern Europe. This sample of five participants, although small, has provided a sufficiently promising data set for this initial study.

All participants described themselves as white. Three described their cultural background as 'White British', one was 'White Eastern European' and one was 'White Other'. The Scottish participant (Shoshana) was the only one to mention religious faith. Two participants came from the north of England (Lucy and Jane), one from the south of England (Sarah) and Julija who was born and raised in Eastern Europe and still lives there.

#### Prior Mental Health Conditions

Four participants spoke of having mental health conditions prior to becoming pregnant for the first time. Two participants, Lucy and Jane, had experienced anxiety. Julija had experienced depression. Shoshana had experienced both anxiety and depression.

### Mental Health Conditions in Pregnancy

Lucy experienced stress and anxiety in her pregnancy with her second child. She recognised that she had also been unwell with her first child but had not sought help. Shoshana and Jane were not unwell in pregnancy. Julija said she experienced stress and anxiety in her second pregnancy. Sarah said she was not unwell in pregnancy with her first child. However, she experienced stress and anxiety in her second pregnancy.

### Medication

Three participants took some form of medication for their perinatal mental illness. Lucy took Citalopram and beta blockers in her second pregnancy. Jane took medication for her psychosis. Julija took anti-depressants in her second pregnancy.

### Postnatal Mental Health Conditions

Both Julija and Sarah experienced stress, anxiety and depression postnatally. Jane experienced puerperal psychosis. Shoshana experienced stress, panic attacks and anxiety, and Lucy experienced panic attacks and depression.

### Other types of therapy treatment received

Lucy and Jane were offered CBT by their doctors, and Shoshana was offered a combination of CBT and mindfulness through a psychiatric nurse. Julija and Sarah were not offered any psychological therapy through their doctor. Julija received Imago therapy after the birth of her first child and TA therapy after the birth of her second. Sarah had psychoanalysis after the birth of her first child and when she was pregnant with her second.

### Age

There was a large diversity in age at interview, ranging from 29 years to Sarah who was in her sixties. However, this was anomalous as Sarah was narrating her experience of her psychotherapy from many years previously. Sarah actually fell into the age range bracket of 25-40 when she underwent TA psychotherapy. Due to the nature of motherhood it was not expected to get hugely varying ages. However, the ages of the participants reflects the normal age for childbirth within the UK and Europe. The Office for National Statistics report that in 2013 over half of all live births were to a mother aged 30 and over, with the average age of mothers increasing to 30 years in 2013 (ONS, 2014).

### Marital Status

Four of the participants were married, and one of the participants was engaged and living with her fiancée, the father of her two children.

### Number of Children

Two participants have one child, two have two children and one has three children. With the women with more than one child it was interesting to discover whether perinatal distress had begun with the first child. Julija experienced mental illness with both children, yet she was not unwell during her first pregnancy. After her first child was born her family circumstances changed, and she became the main income earner. At this stage she became unwell. With her second child she was unwell during pregnancy and in the postnatal period.

Lucy said she recognised that she had become unwell with her first child. However, she managed to come through this with no medical support. It was not until she was pregnant with her second child that she became too unwell to function properly and sought medical help.

Sarah, has three children. After the birth of her first child she experienced severe distress. She said she did not have symptoms at all during her first pregnancy, nor did she have the same symptoms after the births of her subsequent children.

Jane has one child and said she was not unwell in her pregnancy, but she became unwell a few weeks after the baby was born. Similarly, Shoshana, said her symptoms of anxiety disappeared during her pregnancy, but returned when her baby was two or three months old.

### Type of therapy received

Lucy began in individual one-to-one therapy, then six months later moved into a therapy group with her therapist as the facilitator. Shoshana began in couples therapy with her husband. She then went into one-to-one therapy when her daughter was a few months old, although she and her husband also had a few couples therapy sessions. Jane and Sarah had one-to-one therapy. Julija began in one-to-one therapy then moved into a therapy group, again with her therapist as facilitator.

## **4.5 Participant compensation**

There was no participant compensation scheme for this research project.



**Table 4.2 Relevant participant information**

Name	Marital Status	Age at interview	Cultural Background	Number of Children	Prior Mental Health Conditions	Perinatal Mental Health Conditions	Medication	Mental Health Conditions in Pregnancy	Mental Health Conditions Postnatal	Other Therapy Received
Lucy	Married	35	White British	2(2)	Stress & Anxiety	Stress, Anxiety then Depression	Yes	Stress & Anxiety	Depression	CBT
Shoshana	Married	31	White Other	1(1)	Stress, Anxiety & Depression	Stress, Anxiety & Panic Attacks	No	None	Stress, Panic Attacks & Anxiety	CBT & Mindfulness
Jane	Married	29	White British	1(1)	Anxiety	Psychosis	Yes	None	Psychosis	CBT
Julija	Lives with Partner	33	White Eastern European	2(1,2)	Depression	Stress, Anxiety & Depression	Yes (2)	Stress & Anxiety	Stress, Anxiety & Depression	Imago Therapy
Sarah	Married	60's	White British	3(1)	None	Distress	No	None	Distress	Psycho-analysis

2(2) The first number denotes how many children the participant has had, the number in brackets denotes with which child she had psychological distress

## **4.6 Interview settings**

All participants were interviewed alone with only the researcher present. All the interviews were audio-recorded. Due to the subject area and its personal nature it seemed appropriate to interview participants within their own environment, or somewhere which was private and confidential. Lucy, Jane and Sarah were all interviewed at their home. Shoshana was interviewed in office space rented specifically for the interview. Julija was interviewed in the office of a psychologist in Eastern Europe. Julija spoke English fluently. She was offered a translator, but declined. There were no language barriers during her interview.

Careful consideration was given to the nature of interviewing research participants in their own home. Consequently, participants choosing a home-based interview were offered several different options for interview setting, such as an office space rented for the purpose. Julija chose not to be interviewed at home as her children were there and she felt it would be difficult to stop them from interrupting the interview. Shoshana also chose not to be interviewed at home due to childcare issues.

## **4.7 The data collection procedure**

Two data collection methods were used: participant interview and creative method.

### **4.7.1 Participant interview**

The interview was influenced by the FANI method of data collection (Hollway and Jefferson, 2013). The interview technique was constructed to allow the participants to talk about their experiences as freely as possible, with a lead-in question to allow them to give their context. In addition, it would help settle them into speaking about their experiences, to elicit a rich data set. The primary aim was to have as little agenda as possible within the interview, so as not to suppress the participant within their story telling (Mischler, 1986), with the participant, as far as possible, setting the agenda. Although the theme and the topic were set, the researcher did not want to influence the order in which the participant told their story, as she wanted to see if there was a continuum both within their illness and their treatment. The questions were often spontaneous and prompted by a need for clarification. A pro forma was used to gather biographical information which the participant usually offered freely within the interview. If required information was not offered, it was asked for at the end of the interview.

It could be argued that this research study is not FANI in its entirety, as the data collection and analysis do not follow the FANI protocol, explicated by Hollway and Jefferson (2000). The data collection was based on FANI, and in some aspects it may not conform to some ideas of 'free association'. However, as opposed to using a semi-structured interview style, the method used had no prompts or areas of exploration that the researcher kept to. The fullest form of free association, within the constraints of the interview setting, was used. The contextual circumstance for choosing an alternative method of data analysis is explored within the data analysis section.

The FANI style of interviewing offered many elements that corresponded with TA psychotherapy, which was a primary reason for choosing it. In particular, within FANI there is the idea of the participant and researcher co-producing meaning to the narrative within the interview, in a style that corresponds closely to relational co-creative TA. Within FANI it is important that participants do not get bound up in words and meanings, nor that their narrative is limited by the use of closed, structured questions. This is similar to relational theories of psychotherapy, and in particular, relational TA. In relational TA the aim is not to close down the client, as this is not conducive to good therapy. Instead the therapist will ask open questions and will reflect back the narrative the client has chosen. This is to allow for difference in the value and meaning of the many aspects of experience. This style of interviewing was chosen for precisely this reason, so as not to close down the participant's story, but to provide a space for them to order their narrative in the way that suited them. This style of interviewing may produce a different discourse than the dominant studies already researched. Prior to the interview, these women would have already been implicitly guided, to some extent, by what they thought the researcher would like to know or hear. They may even have been expecting specific questions. To mitigate this situation, a free flow of narrative was engendered, to as great extent as possible. On the whole, participants spontaneously gave information about those 'conventional aspects of their lives' (Chamberlayne et al., 2002) such as family, work, friends, and support networks. They were asked to expand on events that seemed to be important to them, and any elements that were absent within the interview were noted.

There was co-construction and active narrative listening, which did stretch into something more like a two-way shared dialogue. The researcher was alert to particular areas of information, such as medication, and prior treatment. If they did not voluntarily offer the information, participants were asked if anything within the treatment was helpful or unhelpful. In a couple of instances the researcher did return to a participant to clarify facts, if they were ambiguous after the interview transcript was written up. This was done by email after the interview.

#### 4.7.2 Creative method

The second data collection method was the creative method. Each participant was asked to bring an object or item of their choice with them to their interview, such as a piece of art or nature, a poem, photograph or piece of writing, that they felt depicted their experience or some element of their TA psychotherapy treatment. The object represented a visual means through which to explore their experiences. The hope was that this creative way of engendering narrative might offer a means to express those feelings that they might previously have been unable to give voice to.

This means of data collection is not common although there is a small evidence base for using creative visual means to elicit information. In particular Broussine (2008) includes chapters within his book on using poetry, stories and art as ways of eliciting data, which were useful in formulating how this creative element might work. Mannay, (2016) and Rose (2016) have also written detailed books on using these types of methods. However, neither book fitted the aims and objectives for using this form of creative methodology. It was therefore felt necessary to create an idea of how this might work, what this method could achieve, and what would not be possible. This type of data collection would fit into a psychotherapeutically-informed method, as its aim was specifically to unlock memory and feeling, without only relying on language or narrative. The hope was that the object might also speak for the participant, because of what it was, in itself. A co-creative narrative, through dialogic form, would enable the participant to explain the significance of the object, and why it was chosen. The primary aims were to understand the meaning of the object, its significance to the participant, why she had chosen that item; and the part it played within her treatment. This is a subjective element, and it may be considered unorthodox, eccentric, or difficult to interpret. However, as perinatal mental illness seems to engender shame and many women choose to remain silent about it, a creative element could offer a means to unlock the silence and provide a powerful visual form that may offer a narrative within itself. This style of creative research has been noticeable in organisational research since the 1980s, yet it does not appear to have been used for psychotherapy research, until now. This creative element was included within the tape-recorded interview and was a sub-set of the interview. A photograph of the object was taken. Both the picture of the object and the narrative created about it is found within each participant's story. Not all participants brought an object. Two participants did not bring anything, although they then spoke of a memory, which was then treated as if it were an object.

#### 4.8 The data analysis procedure

The findings for each participant are described in their own chapters. This is because each participant's story was very different, as was her experience of treatment, and a separate chapter for each seemed an appropriate way of honouring these individual stories.

The narrative was transformed into text by transcribing the dialogue verbatim. Each participant, as well as those important people in their life such as family members were given pseudonyms to keep their identities confidential. The interviewer is kept in the transcript in parts as an active presence, and because of the co-construction within the data formation. It would have felt strange to leave the interviewer out of the data, as this would make some of the participant responses seem oblique and out of context. Some researchers do omit their contributions (Riessman, 2008; Williams, 1984).

The text was not reduced, or parsed into clauses. Every pause, sigh, or behavioural movement was noted within the transcription, as these were important and added depth to the data, as well as context and understanding. Important aspects were the language used, the way it was used, the temporal movement of the story, the way the story was constructed, the different actors within the story, and to whom the speaking roles were given. Any storyteller needs to convince their audience of the veracity of their story. Riessman (2008) believes this is achieved by provoking the same emotion within the listener, as they themselves felt, as a way of arguing 'hey this did happen to me'. In psychotherapy this is known as transference. It was important to discover how each participant 'solved' this question of veracity. Participants can subtly 'tell' a listener how to read their story by how they convey their plot, it's meaning to them, how they contextualise the events by using background information, and the way this was done. The difference between each participant's story from the others, and whether they were making a different point or highlighting a particular part in their story was noted. Changes in the pitch of voice used in different parts have been included, to highlight and emphasise what is being said and often gives context to why it is being said. It is also information that the participant wants to give (the audience), as are the prosodic features (intonation, stress, rhythm, and subtle shifts in pitch). All these elements were important, allowing understanding of the participant's story.

The meaning that the participants gained from their object and how they transferred that meaning within their story to the researcher (their audience) was also of interest. The researcher's responsibility was to see the meaning and interpret it in the most literal way (Becker, 1986), as well as to pay attention to their own response to the object. They also needed to listen and hear the participant's narrative about that object. It was a dual process of visual and

audible analysis, as well as an analysis of the interface between the two in order to draw connections between the discourse and the object (Riessman, 2008).

Each part of the narrative seemed to be a way in which the participant was able to allow the researcher to feel what they wanted her to feel, and for her to know what it was like for them. In the transcript provided (Appendix 6) particular elements have been highlighted with different colours. In each transcript the elements highlighted were different, due to their relevance in the narrative of that particular participant. Transcript lines are numbered to facilitate referencing of the narrative. Due to space limitations only the first transcript is provided. Providing transcripts gives greater transparency and validity to the interpretations, showing how they were transcribed, and indicating the highlighted elements. This type of detailed analysis of the nuances of the narrative (and transcript) generated insights, and enabled and enhanced the interpretation.

A work sheet was used to track the contrapuntal voices, recording the participant voice in one column and the interpretation of who was speaking in the second column. This helped to track the change in different parts of the participant's self that spoke at particular times of their story. For each participant these contrapuntal voices have been tabulated (Appendices 7-11), and are referred to within the data analysis chapters, to show the temporal movement of the voices.

During story analysis particular aspects are produced in their entirety (the element's entirety). These 'units of analysis' are bounded by the researcher to suit her needs, to illustrate the elements that are a part of the study's aim/objectives. All the features of the oral version are retained. All parts of the researcher's speech and that of the participant are shown in the transcript. The researcher is powerful within this analysis, as she has control over what is highlighted. The researcher is also cognisant of her own position of a white, middle-class psychotherapist/researcher and the affect this would have had on the participants and the way in which they would have perceived her. Each participant knew she was a TA psychotherapist and also knew that this research was part of her PhD. This knowledge will have affected the way they viewed her, and it may well have affected the way in which they chose to tell their story. Below Gilligan's (2015) three-step process has been highlighted, which was used to analyse the data. Although each of the transcripts were initially analysed in this way, when it came to writing up, the first and second listenings were integrated. By simply following Gilligan's process for those two listenings, then presenting them in the analysis section, the text became fragmented and difficult to read. Certainly it did not remain as 'narrative'.

#### 4.8.1 The First Listening: Listening for the plot

This listening is designed to address the question “how does one establish where one is psychologically?”

In this first listening, Gilligan (2015) directs the researcher to pay attention to the landscape of the interview (who is there, who or what is missing, are there repeated words, salient themes, striking metaphors or symbols, emotional hot-spots, gaps or ruptures) and to the stories told. Firstly, the researcher simply listens to the interview. Then, on listening again, notes are made of all those parts that are present and what is missing. This style of listening helps researchers to locate themselves in relation to the data (Gilligan, 2015). It also helps them to focus on and listen for nuances, which they might not have done otherwise. The researcher is encouraged to explore their own thoughts and feelings about each participant, and to be aware of their own countertransference. This is to mitigate the researcher projecting their feelings and thoughts onto the narrator or within the writing up of the research. Being aware of what is going on for the researcher within their own intra-psychic process allows them to know what is theirs and what is not. This is commonly used within TA psychotherapy, as the psychotherapist pays heightened attention to their own internal processes within the psychotherapeutic process (Clarkson, 1992), particularly in relation to transference and counter-transference (Freud, 1920). This element of the psychotherapeutic process would not necessarily be explored or even spoken about with a client, but more often would be explored either within the therapist’s own note-making process after a session or within clinical supervision.

Gilligan (2015) encourages the researcher to actively seek out emotional hotspots and metaphors within the first reading. Whilst Woodcock (2012) suggests adding to Gilligan’s method by looking for contradictions, omissions and revisions as well as silence and silences within the narrative.

#### Reader Response

The final stage that Woodcock (2016) draws attention to is the ‘reader response’. This means how the researcher’s own voice is used to tell their own story within the participant’s story. Brown and Gilligan (1992) also highlight how necessary it is for researchers to pay attention to their own counter-transferences, their own responses to both the participant and the participant’s story. This is because personal agendas could hijack and therefore inhibit the listening process (Anderson & Jack, 1991). Raider-Roth (2000; 2014) suggests the researcher take notice of and account for their own reactions to the story, and to develop a closeness to these reactions, so that this counter-transference can be

explored fully and used as prompts for further analysis. Woodcock (2016) states: *“this reader response feature of the method helps to strengthen validity in the ways it pays attention to personal reflexivity”* (p4). To account for her responses to each of the participants the researcher has included a reflexivity section at the end of each of the five chapters.

#### 4.8.2 The Second Listening: Listening for the “I”

Gilligan (2015) uses the second listening specifically for the researcher to notice and be aware of the “I” sentences, the first-person voice. Gilligan believes that these “I” sentences pick up an associative stream that flows through the narrative, running underneath the structure of the sentences, in particular evoking a voice that is speaking under a surface of dissociation.

This listening helps the researcher to tune into the voice of the participant and be aware of and note down each of their “I” sentences. This is to gain clues about how each participant acts and behaves in the world. Taking each “I” sentence (pronoun and verb, with or without the object), they are then listed in order. This method shows how often “I” sentences are used in an interview and the way in which those sentences change in order of appearance while the story is being told. This allows the researcher to see the temporal change of the “I” sentences. The “I” statements in themselves almost form a poem, and some researchers using this method have highlighted this poetic element (Edwards & Weller, 2012; Zambo & Zambo, 2013).

#### 4.8.3 The Final Listening: Listening for contrapuntal voices

In this listening, the researcher directs their attention towards elements of the text that speak to, or of the inquiry. The researcher is listening for harmonies, tensions and dissonances between the participant’s different “voices”. All humans have different parts of themselves and some parts are louder than others. This style of listening allows the researcher to hear those different parts, some of which may have been dissociated, and to pay attention to them. This is a listening for nuances, modulations and silences. The purpose of this is to resist binary categories and to hear complexity rather than flatten the data.

Within this study, these particular listening techniques have allowed the researcher to hear those distinct parts of the interviews, and the stories those distinct parts tell. In TA psychotherapy, the terminology of ego states is used for these different parts of self. TA therapists notice and use each person’s distinctly different ego states as part of the therapy to determine which one they might be using, at any given time, by listening to their narrative and attending to the way



they are behaving. This part of the Listening Guide method provided an opportunity to hear those different voices and to listen to what each was saying. These different voices are shown in tabular format for each participant (Appendices 7-11), and show how they moved through these different parts of self when narrating her story.

#### 4.8.4 A critique of the Listening Guide method

At the outset, I followed the method set down by Gilligan (2015), and went through the three-step process, enhancing some of the listening with other areas I noticed, such as changes in language, and the way a participant broke up their own narrative, or the way in which a participant 'ventriloquated' (Bakhtin, 1981) another person's voice. I then began to analyse the data, one participant at a time, using what I had found with this process.

However, when I began to write the participant's story, I found this process fractured the narrative into small chunks, which I grouped together under a heading such as 'metaphors', or 'emotional hotspots'. I would go through the entire interview looking for chunks of narrative as 'examples' of whatever it was I was seeking. All this achieved was to rupture the story, and feedback was that it was difficult to read and was not what I had set out to do.

Instead I have chosen to honour each participant by telling their story, in the temporal manner they narrated it to me. I have kept those examples of the various elements Gilligan (2015) states should be looked for, and I have placed them in each of the participant chapters, under the heading 'other notable aspects of the analysis'.

This is not to say that I disagree with the process of the method. I do not. It provided a way for me to delve deeply into the narrative, to look for particular elements of the data that I possibly would not have sought without Gilligan's guidance. I believe I was able to grasp many of the underlying meanings in the stories, and it allowed me to hear more clearly the different voices within the stories.

### **4.9 Ethical considerations**

This research involves participants, who are interviewed, whose life and therapy are scrutinized and examined as a part of this research study, and will be in the public domain. As such it required ethical approval to be granted by the University of Salford. Not only is their interview examined, but also within the interview these women are giving personal information about family members, their social situations, their therapist, other group members and acquaintances.

Therefore ethical considerations should be taken into account. McLeod (2010) suggests following those sources of principles which originate from Beauchamp and Childress (1979) and Kitchener (1984), which together form the five moral principles of counselling and psychotherapy practice and research: autonomy, non-maleficence, beneficence, justice and fidelity. Each of these moral principles has been addressed according to this thesis. Other ethical principles pertinent to this study have also been added.

#### 4.9.1 Autonomy – informed consent

In research, autonomy refers to the participant's autonomous decision (not coerced in any way) to participate in the research using the procedure of informed consent. Every individual has the right of freedom of action and choice, as long as this does not affect another's autonomy. For this study, all potential participants were given a copy of the Participant Information Sheet so that they could read it and consider it, and if necessary take advice on it, before agreeing to participate.

Informed consent does not start and finish only in the initial phase of the research, it continues throughout the project. It was important to reiterate throughout the interview process and within any subsequent correspondence that participants could withdraw at any time prior to the submission of this thesis. This was due to the nature of the interview process, and the possibility that within the interview or afterwards, the participant may disclose information that they then prefer to keep private. This information might not be about the participant, but might affect the privacy of another individual, for instance if any physical or mental harm is disclosed. The possibility of a participant disclosing such information and the courses of action that might be considered formed a part of the risk analysis element of this study's ethical application and subsequent approval.

There is a need to be open to the subtleties of privacy and confidentiality, and informed consent. A participant may agree to being involved in research without fully understanding the repercussions this might have on them. In this instance, there was a possibility of bringing up past trauma for participants, which could be distressing. This possibility was addressed within the initial contact information and also within the Participant Information Sheet, with the option of a 'debrief' session after the interview. This would be with either a qualified psychotherapist, or with the participant's own psychotherapist.

#### 4.9.2 Non-maleficence – do no harm

Within any research framework it is important to do no harm. It is also important that, before consenting to participation, each participant understands that harm will be minimised (non-maleficence). The Participant Information Sheet should make explicit any possibility of harm so that the participant has the information to give informed consent. It is not a certainty that a participant who becomes distressed will be harmed by participating. It could be more important for the researcher to be cognisant they could become distressed, and therefore create a safe environment where this could be managed well (Thompson and Chambers, 2012). This is relevant to researchers as well as participants, due to the nature of qualitative mental health research and the possibility for disturbance when recalling, reflecting, listening to and sharing experiences.

#### 4.9.3 Beneficence

Beneficence in research relates to a commitment to participant's well being and to ensure that the study makes a useful and worthy contribution to knowledge. It is also possible that participants could benefit from participation, either from some altruistic benefit or from the process of reflection which may be therapeutic in and of itself.

#### 4.9.4 Justice

When researching oppressed or minority groups the principle of justice is important. Justice means fair treatment for all. The researcher needs first to consider and secondly ensure they "*promote the worth and dignity of each individual, we are required to be concerned with equal treatment for all individuals*" (Kitchener, 1984, p50). Women with perinatal mental illness fit into this need for justice, therefore this study needs to ensure that each participant and their data are treated accordingly. Within this study one participant with puerperal psychosis might not have been included, if it had not been decided to widen the inclusion criteria, as her story was so important, and this ensured she was treated equally to the other participants.

#### 4.9.5 Fidelity - confidentiality

Fidelity relates to the integrity with which data is used and maintained. It relates to confidentiality, but also reliability and use of data, specifically not exploiting the data by lying. Confidentiality is a vital part of psychotherapy and this style of psychotherapy research. In this research it was important that the participants did not give data about themselves that would make it easy to identify them. Pseudonyms have been used throughout for all participants, their family

members and therapists. The full transcript of one of the interviews is held within the appendices, and some of the identifying features within that transcript have been removed, to maintain confidentiality. Few TA psychotherapists have worked with women with perinatal mental health issues, making it possible that those psychotherapists, and consequently their client, become identifiable. This has also meant removing other identifying features from the transcript and analysis, such as locations.

#### 4.9.6 The ethics of power and politics within qualitative research

There is the real possibility of power imbalance within this research. It is possible within the project itself between researcher and participant, and between the narcissism potentially engendered between researcher and participant. Therefore it is useful to think about this element using psychoanalytic theory from the participant's position:

*'When we work empathically in the interview situation to understand our participants, we may be evoking what he calls 'mirror transference'. ... We have, indeed, aggrandized our participants by regarding them as important enough to write about – but the grandiose self is always tinged with shame' (Josselsen, 2011, p44).*

From an ethical viewpoint, it is important to try to mitigate this possible grandiosity within participants, to also mitigate the possibility of the shaming experience Josselsen talks about. A research participant is not a professional and may have little knowledge of the repercussions of participation. Potential negative impact may simply not occur to them.

Yet there is also the potential for narcissism from the researcher's position:

*'There is always the dread that I will have harmed someone, ... The guilt, .... shame, ..... that goes with writing about others and then encountering them afterwards'.* (Josselsen, 2011, p45).

There is also likely to be a form of duality with this particular research study. Duality relates to researchers who may be involved in their own practice-based research, which is not relevant in this instance. However, it also relates to the dual roles of psychotherapist and researcher with duality in subjectivity and possible conflict of interest (Thompson & Chambers, 2012) a reflection on which is in section 10.2.3.

#### 4.9.7 The ethics of the duality of roles – researcher/therapist

The British Association for Counsellors and Psychotherapists (BACP) has published a book on research ethics for counsellors and psychotherapists (Bond, 2004) to promote “ethical mindfulness” in research practice within counselling and psychotherapy. This effectively adds to the ethical dimensions of psychotherapy practice by taking account of trustworthiness, not only in relation to the researcher/researched relationship, but with the construction and application of new knowledge. BACP acknowledges this is particularly difficult in relation to cultural contexts and power/status within research. As such BACP seeks to promote openness and accountability within research, covering the entire research process.

Practice-based research is a focus of BACP guidelines, due to the dual relationship created when a psychotherapist is also a researcher of their own psychotherapeutic service. Although this was not practice-based research, it does feature within this study. There is reflection upon the researcher’s own practice throughout the research. There is curiosity about the research participants, their experiences and their therapy, and their experiences may bear resemblance to the researcher’s own clients, and how such experiences might be used to enhance both her own and her supervisees’ practices. Throughout the study process supervision has been used to monitor and if necessary address, any issues that might cross the boundary of researcher/therapist. There will always be a blurring of this boundary, as the researcher is a practicing psychotherapist and her client work is with women with maternal illness. Both clinical and also research supervision throughout the study, have helped her to navigate the challenge of the impact of this boundary. It is not possible to mitigate against this blurring of the boundaries. However, using reflexivity within this study has helped to tease out those difficulties.

#### 4.9.8 Feminist ethics – the ethics of care

Feminists have criticised traditional Western research ethics due to their focus (seen as a patriarchal focus) on ‘truth and justice’ rather than focusing on ‘care’ (Gatens, 1995; Gilligan, 1982). In 1982 Carol Gilligan published a book called *In a Different Voice* in which she highlighted the different ways men and women speak about ethics. She summarises her findings into what she calls an “ethics of care”: “The logic underlying an ethic of care is a psychological logic of relationships, which contrasts with the formal logic of fairness that informs the justice approach” (Gilligan, 1982, p73). She summarises that an ethics of care is one of a non-violent approach, that is also non-selfish, puts the relationship in primary position and is an ethics in which nobody should be hurt. This is in contrast to an ethic of justice in which everyone is treated in the same way.

Gilligan's work sparked controversy and initiated a dialogue about the way in which ethics are done. She highlighted that there was not only the traditional way of doing ethics such as Kantianism and utilitarianism. Tong (2000) defines feminist ethics as *"an attempt to revise, reformulate or rethink those aspects of traditional Western ethics that depreciate or devalue women's experience"*.

Feminist ethics do not just apply to women. Rather, ethicists are more concerned with the difficulties in the traditional way of thinking and doing ethics. Such criticisms about traditional ethical approaches are:

- A disinterest in women's lives and interests (Card, 1991).
- A focus on rationality rather than emotions or feelings
- Universal decision-making (impartiality)
- A deeply individualistic emphasis/detachment

Feminist ethics therefore focus on:

- An emphasis on care as well as justice
- Relationships are fundamental to decision-making
- Moral decision-making will be different dependent upon the relationships with those who are part of the decision
- Every decision is unique, bound up in context and will have specific elements which are solely applicable to that decision
- mothering can be used as a model for thinking (maternal ethics)

Feminist ethics is committed to ending the subordination of women. Certain characteristics from feminist settings which are now becoming significant are co-operation in dialogue rather than adversarial debate, with listening to (and hearing) others as important as speaking, including personal reflections and experience, removing abstract rules and principles and replacing them with emotional, including diversity as a matter of course, and aiming towards consensus whenever possible.

#### 4.9.9 The ethics of interpretation

An element of ethics that needs to be considered regards the difference in frame of reference and the power over data. Squire (2013) draws attention to the difficulties of keeping and guaranteeing anonymity within a research enquiry. In this case, women's experiences of psychotherapy are an under-researched area. Therefore, there is a possibility of 'deductive disclosure' whereby others may recognise the women who take part in this study, particularly as so few women have actually had TA psychotherapy for this condition. This causes a dilemma, as guaranteeing anonymity may involve removing elements of the richness of data

because it may contain identifying features. To overcome the concept of ownership and power over data, participants were informed that their names and identifying features would be removed from the thesis.

There is also the dilemma concerning asking participants to contribute to the analysis and interpretation of their own data. Hollway and Jefferson (2000) believe the participant may not know their whole story, and that there will be an element of it created by the researcher, particularly as they use a psychoanalytic frame for their research interpretation. They advocate giving the transcript to the participant, but not inviting interpretation. Other researchers choose to feedback their interpretations to the participants and then note the participant's responses (see Chamberlayne et al., 2002). As the data set is vast and two of the participants know each other, all participants were offered a summarised copy of the thesis once completed.

#### 4.9.10 The ethics of creative visual methodologies

When exploring the use of creative methods it was also necessary to explore the ethics of these methods. The Economic and Social Research Council (ESRC) set out ethical principles for research and include visual/vocal methods (ESRC, 2015:10) as suitable for a full ethics review due to the risk of identifiable material used or generated. Photographs in particular are likely to create data whereby the participant and individuals are identifiable and therefore would not allow for required confidentiality. Anonymity within photographs and visual methods is a challenge (Pink, 2013; Rose, 2016; Warren, 2002; Wiles et al., 2011). In this thesis, the exploration of the creative methods findings in each participants' chapter, any personal identifying marks have been removed or features blurred to protect identities and confidentiality.

#### 4.9.11 The ethics of lone worker policy in research

Due to the subject area, it seemed simplest to conduct the interviews in participants' own homes, or in a place they might feel safe enough to share their experiences. However, this brought up issues of risk, in particular to the researcher. To minimise risk, the researcher followed the Health and Safety Executive (HSE) guidelines on Lone Worker Policy (HSE, 2013). This involved informing a colleague of the time and place of the interview, with an agreed phone call at the end of the interview, to let the colleague know the researcher was safe. The researcher, due to a long-term role in the NHS also had previous training on safeguarding within a mental health setting and other aspects of conflict management and resolution.

#### 4.9.12 Safeguarding

Within the detailed application for ethical approval provision was made for a debrief session for any of the participants who asked for this, once the interview was over at no cost to the participant. This provision was re-stated to each of the participants at the end of their interview. This debrief was possible either through another psychotherapist who had agreed to fulfil this role, or with the participant's own psychotherapist.

#### **4.10 Summary**

This chapter sets out how the data was collected and analysed. It began with the style of sampling – judgment sampling, and the inclusion/exclusion criteria, leading on to the participant recruitment process. The chapter went on to explore in-depth the two types of data collection - interview and creative - and the chosen data analysis procedure. It ended with a significant section on ethics, due to the nature of the research study including the context, the significance of both feminist ethics and the ethics of vulnerability due to the study revolving around mental illness and its treatment.



## CHAPTER 5

### Lucy's story

#### 5.1 "The Madness of Thinking"

This is Lucy's story, in which she talks about having anxiety in her second pregnancy, leading to "*severe health anxiety*". Lucy believed her illness began with stress which increased into anxiety, which turned into depression when her anxiety became 'too much'. She acknowledged having anxiety in her first pregnancy, but said it was not bad enough to seek medical help. She also recognised this anxiety from her past, due to stress at work.

Lucy is 35 years old. She lives in the north of England with her husband and their two children. She re-trains people changing career, or who have been unemployed long term. The interview was conducted in her home in October 2016. Her object was a poem, explored in Section 5.6. A full transcript of Lucy's interview is in Appendix 6. For transparency purposes, the transcript line numbers are included in brackets. Lucy's narrative is in italics and the researcher's are in blue. This is so readers can pinpoint who was speaking. Any TA terms are described in the glossary of terms (Appendix 1).

Lucy was unusual because she had received both CBT (through her doctor) and TA therapy within a few months of each other, so could give a clear comparison of the two therapies. She had written an article about this. She said her experience of CBT was "*missing what was really going on for me*" (31), primarily because it was only about symptomatic relief, rather than addressing the cause of her anxiety: "*CBT literally just responds to the symptoms and doesn't really understand why they're there*" (379). Lucy expressed positive experiences about her TA therapy, and still attends group TA therapy several years later.

Lucy spoke vividly and dramatically in her interview and it was clear how devastating and frightening she had found her illness. She used two words in her interview that encapsulated this: "*hideous*" (173, 558, 786) and "*horrendous*" (244, 474). But a phrase she used part way through her interview really captures Lucy's experience of perinatal mental illness: "*the madness of thinking*".

This 'madness' seemed to play out in her voice. Its resonance was striking, including the frantically hurried way she spoke which she named as "*my process is rushing*" (176). This gave a sense that there was so much to say and it needed to be all jammed in, or possibly that she needed to speak it all as quickly as possible, to get it over with, or even get it out. This hurried, quite frantic speech is difficult to capture within the transcript. The voice resonance was noticeable, particularly at the beginning of the interview, with her voice changing in

particular parts. These changes, as well as when she sighed, laughed, took deep breaths or paused, are all marked in different colours on the transcript.

Lucy was noticeably tentative throughout her entire interview and used phrases such as “*sort of*” and “*kind of*”, as well as repeating words, which seemed to highlight her tentativeness. Her sentence structure was difficult to follow, particularly in the first part of her interview. It felt chaotic, which paralleled the feeling she said she had of growing up being “*chaotic*” (199), and how this “*chaotic-ness*” was part of her process in her illness (441, 655).

### 5.1.1 Becoming unwell

Lucy began the interview by saying that anxiety, particularly anxiety around her health, had brought her initially into CBT through her midwife, and quite quickly she acknowledged that her thinking was already “*going a bit, sort of, peculiar*” by this time:

*Erm, what actually happened was I started to experience anxiety during the pregnancy. So, the first time I thought, um, something's not quite right, was around the December time, kind of half way through the pregnancy, ... (deep intake of breath), erm, and I, (pause), when I sort of look back, my thinking was already going a bit, sort of, peculiar. So, I sort of, kept that almost a bit separate and almost wanted to deal with the anxiety (pause) and, (pause), I mentioned it to my midwife and she, err, referred me into, it was called 'the single point of access', that's what I was referred into and then sent out to see someone for basically CBT counselling. Which is what I wrote the article about (14-23).*

Lucy went on to briefly describe the CBT she received and then said why it did not work for her:

*I kind of understood the theory of the CBT but I didn't, it wasn't really hitting what was going on, and I didn't really understand it, my symptoms were, erm, health anxiety, really, (drops voice) well I think its awful, you know, all the time thinking about my health.*

EH **So yours, not the baby's?**

*Mine, mine yes, that wasn't something totally new to me, I had experienced that about 5 years before when I'd been really stressed at work, erm, and I had had a, not much therapy. But about 3 or 4 sessions, and I'd taken Citalopram, only a low dosage, but it was enough to, sort of, get me through that period, and I thought all that's done and dusted, you know. Anyway, it reared its head when I was pregnant and it was about my health, erm, and, it was just a real process, like an internal process of “maybe this is wrong*

*with me, let's try and figure it out, and let's try and solve it", so fuelling this idea that something was wrong with my health. Erm. So the CBT was focussed around that to challenge my thoughts really, erm, and it just wasn't really working, and I wasn't in a place where I could really think cognitively. My head had just gone skew whiff, really by that point, erm, so, I carried on with that therapy through having Oliver (33-50).*

Lucy talked about the differences between TA and CBT again about half way through the interview, when she was explaining how TA therapy helped her:

*Whereas I guess the CBT literally just responds to the symptoms and doesn't really understand why they're there, so it never really made sense to me, it was a bit like well you know maybe I can convince myself one day that if I think something else then it, you know, if I challenge my thoughts, that might work. ... Sometimes I think if you are functioning ok, CBT is sometimes useful, if sometimes, I don't know, if you see something on the TV where you think, you know there is something about cancer on the news, I could use a CBT technique and think, you know, hope I don't get that. Well then you can say, well you probably won't. At that time I couldn't do that, I just couldn't do that, to me it was like well I might do, erm (pause)*

EH [So you couldn't have that internal dialogue?](#)

*No, the chances of this happening are, you know, it probably isn't going to happen it, your going to be ok, I couldn't have that at all, it was like if I thought it, I just couldn't soothe myself at all, and I would carry on, more and more with it. It was quite OCD-ish really, quite compulsive thinking and just I really found it so hard to break the pattern of thought, really (380-395).*

Lucy alluded to how often she thought about her health during her illness, and the cycle that would begin with her trying to work out why she was thinking the way she was, and trying to solve her own thinking by controlling it:

*It was ultimately like a control thing for me, I thought well if I could control, if I am going to get ill I need to control it and get help and so it became, like, I think a way of just trying, it was definitely a distraction, the health anxiety was a distraction I think from what was actually really happening. So it's like I, if I think about that and I really worry about that and I become obsessed about that and if I can sort that out, in my sort of skewed thinking, it was then a distraction away from something's really not right for me inside here, more about, like it's another way of ignoring myself really (336-343).*

### 5.1.2 Panic attacks

Once Lucy had given birth, her anxiety increased dramatically and she began to experience panic attacks:

*Yeah, 3 weeks into being at home with Oliver, and ... so we had some sort of other stuff going on which I think maybe escalated, erm, where I was at the time. I went to my mum's house and I just was having panic attacks really and I just, sort of, hit a wall and just said you know "I can't do this, I can't do this, I can't do it, I can't, I've just gone, I can't look after Oliver, I can't". I had my daughter with me as well, erm and it was me just saying "look I can't cope", you know, and it was just fairly dramatic, can't cope you know. I didn't leave my mum's house for two weeks then, and (pauses)*

EH *And was it, was it about you not being able to cope with yourself or with the children, or was it everything?*

*(pause) it felt probably like everything, because I think I knew that my thinking, and this sort of health anxiety and checking, and I sort of knew enough to know, you know, I probably am ok but I couldn't stop the thinking and I'd, I'd got to a point where I just can't function because I, I'm thinking all these thoughts and I just don't know what to do and it felt, and it just felt like erm, like it would, how could I exist like this, "I can't exist like this because I can't", it was depression as well by this point, so there was the hopelessness, ... as well as the anxiety, so it felt very hopeless and it felt, I was very frightened of having panic attacks with the kids, so I thought, if I have a panic attack and I can't breath and you know, I'm holding Oliver or, my daughter's there, she's going to worry what's going on (voice elevates) and so of course the worry of having it fuelled having them, so that was a big thing for me, so that made me think I couldn't really look after them effectively, that I sort of needed other people around in case, you know, I was going to panic (62-88).*

### 5.1.3 Lucy's continuum of illness

Later in her interview, Lucy returned to what seemed to be a continuum of illness, beginning with stress, elevating into heightened anxiety and panic attacks, and then finally changing into low mood, which she perceived as depression. She believed this episode of illness began when a company she ran with her mother went into bankruptcy, a year before her son was born:

*So what happened, erm just before I got pregnant with Oliver I used to work, work in the family company, ... and I was erm a director with my*

*mum when, our business, ... went (pause) bust, err probably a year almost exactly to the date of me having Oliver, so that ... happened, and it was horren, it was so stressful that it was a really awful experience and then, in terms of the actual stress of it happening, but in the family too. And then erm on top of that we'd moved into this, ... it looked like a building site whilst I was pregnant (234-248).*

Rather than deal with the stress, she re-framed it into a need to distract herself, to fill her life by being busy and chaotic. She even described this time as “*OCD-ish really, quite compulsive thinking*” (393) and by this she seemed to mean that she became obsessed with filling her life up, which she was convinced served only to feed her feelings of anxiety. To distract herself from her anxiety she focused on her health, becoming anxious about herself, as shown above (section 5.1.2) in which she narrated her panic. This manifested in her becoming convinced that she had a brain tumour and would die.

Lucy's anxiety then shifted to what she perceived as depression. Research is beginning to show how stress and anxiety, particularly in the long term, can affect the brain causing ‘allostatic overload’ (McEwen, 1998; 2008) and its effect, in turn on the functioning of the central nervous system, one outcome of which may be depression (Caspi et al., 2003; Kessler, 1997; McEwen, 2008). The continuum Lucy described seemed to confirm this experience:

*Like this is going to be forever, and err, yes, and I think that was, I think that was my kid [Child ego state], just, again I can't keep this level of anxiety up, I can't keep this fear up, and erm just sort of, you know just sort of really that low mood and helplessness just sort of kicked in, as a sort of almost opposite to the heightened, you know, busyness, chaotic-ness, awful thoughts, so I guess, I guess the sort of anxious thoughts sort of did settle, I think really, once the depression did sort of kick in, actually, if I'm really, you know, sort of honest (line 437 – 445).*

*I think it was sort of, once the depression really sort of kicked in it was sort of like, it felt preferable actually to the anxiety. It felt more manageable (471-472).*

Lucy recognised depression because she said she began to feel helplessness, which for her was the opposite of chaos. Finally, when the depression came, Lucy said it was a “*relief*” from the experience of anxiety, and panic attacks.

#### 5.1.4 Pressure

Some women speak of the pressure they feel to be a good mother which can manifest itself in many ways. Lucy felt pressure to breastfeed. Pressure can build leading to a fear of self-harm. Lucy talked about her fear of this in the beginning of her interview, when she described a particularly difficult point in time after her son's birth:

*I never at any point thought I would do anything to the kids, it wasn't that sort of depression, you know, it wasn't that sort of (pause), I really bonded actually with Oliver, probably more than I did with Olivia and I do wonder if I did have, you know, a bit of, of similar stuff going on after I had my first child, erm, and that sort of really wasn't perhaps sort of dealt with as well as maybe it could have been. Cos I went back into work quite quickly and there was probably a lot more distracting stuff going on, we moved into this house after having my first, after having Olivia and so, yep, so you know I felt the bond there with Oliver and so as I never feared I would do something erm, I didn't think I'd ever really do anything to myself, but I did think, "I don't know how long can I go on feeling like this, and if this is how I'm going to feel forever, what is the point in living" (voice get's shaky), so that was there too. But I was never going to actually do anything to myself, erm, so ... (88-101)*

The pressure Lucy felt to breastfeed both of her babies, and the failure she felt when it was so difficult for her, is something many women talk about (Mauthner, 2002). Lucy thought it was a contributing factor, and explained how her 'failure' at it with her first child played a part in her decision not to breastfeed Oliver for more than a few days after his birth.

*I really wanted to feed my daughter and, I found it really difficult and erm, got a lot of erm, well she had a tongue-tie, to start with and then I got really really damaged nipples, erm and, I don't know if she was really getting enough or not, it's all a bit hazy but it felt like the hardest thing in the world at the time,... and I fed her for about 3 weeks and stopped, but I really didn't want to. I did, so there was a lot of failure around that really, and I was worried about doing it again, err, so I did feed Oliver for about 3 days and then moved onto bottles, cos I just think in my head, this is going to be something else that makes me feel crap. So if I take control of this, this wouldn't, then erm. And looking back, I don't know if I had fed effectively, what sort of difference it would have made, in terms of how I was feeling, erm. I am glad that we did move onto bottles, because I did need so much help around that period, that if I'd carried on breastfeeding, it might have*

*been difficult, especially when, sort of like, erm. I used to get panic attacks, ... so yes, if I had been feeding while experiencing all of that, I think it would have been, erm, really difficult. But yeah, feeding, I think, is a big thing ... for women with depression, I have spoken to a lot of people with similar sort of things (109-138).*

Lucy's sentence "it felt like the hardest thing in the world at the time" (112) gives a sense of how difficult she found this time, how hopeless she felt, and how frightened she was, all emotions evident in her shaky voice (99).

#### 5.1.5 The impact on Lucy's relationships

Lucy talked about the impact her illness had on her relationships with her husband and mother, and how she was still working through these in group therapy:

*We do still talk about that period of time ... in a lot of sort of reflection about how that impacted, I guess, on my life, how it was, my relationships, because I think, you know, there are still problems, my relationships are still affected now from that period of time. (158-163)*

She went on to describe how her husband and mother experienced her illness:

*It was a terrible shock really to my husband and my mum, even though we knew I was getting these CBT sessions, it was still like, "oh my god I didn't know you were that ill, really, and it was that bad", because it was just the real cover all the time, really*

EH [your cover?](#)

*my cover, yeah, erm and I do think that my, people in my life played into that too, I think it was easier for them if I was alright, you know, you will be all, alright, yeah (226-232).*

This section of narrative highlights Lucy's internal process. In the first sentence she uses "we" rather than "they" when she talks about her husband and mother knowing about her CBT sessions. Lucy may not have understood, at a deep level, how unwell she was at the time, using the "we" to include herself in this uncertainty. It seemed almost as if her 'cover' had hidden her illness from everyone, including a part of herself. She went on to narrate the difficulty she had initially, as her cover hid her illness from her husband, meaning he did not understand how ill she was:

*Well I think definitely, when, when, when it first started to uncover, actually how ill I was, erm there was a bit of resistance at first, and I think he just*

*thought, ok, her mum's helping her, because I'd sort of ended up at my mum's house. ... I think he, part of him was like "oh good, she's there and she's getting looked after there" and he was carrying on working and stuff and then it started to dawn on him, I think, that this wasn't gonna just be ok, it was gonna be a long process and you know, I wasn't going to take a tablet and I was going to, you know, get better. So once he realised that, and he never, he never said erm, you know, come on pull yourself, come on pull yourself together sort of thing, ... (intake of breath) erm, but I do think it was, a bit like, umm, I don't think he really got it at first, until he saw how bad it was and how sort of like, how I couldn't control it, you know, (pause)... so once that dawned on him, he was pretty good really (270-286).*

*We often talk about how much I've changed, and he's he's alright with that, but we've managed to keep the relationship ok ... during the change, I don't know how alright it would have been (wry laughter) you know, the relationship had gone the other way with all the change we've been through, erm, there's been ups and downs really there has been ups and downs too, erm, really (300-306).*

She talked about the emotional rather than the physical absence she felt from her husband:

*He doesn't, erm, you know, abandon me, in terms of he's here, but sometimes I think, you know, how sometimes we're not really here when we're here, so you're sort of busy with whatever's going on for you or whatever, sometimes it's a bit like I need a bit of you, I need a bit of decent communication" (309 - 313)*

When talking about her relationship with her mother, Lucy acknowledged it was an 'enmeshed' (204; 236) relationship. Later on, she said how hard it was to admit to her husband about the difficulties she had with her mother and how she tried to keep it ok:

*he knew bits, but he didn't know sort of how, quite how chaotic it was at times and erm, or I wouldn't ever say you know I'm not really happy with the way I am with my mum or you know, I just think I convinced myself everything was ok (655-658).*



She said her relationship with her mother changed after her illness and therapy:

*she's got her own, erm stuff going on, which I'm really working through, as well in therapy that, how I manage that and how I separate myself (599).*

*Really hard is my relationship with my mum, because I've kept it ok and then I've had times when "do I really want to talk to you anymore?" Erm, so that has, that's probably been the hardest bit. Because its sort of like that, and because I am still, I talk to her every other day and, you know, she looks after the kids one day a week and stuff, so, so she's very much there so, there is stuff she would have done historically, or it would have played out in our relationship historically and I just tolerated. I don't anymore, so even though I feel stronger in some ways, I also feel sadder and I guess the grief of, part of this relationship isn't what I thought it was, has been really hard. We're kind of at a stage where it is sort of like, I think we are re-figuring out our relationship together (705-716).*

Lucy's father was virtually absent from her interview, and there seemed to be a parallel between her father and husband, of being there but not there. Towards the end of the interview she responded to a question about whether her dad was around:

*Yeah, yeah, he's still around, erm (pause). He is around, but he's not around in the sort of way I'd want him to be (585).*

## **5.2 Therapy**

Lucy quite quickly began to talk about her TA therapy and the hope this gave her. She said she had a TA therapist in the background waiting for her to feel able to come into therapy:

*Well she [the therapist] actually asked me to come in and see her, erm, so I did, ... and she didn't, spoke to my kid [Child ego state] basically and she said, "you know, this can be ok, you can start to feel ok again. But it will take time." ... I think she was my first port of call, to see if I liked her and we got on, and we did, and I had my first session, it was in July I think, so only a couple of months after Oliver was born, so quite soon ... and I started off with hour sessions each week and this took priority over everything obviously, erm and I started to see her and that's when really I did start to, sort of, I didn't, I wouldn't say I felt well quickly, but I started to feel a sense of grounding and a glimmer of hope, really, that this isn't going to be the same for ever (140-156).*

Lucy described the elements of the therapy which had helped her begin to understand what had been happening in her thought processes which had led to her anxiety rising:

*The first thing that really I remember was “this is your kid [Child Ego State] asking for something here and it’s like you’ve put”, (voice changes) she’s put her hands up and is saying “hang on I can’t do this anymore and I need help” (pause). So I could start to understand that there was like, this frantic anxiety, wasn’t about being ill, it was, and having health problems, erm, it was about something that I was ignoring really (pause). There was something else going on which she [Child Ego State] just, really wasn’t happy about, erm, so that was the first thing I remember making sense. And er it was [name removed] that had said if you start to listen to that, your symptoms will start to alleviate.*

**EH** *And they did?*

*Well I did have a, a, a small relief after that conversation because I remember thinking “ok maybe there is something I can do about this” and it starts, I guess, a bit of Adult [Ego State] came into play where I could think, right this is manageable (351-365).*

Lucy went on to explain the way she had perceived her illness as something external to her that she had no control over. In therapy she learned that this was an internal rather than external process:

*It felt like, the anxiety and everything, and the depression felt like something that had sort of attacked me. It, it sort of felt like it was external to me ... and for some reason and it felt like (pause), it felt like it (pause), was something that had, had almost attached itself to me and I couldn’t control and I think that was this, like this really scary part. It was just like (intake of breath) whereas understanding it was an internal process ... there was, I was soothed by that, because I could think, well this is me, it’s me that’s, even though I suppose I could sound quite critical that I’m doing this to myself, it didn’t feel critical because I could think, hey this is just me and some thoughts that I’m having, and, we can respond to them and try and alleviate whatever there is going on and understand it (367-380).*

*We went really quite quickly into me and who I was, and my past, and history and stuff. (Pause) we did talk about the health anxiety, and and my symptoms, but not a huge amount (pause). I guess what she was doing was working with my kid [Child Ego State] and giving me the permissions (pause) she started to nurture and give permissions really really early on*

*and I think that, that did soothe my kid [Child Ego State] and start, and then I started to take those as well (407-422).*

### 5.2.1 Lucy's script

In TA a theory called script beliefs (Erskine & Zalcman, 1979), denotes beliefs from childhood about self, others and the world. Lucy's script belief about herself was clear throughout her interview:

*I'll be alright if... (I'm a good girl)" [Child ego state, and Please Others driver].*

She named this early on, when describing her thoughts during her post-birth experience of needing to go into theatre:

*and in the back of my head I'm thinking "oh god, what's going to happen, what's going to happen" and I bled quite a lot too. Erm, and ended up having to go down to theatre as a piece got stuck, erm so, I did what my script behaviour is of "oh this 'll just be alright" and all the time I kept on thinking, during the pregnancy, I'm thinking all this stuff and I'll be alright once the baby's here (58-63).*

She named it again when talking about her childhood, and how she would try and act as if everything was ok, but internally it was not:

*I lived with my mum and we're we're very sort of enmeshed, quite symbiotic and (pause) she's very, she's very erm, she's quite narcissistic and quite, very sort of, she knows what's right and I, I've responded very much in a very "ok then I'll just be the quiet person that pleases others" and erm, she, I had a memory which I did take to therapy that erm, what, one time my parents were arguing in the house and my auntie came, and they were having a fight or whatever and I was, I just turned the television up and sat there just with the volume up and we all would say that I would turn the volume up to just say well "you know, I'm just going to ignore that or it'll be fine, it'll be fine" and erm, I think that is probably a replay that I do when I find things hard erm so whilst on one hand I sort of project to the rest of the world that I am very much in control and I'm very erm, ok, and and you know fine, it's, it's really not the case inside (204-215).*

Her script was apparent again when she talked about going back to work four months after Oliver was born:

*I was going to start [work] sort of quite soon after Oliver was born, really I think that's part, looking back that was part of "well I'll be fine" (613-615).*

Lucy clearly believed that if she pleased others by going back to work, not bothering her mother, or the medical professionals in the hospital, then everything would be all right. This was also a way of her discounting herself, highlighting her belief that everyone else was more important than her.

### 5.2.2 Discounting

As well as pleasing others, Lucy enhanced her script by discounting herself, using the word *'just'* often in her narrative, as in *"my head had just gone skew whiff"* (48) and *"I just was having panic attacks"* (66). She continued to do this throughout her interview, although it did decrease in the latter half.

*"I just"* was the second most prevalent sentence construction in her interview, with *'just'* frequently used before a description, as a way diminishing herself, her actions and her words: *"I just was having panic attacks"* (66) or *"I just can't function"* (77). This need to discount herself would be seen in TA as a characteristic of a lack of sense of self, of the injunction 'Don't Be Important' (Goulding & Goulding, 1972; 1976) within the world.

The word *"need"* was also prevalent. When she combined *"need"* with *"just"* it gave a sense of her berating or criticising herself: *"I just need to get away, just need to get away"* (125). It also highlighted her belief that whatever it was that she *"needed"* to do could solve all her difficulties. The word *"need"* continued to the end of her interview, suggesting there is still work for Lucy to do in her therapy, which she acknowledged:

*And I don't think I give myself space for that, to think that, a lot of the time, a lot of my process is rushing, and getting better and being ok, a bit of a 'hurry up' [Hurry Up Driver] and it's almost like, I've still got to really, integrate that into part, who I was and what happened in that time (175-178).*

*I think it was part, part, the experience I had then was just part of me and still needs working on" (186).*

### 5.2.3 Gallows laughter

Another form of discounting Lucy used was 'gallows' laughter, a way of her discounting something that was really difficult or traumatic for her by laughing about it. The gallows laughter first appeared when she was talking about

stopping CBT and going into TA therapy: *“at that point I think I’d have just done anything (gallows laugh) to try and feel better”* (146). It felt incongruent to listen to.

Lucy used this style of laughter a great deal. She laughed when she remembered her house being a ‘building site’ during pregnancy. She laughed when relating a visit to the GP with her husband about her extreme anxiety. The GP had used the metaphor of a Meer cat, to describe how he experienced Lucy’s anxiety and this metaphor clearly resonated with her. She laughed when she described making a tiger mask in a creative workshop, and this laughter seemed to be at the absurdity of her making such a mask. Finally she laughed when describing how difficult her relationship was with her mum, but then acknowledged her mum also had difficulties with anxiety. The laughter is most noticeable, however, when she talked about the possibility of her relationship with her husband faltering if she had not had TA psychotherapy. It was significant that she said *“I don’t know how alright it would have been”* (303), then laughed in quite a wry way. Using humour when describing times of difficulty was clearly Lucy’s defence mechanism.

### **5.3 Other notable aspects of the analysis**

Woodcock (2016) added to the Listening Guide method by suggesting the researcher actively look for contradictions, omissions and revisions within the narrative. There were contradictions in Lucy’s story such: *“I kind of ... but I didn’t”* (33), *“I didn’t think I’d ever really do anything to myself”* (98) followed by *“if this is how I’m going to feel forever, what is the point in living”* (99), and *“I didn’t go agoraphobic, but I didn’t want to leave the house”* (141). Lucy’s daughter and father were absent figures in her narrative. She spoke of her daughter only in the third person, and she only spoke briefly of her father when his absence was highlighted to her.

Gilligan (2015) suggests looking for metaphors within the interview transcript, and Lucy’s first metaphor was a TV. She said she would turn her internal volume up in order to drown out things that were going on around her: *“I would turn the volume up to just say well you know I’m just going to ignore that or it’ll be fine”* (209). Lucy had a second metaphor. This was a Meer cat. It was a metaphor her GP had used to help her understand her anxiety and hyper-vigilance, which resonated with Lucy as she used it within her interview.

### **5.4 Listening for Lucy’s other voices**

Four distinct voices were noticeable when listening to and re-reading Lucy’s transcript (see Appendix 6). There was no overlap between the first and fourth

voices, although the third and fourth voices overlap within the latter stages. This was expected as Lucy had not completed her psychotherapy. Each sentence within her interview gave distinct clues about which part of Lucy was speaking. There was temporal movement within the four voices, also mirrored by the actual process of her interview.

Lucy's first voice was the part of her that was lost. In TA terms this was her Adapted Child ego state, which she associated with her script behaviour of pretending that everything was ok but actually wanting to run away and hide through fear. This was the part that would cover her feelings up (her mask) so her husband, mother or others would not know how bad it was. This part narrated her sense of not knowing whom she was anymore, having lost her identity. In TA terms this fear would be seen as coming from her Adapted Child ego state. In order to keep herself ok, this voice was telling her she needed to remain silent, not admit she was unwell, in order to please others. The Child ego state was the part that distracted Lucy from what was really going on internally, by focusing on her health anxiety.

Lucy's second voice was the one she began to find in her TA psychotherapy, the part of her that could begin to make sense of what was happening to her. This was the part that began to uncover her process in psychotherapy. This is the part of Lucy which could acknowledge that anxiety and depression had not attacked her. This part could listen to her therapist and understand what she was doing. She acknowledged that her therapist helped her to soothe her frightened Child ego state, gave her permission to look after herself and to acknowledge that she could be quite self-critical [Critical Parent ego state]. In TA terms this would be activating her Nurturing Parent ego state in a way that calmed the frightened child and helped her nurture herself. This voice questioned herself, asking what was going on, and why. This was the part of herself that began to uncover why she hid herself away behind her 'mask'.

Lucy's third voice was the one that really engaged with her TA journey of recovery. In TA terms this would be called 'integrating' (Tudor & Summers, 2014) "*the process whereby humans take in material either through some internal process (such as reflection) or directly from the environment (such as feedback or appreciation)*" (p266). This was the part of Lucy that was more accepting, that allowed herself to ask for help. This third voice was able to discuss with her husband how much she was changing, and could acknowledge how she was being helped. This part listened to her Child voice, and understood that she was unhappy. It also listened to her self-critic, and understood this was her own internal process and that others could help her, she did not need to hide from them, nor silence herself.

Lucy's fourth and final voice was one that she said she was still working on in therapy to understand. This was the stage of transformation and integration, of completely integrating all parts of herself, even those she found uncomfortable. This was the part of herself that could self-soothe and did not look for, or need others to soothe her. This was also the part that no longer needed to hide and could speak to others about her experience without feeling ashamed about it. In TA psychotherapy this is the part that is called the 'Integrating Adult' – "*a metaphor for that aspect of the personality, which, being the neopsyche, is new in that it is constantly updating information derived from processing external stimuli, and internal experience, whether consciously, unconsciously, or non-consciously*" (Tudor & Summers, 2014).

### 5.5 Listening for Lucy's "I" poems

Lucy 'thinks' all the time, which became apparent when exploring her "I" poems (Gilligan, 2015). Within the interview the most prevalent statement she used was "*I think*". She used it much more often than the next most prevalent statement "*I just*". This gave a sense of clarity to her statement "*the madness of thinking*":

*Because the, the madness of thinking, you know, that a lot of my thoughts were "I'm gonna have, I've got a brain tumour and nobody knows and I'm just gonna collapse at home and the kids aren't gonna" you know, "I'm gonna be dead, and the kids are gonna be there (breathes in) erm and I've got to", I used to do stuff like get all of his bottles ready and think "oh good they're all ready", so if I get ill, they're all ready (320-324).*

The end of this section "*and put stuff, err, just sort of*" gives a real sense of the way in which Lucy's thought process was skewed. In the first half of the interview when she thinks, she often follows this thinking statement with a "not knowing" statement: "*...I'm thinking all these thoughts and I just don't know what to do*" (77) giving her story an underlying sense of her thinking leading nowhere, or going around in circles. Such as:

*"I think"*

*"I just don't know"*

Then about half way through the interview this pattern changed to:

*"I think"*

*"I can't really"*

*"I guess"*

*"I guess"*

*"I don't know"*

This temporal change in her pattern of speech showed that her thinking was beginning to slowly and tentatively change, particularly when she added the 'I guess' element. But then she fell back into not knowing again, always culminating in the 'I don't know' phrase, which still gave a sense of her inability to know what was happening to her.

This positive followed by a negative happened throughout her interview. It was particularly vivid within the first half, with 'think' often followed by 'don't think', which seemed to be a counter-narrative, another part of herself disagreeing. Towards the end this pattern stopped. The temporal movement in her story was also noticeable. In the beginning she used 'couldn't', indicating that for her there was no possibility. Yet, as she told her story and it moved temporally, this changed first to 'could', then towards the end, to 'can'. This movement was also noticeable as, at the beginning she often talked in the past, reminiscing - not in a good way - about her illness, with 'I used to' and 'I was'. Yet she moved toward the present within the central part of her interview, talking about her mother and how this has affected her, then talking about therapy: "I need to trust this process really" (675). This temporal structure was even noticeable in her use of the verb 'to know'. At the beginning of the interview Lucy used 'not knowing', and towards the end she was more often saying 'know'.

## **5.6 Exploring Lucy's object - a poem 'Masks' (author unknown)**

Lucy's object was the poem, "Masks", which she was given at a creative workshop when her son was about 16 months old. The title of the workshop was also 'Masks', and in the workshop all the participants made a mask for themselves.

When Lucy was asked what in the poem resonated with her she said:

*That's just me ... (long pause) ... it just made real sense of, erm, actually, "this is what I look like, but this is what's happening inside", and it felt like it was a really nice way of saying "hang on a minute, I'm here" and "I needed your help" really, which I think is what I did" (498 - 510)*

When she talked about "needing your help" it is possible she was meaning particularly from her husband and her mother, as she talked about them not helping her. She discounted herself at the beginning by saying "that's just me". Her whole sentence was said tentatively, highlighted by her pause part way through. It appeared she still found it difficult to admit she wore a mask, or that



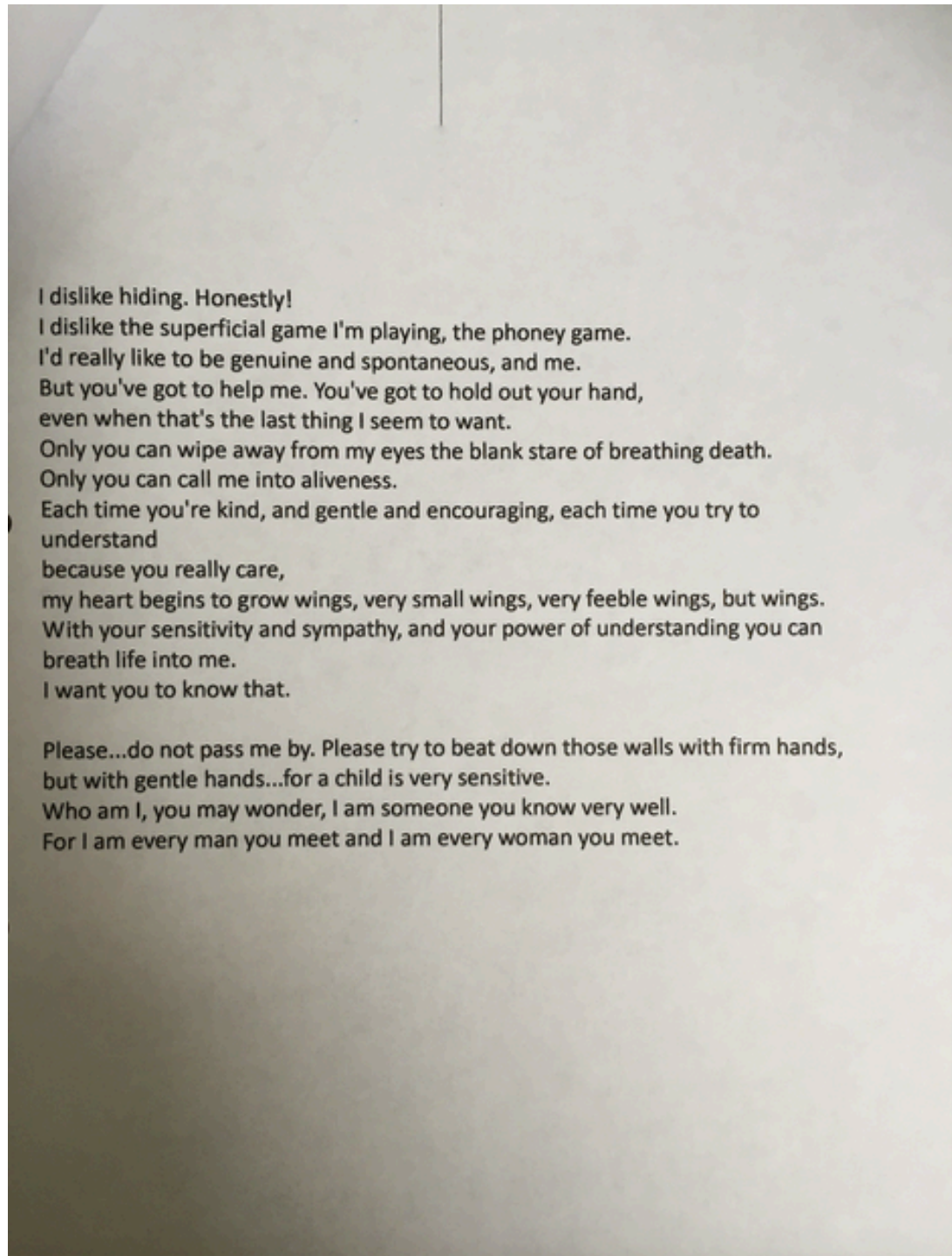
**MASKS**  
**(Author Unknown)**

Don't be fooled by me.  
Don't be fooled by the face that I wear.  
For I wear a thousand masks, masks that I'm afraid to take off.  
And none of them are me.  
Pretending is an art that's second nature with me, but don't be fooled.  
I give the impression that I'm secure, that all is funny and unruffled with me,  
within as well as without, that confidence is my name and coolness my game;  
and that I need no one.  
But don't believe me. Please.

I panic at the thought of my weakness and fear of being exposed.  
That's why I frantically create a mask to hide behind, a nonchalant,  
sophisticated facade,  
to help me to pretend, to shield me from the glance that knows.  
But such a glance is precisely my salvation. My only salvation and I know it.  
that is, if it's followed by acceptance, if it's followed by love.  
It's the only thing that will assure me of what I can't assure myself - that I'm  
worth something.

But I don't tell you this. I don't dare. I'm afraid to.  
I'm afraid your glance will not be followed by acceptance and love.  
I'm afraid you'll think less of me, that you'll laugh at me,  
and your laugh would kill me.  
I'm afraid that deep down I'm nothing, that I'm no good,  
and that you will see this and reject me.  
So I play my game, my desperate game,  
And so begins the parade of masks, and my life becomes a front.

Continued



she had needed help which she perceived was not there for her. Again, when asked about the elements of the poem that resonated with her she said:

*Well just, just really all of it. But in, in particular this "so I panic at the thought of my weakness and fear of being exposed" erm yeah "I put on the sophisticated façade" and its really, you know I, I am really open with people about how ill I was and because I just hid myself really from the*

*world, even like my closest friends didn't really know what was going on, erm (552 – 559).*

Her voice was so low that it was a struggle to hear her, and it is possible this indicated her sense of shame. Not only did she remain silent about her 'hideous' experience, she hid herself away from those people who were closest to her. 'Hideous' is a word that Lucy used several times when describing her experience of perinatal distress. It was even within her final sentence:

*so if I took anything away from that period, it was absolutely hideous, but it encouraged me to go and get what I needed" (785).*

Lucy did not use the word shame, but it seemed apparent in another part of her story, when her voice cracked when she described her mother's business going bankrupt. She began to use the word 'horrendous' again, but cut it off and switched to *"it was so stressful"*. This also could indicate her shame.

*I still don't think people really believe how hideous, well you can't really explain to people (pause)... well, how awful it was, I think, unless somebody is in it, or works with people, or have experienced it themselves, its quite hard to explain, and I still think people think (voice changes to a quite mocking tone) "well look at you", you know, "well you're alright", (voice changes to sounding sad) you know, so that is there. And I'm always conscious of that now. So, actually I don't just pretend. (553 – 575).*

Towards the end of the interview, when talking about the poem and the mask she made, there was an element of Lucy drifting elsewhere in her head. This happened when talking about the poem and her journey to recovery:

*when I started to, sort of, start the journey of recovery, all that actually really matters is this, within my four walls really and that was, so, "right this has to be the focus now", yeah so maybe in some ways, you know, its like a protective, "this isn't", you know, "this is what's going to make me happy, if I've got this right" (540).*

Shortly after this she drifted off again when asked a clarifying question about a mask being protection, but then acknowledged:

*Hmmm, yeah yeah, which is kind of what the poem is about (547).*

This happened for a third time when she talked about being given permission to tell her story. She was asked if it would have been difficult to tell her story. She was at first lost in reverie, then responded:

*yeah, yes really difficult, I mean I didn't even really tell my husband really my story (649).*

Lucy's poem represented protection, hiding her true identity behind the metaphor of a mask of ok-ness. Once she began psychotherapy she said she could understand why she did this. Discovering why was important to her, as it allowed her to choose whether to continue the behaviour or not. When she described the tiger mask she made, she laughed:

*it was quite unconscious, but I feel I (pause), I think it was at a point where I was actually starting to feel more, erm, I wouldn't say powerful, but a bit more "hang on this is who I am, and I've got strength and I've got" you know, "a roar and everything" you know, "it's here". So it was quite unconscious I think. But on reflection ... I think it was sort of about erm me finding my place a bit, and taking it (523 - 528).*

There is another part of the poem, which Lucy did not point out, but which was very similar to her own narrative. The line of the poem beginning:

*"But such a glance is precisely my salvation. My only salvation and I know it that is, if it's followed by acceptance, if it's followed by love" (Poem page 1, verse 2)*

Lucy said towards the end of her narrative:

*because I'm presenting alright, I am, it's a constant check, you know, 'I'm afraid your glance won't be followed by acceptance and love' and that's a massive thing actually, and ... and I got a massive lot of acceptance from the group. And that has been a big thing for me, you can expose, you know, the bits of yourself that you are uncomfortable with and still experience acceptance and support (565 - 572).*

The poem has a strange history. It was a version of a poem often cited as "author unknown" or "anonymous". There are many different representations of it on Google. Charles C. Finn claimed to have written the poem in 1966 when he was training to be a Jesuit priest, and had given it the title "Please Hear What I'm Not Saying". The poem's history and Lucy's experience resonated with each other. There also felt like something serendipitous about this poem and the theme of the research, and how mothers narrated the need to hide their identity behind a mask of ok-ness, to remain silent, possibly due to shame and embarrassment.

## 5.7 Reflections on Lucy's interview

From the beginning of our interview I was curious about Lucy's anxiety and the pressured way she spoke with speed and at great length. Her speech was so quick and full it felt quite overwhelming and confusing at times. This occurred particularly at the beginning of the interview, with a torrent of dialogue, almost as if the floodgates had opened and her narrative was pouring out, with little time for her to even draw breath.

I wondered what this was. I had a sense that she had a need to perform for me, or indeed for her own psychotherapist, and say the right thing, whatever that might be. It also felt like she needed to be "a good girl" [Child ego state] and maybe to tell me what she thought I wanted to hear. It could have also been a fear of talking about her therapy and experiences, a fear about what these might evoke in her. When I left the interview I felt full, exhausted, and yet on high alert. The torrent of narrative that continued to come from her throughout the interview was overwhelming - maybe it was Lucy's way of letting me know how overwhelming her experiences had been for her.

When re-listening to the interview, I noticed that I paralleled her anxiety and found chaos in my own sentence structures when I fed back what she had said to clarify her meaning. Often I was not clear, particularly in the beginning of the interview (188 to 196). I also missed links that would have been good to explore. Even writing up the analysis, chaos seemed to prevail. The initial drafts jumped around, with quite bizarre sentence constructions.

When reflecting on the interview, listening back through the tape and reading the transcript, Lucy's need for me to understand the depths of her experience and how her 'journey' had transformed her and her life was compelling. Once I began to analyse her data this need to be understood fitted with her sense of having felt she was 'going mad' when she was unwell, particularly when she remarked upon "*the madness of thinking*" (320). I wondered how frightening that experience must have been for her. I also wondered whether the tangible sense of anxiety within the interview room was another way of allowing me to feel her fear.

In the 90 minute interview I had a sense of her being 'lost' and when I began the analysis the underlying sense of madness became clear. In the interview she manifested what she said had happened to her, within the process. I then paralleled this within my analysis, thinking at length about the data, going back again and again to attempt to drill down further for meaning within that thinking. In retrospect, I was searching for meaning, just as I believe Lucy was. The interview process also seemed to parallel her experience of the continuum

of her journey. Firstly, her anxiety and chaotic sentence structuring were noticeable, with quite a marked pressure on her speech. Once she began to talk about her psychotherapy experience, this changed to a more cohesive process, with quieter, calmer, less pressured speech, less anxiety, with a more fluid, less chaotic, sentence structure. The data analysis style highlighted the different parts of Lucy's self, which in TA are called the ego states and are the most fundamental part of TA theory. This style of analysis allowed those parts to be shown within a tabular format, and to speak, loudly and clearly, and be heard.

## 5.8 Conclusion

Lucy's interview seemed to parallel her experience of perinatal mental illness, which was interesting. It began in such a frantic, hurried chaotic way, but then as time progressed the interview changed, and Lucy changed. Many elements of her story match those of other participants. For example, the feeling of being attacked by something external to her; the need to hide herself away, by wearing a mask to cover her real experience, so that people could not see how ill she was, and possibly even allowing her to hide from herself; her anxiety becoming health anxiety, similar to Jane, and both these participants have a feeling of 'mania' to some of their story.

Lucy also described a continuum of illness, beginning with stress, moving into health anxiety and panic attacks, and then ending with helplessness and hopelessness in depression. She expressed that TA psychotherapy was more helpful than CBT, which she felt only offered symptom alleviation. Her therapy began with one-to-one and went onto group therapy, both of which worked in quite different ways. It is possible that women who struggle with stigma and shame at the outset of perinatal mental illness, may prefer to have a period of one-to-one sessions, which could be followed by group therapy, as and when it is appropriate. Lucy's experience seems to show that this was a helpful pathway for her and appropriate for her experience.

It is also clear that TA therapy helped her to understand her own internal process and experience, and gave her a framework to understand what was happening to her. She found it calmed and soothed her, that it gave her a deep understanding of why she behaved the way she did, helping her to understand the impact of her childhood and how this influenced her relationships:

*It's been massively powerful, [...] massively powerful, it's given me a new way to look at the world really and myself, which I just really needed, you know (779-781).*

## CHAPTER 6

### Shoshana's story

#### 6.1 "Pushed off the precipice"

This is Shoshana's story. It tells of how she first became involved with therapeutic services as a teenager, what those services entailed and why she has continued to use them. This leads in to her description of the stress she felt in the perinatal period, leading to her feeling like she was "pushed off the precipice". Her story culminates in her description of couples TA psychotherapy during pregnancy and one-to-one TA psychotherapy postnatally.

Shoshana is 31 years old, and lives in Scotland with her husband John and their two year old daughter, Isla. Shoshana and John accessed couples therapy after she had an ectopic pregnancy and just before Shoshana became pregnant with their daughter. Shoshana and her husband were from different cultural and religious backgrounds and she believed it was important to have a therapist who understood their mixed culture and religion. Their choice of therapist reflected this difference within his own personal life. This need in Shoshana to want the 'same' or a 'mirror image' in her therapist was important to her.

As a teenager Shoshana was diagnosed with a "*mild depressive disorder*", which had continued throughout her life. After the ectopic pregnancy and before attending couples therapy, she was referred to the mental health team by her GP and saw a psychiatric nurse for a short period. She and John then chose to go into private couples psychotherapy.

They continued in couples therapy until their daughter was born four weeks prematurely. Two months after the birth, Shoshana began to experience panic attacks and went back into therapy on a one-to-one basis with the same therapist, as well as having a few sessions as a couple. Overall, Shoshana was in therapy for about 18 months.

Although it appears at first glance that Shoshana's difficulties were of a relationship nature between her and John, she said her extreme anxiety played an important role in these difficulties, in her mental health issues before becoming pregnant and after her daughter's birth. Shoshana's story of TA therapy is a mixture of couples and one-to one therapy, which she called an "*intertwining journey*" for herself and John. Yet it is also her story of a mix of therapies, beginning in personal therapy (as a teenager), moving into couples TA therapy and then a combination, after the birth of her baby. This moving in and

out of therapy, and also the mix of therapy, somewhat mirrors the 'mix' in her personal life, both of culture and religion.

The fact that Shoshana experienced couples therapy for perinatal mental illness is unusual. She and John recognised that both their past histories played into their relationship difficulties. The experience of the ectopic pregnancy, then being referred to the mental health team precipitated a decision to seek out a private couples therapist.

The title "*pushed off the precipice*" comes from Shoshana. Her story is of the extremes of many different aspects of motherhood. These extremes were in her mood, from no anxiety to panic attacks; in her emotions about becoming a mother; and about the extremes of lack of sleep and coping with a premature newborn. Although her speaking was measured during her interview, and at times felt quite controlled, this may have been a need to remain in control as a coping mechanism when re-telling such extremes. Shoshana often paused or used "*erm*" to gain time to collect her thoughts or perhaps control her emotions. Her voice was often flat when describing things, yet her use of heighteners such as: *always, massive, ever, completely, really, never, immediately*, seemed to suggest an experience that did not quite match up with her controlled speech. These heighteners seemed to be a way of her showing the depth of emotion, difficulty or stress she felt, even though her narrative was often delivered unemotionally. The heighteners are noticeable in the first half of her interview, but disappear when she begins to talk about her therapy.

The interview was conducted in November 2016, at an office building with a rented meeting room. This addressed Shoshana's preference to be interviewed away from home as she felt it might be difficult for her family otherwise. The interview was conducted after she had finished work, but before she went home for the evening. Shoshana did not bring an 'object' to her interview. Instead she narrated a significant memory.

#### 6.1.1 Previous illness and treatment

Shoshana began her interview by explaining that she had experienced a long-term mild depressive disorder, with a period of 'yo-yoing' in and out of different forms of medication and therapy, none of which seemed to work. She finally discovered, by coincidence, that she was suffering from anxiety, not depression:

*I'd been through various forms of therapy, probably since I was about 15 years old, on and off [pause] starting off primarily for symptoms of depression when I was a teenager, and I was diagnosed with a mild depressive disorder and that kind of carried on throughout my adult life. [Pause] kind of having again, going through better periods and lower*



*periods and erm, I went through a lower period and went back on medication, or tried a new medication, various forms of medication [pause] I actually, erm, had, was proof-reading a book for a friend of the family, who's a psychiatrist and who was coming out with a book that was more, erm, kind of mass consumption type book and I was proof-reading it for him and got to a section on panic and anxiety and kind of went "oh" (laughs and voice changes to reflect a sense of surprise) "this is me", so I started to look at things more from an anxiety perspective.*

This helped Shoshana to have a greater understanding of what was happening to her, and steered her towards looking for coping strategies for anxiety rather than depression.

After suffering an ectopic pregnancy, her GP referred her to see a psychiatric nurse. She referred to this as:

*really kind of crisis management, rather than any sort of in-depth plumbing of my psychological past.*

She saw the psychiatric nurse for about two months, but then stopped because it was not giving her what she needed. Instead, she and her husband decided to go into TA couples therapy. They remained in therapy until Shoshana gave birth, at which point her husband continued on his own:

*My husband and I had been always struggling with fights, but, uhm, it was getting to the point where we were really having the same fight over and over and over again. ... I then had the baby a month early, so that cut things off abruptly (laughs) and my husband continued on, individually.*

### 6.1.2 A premature baby

Shoshana's illness really began to take hold after the birth of her daughter Isla. She described Isla's birth as a shock, and it was within this section that her use of heighteners (marked in blue) was particularly noticeable. This felt like a way for her to accentuate how difficult this period was, even though her narrative was slow and quite controlled. Her choice of words gave a sense of the stress she felt, as did the way in which she delivered her narrative, chopped up and chaotic in places:

*So there was **a lot** of stress around the birth, [pause] and, [...] I had known it would be a medical birth, but I also had pre-eclampsia and so I was in hospital for about a week and a half before they induced, erm, because erm my protein levels were kind of **going off the chart**, so erm we, so she was*

*always fine, she was born and she was very small and she was very sleepy so from the very start we were finger feeding, we were trying to breast feed and trying with bottles, and cups and every feeding method known to man and waking her up every two hours and so from the start there was this, well there is always stress but there was this this perhaps additional stress in just making sure that we got food in her and erm, and ever since then, erm she woke up every two hours, there were nights when she literally woke up every 15 minutes (laughs wryly) it was the, erm just the enormous, the enormity of this kind of piling on top of each other, and John and I had learned a lot about how to communicate with each other, but even that was really pushed to about as far as it could go and we were, still we were starved for resources. We were taking it out on each other, [pause] it just became so huge, so it was in the context of all of this and then my periods came back and it was just kind of and that pushed me off the precipice so to speak.*

The end of this section shows the way she controlled herself while describing elements of experience that were clearly disturbing to her. Yet she ends the section quite matter of factly which was surprising.

Her story also gave a sense of the difficulties they experienced looking after the baby:

*this was also in the context of the crazy stress of having a newborn child (laughs wryly and drops voice) and this is a newborn child who never slept, she was a month early (voice goes back to normal again) so there was a lot of stress around the birth*

It appears from her description that Shoshana's illness began with the stress of being medically unwell with gestational diabetes, then pre-eclampsia. Giving birth four weeks prematurely with all this entailed, only added to her stress. This stress developed into anxiety, which she recognised as the anxiety she had felt previously. This anxiety returned when Isla was around two months old. Shoshana's continuum of illness seemed to begin with the stress around the birth, which became anxiety about eight weeks after birth. She acknowledged she felt there was a connection between stress and anxiety for her, as she believed her anxiety was a "physiological response to the stress". She did not describe herself as depressed after her daughter was born.

### 6.1.3 Being unwell

Shoshana said that throughout her pregnancy she experienced no anxiety at all, which she had found surprising:

*Interestingly, I, for the majority of my pregnancy I actually stopped experiencing anxiety for probably the first time in 10 years or more.*

As she had been depressed as a teenager, she said she knew she was not suffering from postnatal depression. The excerpt below has elements highlighted in red. The red coloured sentences show when she would begin a sentence (marked in red), only to go off at a tangent mid sentence, and then return back to the original sentence towards the end (again marked in red). It seemed that, while she was talking, she was trying to make sense of what had happened to her:

*(sighs twice) I probably wouldn't characterise it as depression now, erm, I have experienced depression in the past, erm, not so much recently, I would say, in the last 8, 9 years or something in that range, definitely as a teenager but less so as I got older, erm, yeah in terms of, I'm not, to be honest I'm not sure how to distinguish between stress and anxiety erm, [...] but, then high levels of stress because there was a lot of external pressures going on, and that was, surprising in that I was less anxious about motherhood, and mothering. I'm trying to, kind of, yeah it wasn't (pause). The anxiety itself, (pause), I'm trying, it sort, it wasn't really around being a mother it was more, it almost felt more like a physiological response to the stress rather than an extended period of rumination. I didn't have time to ruminate, I wasn't ruminating, which is what would normally kick me off, erm, it was, it was, it felt like just my body being pushed to such an extreme.*

Shoshana seemed to be unsure of herself and her sentence structure was chaotic. This was particularly noticeable towards the end of her narrative when she said: "The anxiety itself, (pause), I'm trying, it sort, it wasn't ..., it was more". This style of sentence structure, mixed, chopped up and unsure, happened repeatedly in the beginning of her interview. There is a sense of 'mix' that continues throughout her narrative. This 'mixture' also occurred in the way she projected her voice, changing it repeatedly, breaking the sentence structure up again. In the next example below, Shoshana began by starting to say one thing, her voice then dropped and changed, and she went off at a tangent to give some background information, coming back to finish off the sentence later, changing her voice back again. This gave a real sense of Shoshana having another voice underneath the more dominant one:

*I found, (drops voice) I don't, I can't say whether this was the method itself or just the, the timing or the fact that we went together. (voice changes back) But I found...*

Listening to her speak, sometimes it was difficult to keep track of what she was saying, and at times she left sentences unfinished, or unsaid.

#### 6.1.4 Panic leading to panic attacks

The main theme emerging from Shoshana's narrative was panic. She used this word throughout and narrated how she went from no anxiety or panic at all during pregnancy, to panic being a prevalent part of her life post birth:

*I had some of the worst panic I'd ever experienced ... so it was, it was quite a significant shift for me, and it was quite eye opening. ... I likened it to almost my anxiety felt a bit like static on a TV screen and it just kind of swoosh disappeared, or turned way down low during the pregnancy, and then round about two months after, it just went, turned up to high volume and it felt like, you know, the environment had changed, and that was something that I recognised and had experienced before, but it was, it was very sudden. It felt (pause), and very extreme, and it was maddening as well, having experienced this freedom (laughs) and sense of relaxation I suppose, and to have this kind of come back again, and I probably, I'd say to date the **worst** panic attack I'd ever had, where I was really, erm really feeling the walls closing in and having a lot of physical, ...twitching or tensing, but I was really like ... I felt the ..., feeling almost paralysed.*

She recognised this panic, but it came on suddenly and was extreme, unlike its previous manifestation. She also said that the contrast from experiencing nothing in pregnancy, to extreme panic two months after Isla's birth, scared her. It was this extreme panic that became the dominant theme.

#### 6.1.5 Motherhood - the extremes of emotion

Shoshana vividly described her experience of becoming a mother, the extremes she felt in her emotions and how these extremes caused a physiological response, which led to a sense of rising anxiety. She also described the contrast between these feelings and those she felt when depressed, which she called her "repetitive ruminating pattern".

*I think just the turbulence of emotions involved, so like the extreme, extremes of love and extremes of frustration and extremes of, of (pause) feeling conflicting emotions simultaneously, wanting to be here, wanting to be away, wanting everything, you know, wanting everything to be the way it is, and wanting everything to be the way it was, it err (pause) that all kind of compounded together, erm, but it wasn't, it wasn't the kind of inward*

*spiral that I would often, mentally, get myself into this sort of, erm repetitive ruminating pattern.*

EH *so that was different then?*

*yeah yeah, erm although I have, the more I've kind of focused on more mindful techniques the more I've really erm looked at it, looked at my triggers and noticed my responses earlier and earlier. I have realised the extent to which, erm, I do have a physiological response early on, which I didn't always notice before, and that might then, you know, move into a more ruminating spiral but actually it is quite kind of visceral and immediate to start off with. And so now that I notice that a bit earlier, erm, I realise that, that it maybe isn't so terribly different, I just didn't always notice the kind of immediate physiological side, erm,*

Shoshana uncovered her physiological responses in therapy, helping her to understand and to control her responses. The extremes in her emotions pushed her to the edge of coping, and were overwhelming:

*I would not say it brought back depression. I don't think I ever felt depressed, but I did absolutely feel overwhelmed, erm and (pause) completely pushed to every extreme, to every emotional extreme, every physical extreme, and (pause) that (pause) (sighs), I get (pause) having a baby is not, I can't liken it to anything else. I can't say it reminded me of anything else because it didn't. It feels, felt, so completely unique, erm (pause) but it did bring back similar patterns. So, similar thought patterns, similar (pause) I was probably feeling suicidal at some point, erm (pause) (sighs) I genuinely can't remember. I probably was (laughs), (pause) it happens, erm, but (pause) at the same time, having, because I had done all the work with [therapist], and previously, I think I knew what was going on, so I wasn't frightened in the sense of "what's happening to me", it was just an intense (pause) unusual even, and unusual demands (said matter of factly) putting me into, errr (pause) a terrible, if not unexpected state of mind.*

She paused a great deal when narrating this and her voice was measured throughout. It felt as though she was holding her voice quite tightly. She narrated such extremes of emotion, as well as her feelings of suicidalality, which she almost seemed to dismiss. Then she said: "*it was just an intense (pause) unusual even, and unusual demands (said matter of factly) putting me into, errr (pause) a terrible, if not unexpected state of mind*". The statement did not fit her experience at all and seemed incongruent with the extreme levels of her emotion.

### 6.1.6 The ability to mother

Shoshana said she had felt anxious about becoming a mother as well as around performing 'motherhood'. Similar feelings are related in much of the research into women's lived experiences of perinatal mental illness (Abrams & Curran, 2009; Button et al., 2017; Buultjens & Liamputtong, 2007; Chan et al., 2009; O'Mahen et al., 2015; Stone & Kokanovic, 2016). Yet, once she gave birth, she felt little anxiety at all about her ability, which was a surprise:

*(sounds highly surprised) I expected to be really anxious (laughs) about mothering and a lot of my anxiety centres around my own performance and my own self-judgement and all of that superego voice and all of that stuff and, erm, (pause) so I expected to be really self-critical because so many mothers are so self-critical (laughs) and I actually think, "you know what, I am doing a pretty good job, this is hard (pauses with a wry laugh), this is ok" and I was saying, like I wasn't ruminating cos I didn't have time to ruminate and so in that sense it was ok. "I'm just getting through this and I'm clearly doing the best I can, so there is nothing I can berate myself for". And even now I think I'm pretty chilled out about parenting, erm (pause).*

### 6.1.7 The father's experience

Something often ignored within perinatal mental illness is the effect that pregnancy and the postnatal period can have on the father. Shoshana talked about John's experience of becoming a father, as she felt that he was depressed after Isla's birth. She explained how difficult it was initially to persuade John to join her in couples therapy after her ectopic pregnancy:

*he was like "oh psychologists are quacks and they're just taking your money and" duddleduh, and then he went completely like 180 degrees to like being (pause), he went on longer than I did and really was like recommending the therapy to all of his pals, and so erm its, he had quite a transformation actually through the course of this, and some very key realisations on his part, and then fatherhood, he had erm, he had, when we, after we had Isla, when she was about 6 months we moved, we bought our first flat and we moved in and he had a, a nervous breakdown really, as a result, and discovered that he was susceptible to anxiety which neither of us had seen quite so completely before and it, it actually helped both of us in a way, because he had, he had an understanding of what I went through and I think it helped his empathy and it helped my self-sufficiency or sufficiency for the both of us*

A little later on she went back to talking about John's experience of anxiety and depression after Isla was born.

*John, however, I think John I would, I would probably describe John as fitting more of the description [...] as this kind of resurging of old patterns. He had had a depressed teenage life and he had attempted suicide and all the (pause). And he had a huge flooding back, this was around when we moved, all of his emotions which he thought were completely done and finished, and so he was kind of re-living that experience and his childhood experiences, well which were, which were very difficult, erm and particularly around his, around sensory stuff, which is the age Isla was at, communicating completely with your senses, erm, and he is very verbal, very much in his head and (pause) even accessing that layer of "what do you feel" before he could even get to "what do you need" took about a year, erm, and I'd (pause) I would, I don't know if he would have gone through that, if it hadn't been for Isla, erm, because I think it was a parental link that (pause), that did it.*

The partner's response to becoming a parent is easily ignored, yet it is apparent that partners do become unwell too. Interestingly, Shoshana mentions the experience of fatherhood when bringing up the trauma John experienced in his own childhood. This led to a period of therapy for John, to work through his childhood experiences. Shoshana said she did not know if John would have experienced such a strong "flooding back" if Isla had not been born. As yet it is unknown how often the experience of parenthood might bring back childhood trauma for both partners and the significance of this for the parents.

## **6.2 Therapy**

Shoshana went back into therapy after Isla was born and managing her panic attacks became a large part of her therapy:

*I think the key was, what I did with [therapist] was, rather than simply taking it from a, from the perspective of a general technique, you do this when you feel that, it was about identifying what I needed in that moment, and what steps I needed to take in order to get that. Realising that, in the context of the session, then going back to that when I was in a state of panic. So that involved, erm, techniques, but it was, was coming from the perspective of addressing the cause rather than the symptom, [...] so as to give a slightly more concrete example, erm, it was through the process of a couple of sessions and breaking down that fact that for me, I, the panic, I, I would feel panic when I felt isolated, when I felt powerless or when I felt, most importantly like nothing and (long pause) [therapist] asked me what*

*the opposites were to all of those things. So it's, it wasn't so much as saying "ok I'm having a panic attack, I need to breathe into a bag and count to 10" and you know do all of the things which I can do and which can help me in some ways. It was more about saying "ok, I'm feeling isolated, I need to connect, I'm feeling alone, I need to be in company, I'm feeling powerless, I need to take assertive or positive action, so mindfulness techniques had a space to take hold, or, feeling connection with my family, and so there were techniques which went along with each of those actions, but the fundamental of it was addressing the root message that I was telling myself.*

The most important part of her therapy was learning strategies to use anywhere when she began to feel panic or anxiety. These strategies were directed at the cause of her anxiety, a feeling she had underneath it, which was normally one of several different things – lack of connection, lack of power, or feeling blank. Learning these techniques and having the opportunity to practice with John in therapy, helped both Shoshana and John to notice if the other was struggling and to be able to help each other.

#### 6.2.1 The significance of TA theory

Shoshana said the therapy she and John underwent was successful and helpful. The theory she spoke of as particularly helpful is a way of looking at the dynamics of behaviour between humans. It is called the Drama Triangle (Karpman, 1968):

*Something that has stuck with me, just as, well there were lots of images that stuck with me, but in particular erm, the, towards the end of our sessions actually we, we, [the therapist] brought up the three roles and the, I see, we, I immediately gave them the wrong names in my head and they are the only ones I can think of now, but an aggressor role, which is (laughs wryly) called the arsehole, erm the aggressor role, the victim role and the, erm, the messiah role?*

E.H. [the rescuer?](#)

*the rescuer, thank you, and erm, and that, that triad has stuck with me and continually raises itself in multiple relationships that I have every day, and, erm so that is something that stuck with me.*

Shoshana said that her experience of treatment was positive and she now felt more confident and capable of being able to manage her anxiety.



### 6.2.2 Discounting

Shoshana discounted herself early on in our interview, by using 'just' before a heightener, such as "*just the enormous, the enormity of this*", and "*it was just kind of, and that pushed me off the precipice so to speak*". When she talked about the extremes of her emotions she used 'just' the most. She used "*just*", "*probably*" and "*maybe*" throughout her narrative, and these did not seem to lessen later in her interview.

She also used gallows laughter throughout. However, it was particularly noticeable how incongruent this laughter was when Shoshana narrated feeling suicidal:

*I was probably feeling suicidal at some point, erm (pause) (sighs) I genuinely can't remember. I probably was (laughs), (pause) it happens*

She dismissed feeling suicidal, and then went on to laugh. This was a discount of her experience at the deepest level, significance. Shoshana seemed to be trying to convince herself that these feelings did not matter to her. Maybe, after receiving therapy for 18 months, she was being truthful, understanding that there was a part of her that would feel that need to retain suicide as a possible 'get out' if life became terrible again. However, this was a discount of her emotions. This use of gallows laughter continued throughout her narrative and did not change even towards the end.

### 6.2.3 The importance of the therapist

The therapeutic relationship is often the most important factor in the success of therapy. Shoshana alluded to this when talking about what was important to her and John, which helped them with their choice of therapist:

*It helped that he was Jewish (laughs) quite frankly, erm there are not many Jewish people in Scotland and he, he's also multi-cultural and so he kind of (pause) and family based. (Pause) So there were lots of things that drew us to him.*

EH *so it was more the multi-cultural aspect and the fact that he was Jewish rather than the type of modality that he offered?  
yeah at first it was the person rather than the method*

However, she reiterated that those cultural and religious elements did form a really important part in the success of the therapy:

*I think there was probably gonna always be a natural affinity because of just different languages and different countries and different (pause) culture coming together, it's something that, having somebody who, even, he never talked about himself, he was extremely (pause), erm, conscientious about that (pause) he, (pause) there was, there was just, there was an understanding, erm, that or comfort that we felt knowing that he (pause) probably knew what we were talking about.*

She then went on to talk about the other aspects of his personality and the way he worked that she felt were also important and helped to form that relationship between the three of them and allowed the therapy to be successful:

*He's got a very good sense of humour, which is a very good quality (laughs) especially in a therapist. Erm, he, he has a very high level of sensitivity I think. He's extremely quick to pick up on the dynamics of the situation and very responsive. I would say John and I, I mean I don't know if he found this, but **I guess** he found John and I very different to deal with and he responded exactly the way each of us needed, cottoned on to it quickly and responded appropriately, and (pause) pushed each of us where we needed to be pushed and stopped pushing where we needed to be stopped, erm (pause) but I think the, the fundamental messages were very valuable.*

When asked if she thought the most important thing for her was the therapist or the modality, she said:

*I think its probably a combination and obviously who we are as patients*

The final thing she said about her therapist was the most powerful:

*I've seen a lot of therapists, and by far and away he's the best I've ever seen and I think the method was the right one for us at the right time, for me at the right time*

#### 6.2.4 The importance of couples therapy

Shoshana was the only participant who underwent couples and one-to-one therapy so it was useful to hear her experience of both, and which she felt was more powerful.

*I found it massively helpful to be in a session with John, my husband. Erm and to discuss our interactions as the basis for a deeper personalised relation, and I did much more extensive, much more productive work than I had ever done before, and and I think a huge part of that was simply that he would raise aspects of our interaction that give these windows into my own defence mechanisms and my own history and my own relationship with my parents and my family that I had never unlocked by myself because I wouldn't think to bring it up, you know, in an individual session and erm, but I had to bring it up, I had to confront it, because we were there to, to discuss our interactions.*

A little later when she was narrating the way in which therapy helped her she came back to the topic of couples therapy:

*I found it particularly, in, in the couples setting erm, just because we had that, that mirror and that ability to breakdown the relationships and for me, erm, the key was really there in my relationships with the people I was closest to, which I am sure is not unusual, so erm, having the chance to kind of use existing relationships to unlock that was very very useful.*

And then finally:

*we both found it extremely valuable and I think, I think we both feel quite a lot of gratitude actually to [therapist].*

#### 6.2.5 The impact on the relationship with her daughter

Shoshana talked about her relationship with Isla and how therapy had helped this. She spoke of her fear of her anger, which she said she had experienced throughout her life. She was concerned how this might impact Isla and expressed a need to protect Isla from her anger because she had not received protection against her own mother's anger. Therapy had given her and John the tools to help each other with their anger so that Isla did not have that same negative experience:

*I was always scared of my own anger and how I would express that because my mother's anger was something that was so powerful and threatening to me as a child, so I, erm, I was conscious of wanting to protect her from that, but I think in that tension in that resistance there is a greater danger of repeating, so, and [...] that's the fundamental, help the other person get what they need so we can all calm down for the sake of everybody, including*

*Isla, erm and that, rather than just cut it off or push, shove it further down or, you know, not engage with her or blow up in front of her, you know, to take pro-active steps that actually allow for the anger but keep it in a, in a contained well (under her breath) I don't think that's the right word but you know what I'm getting at.*

At the end of her interview Shoshana came back to her relationship with Isla and spoke about how she thought therapy would continue to improve her relationship with Isla in the future when she is growing up.

*You asked me if I think it would improve my relationship with Isla, I think that, in and of itself, is going to be a huge thing for me, this (pause) this real acceptance of the next stage and because transitions have been very stressful for me and she is constantly transitioning, there is no such thing, you live in the transition and it is something that I'm finding constantly heart-breaking and constantly so exciting and again its those contradictory, simultaneous emotions and if I can, if I can (pause) teach her by example through that, how to transition how she can herself feel like something that (pause) that (longer pause) that's my parenting goal achieved (laughs).*

#### 6.2.6 Unlocking relationships

Shoshana said the most fundamental factor in her therapy was unlocking her relationship with her parents and how her experience of them fighting when she was a child was a cause of her anxiety.

*I think the thing that was the most helpful was (long pause) well I had, well I mean, I had a key realisation which was really like the fundamental key realisation. Taking the experience of my anxiety, the erm, breaking down my narrative around the experience of my anxiety and then relating that to, back to places where I'd experienced that previously which were, which hinged around my relationship with my parents and my experience of their fighting and while, in hindsight [it's] an extremely obvious conclusion (laughs), it was very enlightening at the time and it did hinge around unlocking the, my relationship with John, but other people, with my parents the, the mirror it had on my younger relationships I had with my parents.*

This 'unlocking' allowed Shoshana and John to recognise the triggers that might cause them both to argue, and gave them a safe setting within which to practice avoidance strategies:

*We did a lot of practice in the couples setting, cos one of the earliest things and most consistent things and most frequently done things, and we still do, is in those moments of conflict, is to ask each other what we need. And that was, is amazingly powerful, erm, and its something I've used in my other relationships as well, and I think my mother burst into tears the first time I asked her because she said "no-one's ever asked me that before". So that question (pause) erm, we had a lot of practice asking each other, which meant we got a lot of practice asking ourselves as well. That's what I was able to tap into.*

A final element of her therapy which she said she found helpful was engaging with her own anger:

*It really helped me to (pause) engage constructively with my own anger and particularly in my dealings with John, I'm not always successful, erm, but it's, I think it's helped our communication with each other so much that we're able to, erm, we're able to kind of mitigate the other, or maybe, maybe it isn't the right word, but (sighs), help calm the situation effectively for the other person, or give or help the other person get what they need.*

#### 6.2.7 Experiencing the end of therapy

Shoshana spoke, with wry humour, about the way her therapy ended. This clearly had a positive impact on her. She had thought her therapy would simply continue, with no real end:

[therapist] at one point said we've got a long, an unusually long working relationship, which I said "really? Most people I know have been in therapy for like 10 years!" (laughs) so you know I have a cultural sort of expectation (laughs). Yes, you know, you just keep going for the rest of your life clearly, (laughs) that's what people do (laughing)

Many people have this sense that therapy does not 'end' and will just keep going. This could be due to the way therapy is depicted in television dramas from America, giving a sense that most people are 'in' therapy and that they remain in it for years. Shoshana's therapist decided to address this about 17 months into their therapy, asking her about her need to continue. Shoshana said this led to a realisation that she could stop therapy, and be ok without it, keeping herself ok.

*I don't think I had a massive revelation but I did have a significant change (pause), erm (long long pause) and it was partly through watching John go*

*through what he did. Because (pause) in the course of this, (pause, hesitant) at one point I think this is after John, or John was in the middle of his experience and I came in with, I think we were coming in together at that point, erm (pause) and at one point I was talking about John's experience, like "he's having this one-off", and (pause) [therapist] at one point asked me "well what do you see yourself as? If John's going through a one-off, what do you go through?" And I thought "Oh well, I'm just gonna have this for ever, you know its the way I am" and he said "really?" (laughs) and that's when I went (sounds really surprised) "oh maybe I don't have to be anxious for the rest of my life" and that was very simple and straight forward, as much as it had never occurred to me, and it was only through realising that I saw John going through this, you know, bump, where as I would have this eternal hill to climb that I would never really accomplish (pause) and just that simple (pause) "really?" (sounds very surprised) (laughs) and, and since, to be honest, since then I have not had **anything** like (pause) the panic attacks I used to have. I might have moments of heightened anxiety, or I'll have rough days, erm, but I, I notice what I need, and I do what I need and **it works** on the most part. I haven't had anything like that (drops voice) huge panic attack. I mean I don't think I've even had something I would properly call a panic attack and, erm, (pause) and that really has been a huge shift, compared, it's like the static has been dialled right down and, erm, and that's, that's huge.*

Shoshana said that once she realised there was an end point this was helpful:

*he was always very good about asking us what we saw as the end point. And so, it was something that probably if left entirely to my own devices I would stay in therapy for 10 years, I would never think to leave, so it was good because it did remind me to define what I considered to be the (pause) what I was trying to achieve, erm and so I think I probably (pause) I initiated the end but not without (laughs) a little help (laughs again).*

**EH** From [therapist] or from John?

*Err, probably from [therapist], but just in the sense of like, errr, asking us what was it that we were trying to achieve. This is what I'm hearing about where we are now, so what do you see as the next step, kind of thing. And I thought "ohh, I guess I'm done (surprised)". Well it's an attachment thing. Hang on in there for grim death, which is the 10 years, which is definitely my reversion to type. Whereas he's going, peeling my fingers off one-by-one, "Ok this isn't for ever".*

Finally, Shoshana spoke about her experience of the therapy:

*A pretty positive experience, yes. I mean positive in the sense that I feel much more confident and capable of managing my own anxiety and growing through it, and feeling (pause) I mean my communication with John is a million times better than it was. Although we will still fight, but that's going to continue for ever (laughs) and we fight a lot better now, generally speaking. Erm, and (pause) so over all there were absolutely there were painful bits, but I was also prepared for the pain of therapy, its, you know, not a concept that I wasn't familiar with. So, erm, so that has been immensely productive.*

This way of ending therapy seemed to hold a risk of disconnection, this time from her therapist. This last part of her narrative had a sense in the background of longing for connection, and also a feeling of disconnection. Yet her yearning was for connection and she could have felt that her therapist's insistence of the therapy ending played into her history of disconnection. Her comment "*I guess I'm done*" gave a sense that she was actually pretty unsure that she was 'done', but would go with it anyway, possibly because her cultural heritage was to please others and accept that this was how it would be.

### **6.3 Other notable aspects of the analysis**

Interestingly, Shoshana used the same metaphor within her narrative as Lucy did, which was a TV. However, Shoshana talked about the static on a TV screen to explain how her anxiety was dialled down during her pregnancy and how this was then dialled back up after she began to experience her anxiety again, post birth.

Throughout her narrative Shoshana also kept revising "I" to "we" such as: "*then I, we occasionally did a few sessions separately*". This element is important and is explored more fully within section 6.5.

The final aspect of her analysis which was interesting was the aspects of silence, or silences. An exploration of silence is encouraged by Woodcock (2016). Shoshana used silence in her narrative as she paused a great deal throughout her interview, particularly at times when there was deep emotional content. Also there were parts of her interview in which she struggled to find the appropriate word for the element of her experience that she was describing. Her interview had a great deal more pauses than any of the others.

#### 6.4 Listening for Shoshana's other voices

Shoshana seemed to have five voices within her narrative, the angry voice, the frightened voice, the sad voice, the voice of the nurturing parent, and the pragmatist/realist (see Appendix 8). All five voices overlap within her narrative, the most dominant ones being the fourth and fifth voices, the voice of her nurturing parent, and the pragmatic voice. Both were present throughout her interview. Both these voices appeared to have come through her therapeutic experience, with the nurturing voice calming her down and understanding how difficult this was for her, allowing the pragmatic voice to become more dominant. This pragmatic voice spoke often in the present tense, and was the voice of reality, the voice that understood most of what had happened to her. As Shoshana had been through therapy and had completed it with her husband, it is unsurprising that this voice was present from the beginning of her interview. In fact, within the first few sentences this voice was present. This voice spoke in a measured way, considering her choice of language and tended to be realistic about life and the challenges it can bring. Within this voice her sentence structures were mostly logical, thought through and appeared to be coming from Shoshana's Adult ego state.

The other three voices appeared to come from Shoshana's Child ego state. At the beginning when she was narrating how she and John came to therapy and her experiences of being unwell, she often seemed to be in the angry voice, the clue being the way she used heighteners throughout. She would often say something and then use gallows laughter. She laughed a great deal throughout her interview. There was the sense of the rebellious, angry child and it was not surprising she talked about fearing her own anger. The anger and frustration were there when she talked about her relationship with John: *"we were really having the same fight over, and over, and over again"*. In TA there is a theory called racket feelings (English, 1971), inauthentic feelings that we project, out of awareness, to cover up what is really going on for us. In Shoshana's case, her racket seemed to be anger and the feeling she was covering up was fear, which was her second voice, the frightened voice.

Shoshana used her frightened voice to talk about how frightening her panic attacks were. This was the voice that talked about how difficult she found Isla's birth, because Shoshana not only had gestational diabetes but also experienced pre-eclampsia. This voice continued in the background, but disappeared completely once Shoshana began to talk about her therapy. The only time this voice appeared to come back was towards the end of the interview when she related how, in her mind, John's experience would be a "one-off" but her experience would be forever: *"I would have this eternal hill to climb"*. This sentence was the opposite of being pushed off the precipice and it is possible she



meant metaphorically climbing back onto the precipice. This voice intermingled throughout her interview with the third voice, the sad voice. In fact, at times it was difficult to see a difference between these two voices, and in TA terms these two voices would be called her Adapted Child ego state.

## 6.5 Listening for Shoshana's "I" poems

A few elements set Shoshana's interview apart from the others. In comparison, she used fewer "I" statements, often beginning a sentence in the first person using "I", then quickly switching to "we":

*and then I, we occasionally did a few sessions separately*

*and then I, erm, I, I, we kind of knew.*

She was the only participant who performed this switch mid-sentence. This may have been because she was often narrating her experience of couples therapy, and John features strongly throughout the entire interview.

Shoshana's most used "I" statements within her narrative were:

*"I think"*

*"I had"*

*"I am"*

*"I was"*

*"I did"*

*"I mean"*

Although Shoshana used "*I think*" more than any other "I" statement, it was not hugely apparent within her narrative. This is mainly because she used a diverse range of "I" statements, and there were no obvious patterns of sequencing. When she talked through her experience of being unwell, in the first quarter of her interview, it is noticeable that she spoke mainly in the past tense: "*I had been*", "*I was*", "*I went through*", "*we had been*". This began to change with the odd "I" statement in the present tense: "*I'm not*", "*I'm not sure*", "*I'm trying*".

At one particular point in her interview Shoshana talked about feeling suicidal. She paused a great deal, and was measured in the way she responded, and it appeared she was trying to convey how 'extreme' this was for her. Her "I" poem for this particular part of her narrative was:

*"I would not say"*

*"I don't think"*

*"I ever felt"*  
*"I did absolutely feel"*  
*"I got"*  
*"I can't like it"*  
*"I can't say"*  
*"I was probably"*  
*"I genuinely can't remember"*  
*"I probably was [feeling suicidal] (laughs)"*

This sentencing structure gave a sense of her dissociation from feeling suicidal. She twice used *"probably"* giving a feeling of being unsure, and yet the gallows laughter followed by *"it happens"* adds resonance to this, and also gives a sense of her dismissing this suicidal part of herself.

When Shoshana talked about her depression she seemed unsure about it, using: *"I probably wouldn't ..."*. This lack of surety is apparent again when she talked about not being sure how to distinguish between stress and anxiety. It is almost as if she was trying to grasp, in that moment of speaking, what her anxiety actually was about: *"The anxiety itself, (pause), I'm trying, it sort, it wasn't really around being a mother it was more, it almost felt more like a physiological response to the stress rather than an extended period of rumination"*. Twice within this statement she used *"I'm trying"*, giving the sense that she was really attempting to resolve this, in the here and now, whilst telling her story.

She also used ventriloquation to speak in the first person for someone else in a number of places, many more times than the other participants. Ventriloquated speech is often narrated in the historical present tense, and can give a sense of 'eyewitness' quality (Chafe, 1994). Shoshana used it to emphasise a point, heightening its importance within her narrative. As she used heighteners throughout her interview, this type of speech seemed to add more drama to her narrative, which might not have been possible using only heighteners. This happened when she was talking about the difficulties she and John had with lack of sleep and caring for their premature baby. She highlighted how they had taken their frustration out on each other by ventriloquating for both of them, changing her voice to quite a whine, as an imitative performance of what would then be said by one or the other: *"you don't love me"*. She used ventriloquation again when she talked for John, with quite an offhand and dismissive voice, when narrating his original feelings about seeing a couples therapist: *"Oh psychologists are quacks and they're just taking your money"*. She then added her own evaluative comments by showing his change of heart, from not wanting to go into couples therapy, to then agreeing to it, dramatizing it by saying: *"he was like recommending the therapy to all of his pals, and so erm its, he had quite a transformation actually through the course of this"*. Later on in her narrative she

used it again when she was talking about how difficult it was for John to access his feelings: *“what do you feel”, “what do you need”*.

She ventriloquated her therapist, when she talked about the most powerful part of therapy: *“when you feel isolated, what do you need, you need connection, and when you feel powerless, what do you need, to assert [myself] and when you feel like nothing...”*. She did this several times for her therapist, such as: *“well what do you see yourself as? If John is going through a one-off, what do you go through?”* Her response to her therapist at this point was interesting as she changed her voice considerably and dismissively and then said: *“Oh well, I’m just gonna have this for ever, you know, it’s the way I am, and he said “really?” and that’s when I went “oh maybe I don’t have to be anxious for the rest of my life”* (sounds really surprised at this revelation to herself). The last time she ventriloquated for her therapist was when he was helping her to understand that therapy is not continuous, and she changed her voice to one of mild outrage: *“OK, this isn’t for ever!”*

She also used ventriloquation to highlight how powerful one of the TA techniques had been for others in her life, and imitated her mother’s response, enhancing the impact by narrating that her mother had cried: *“no-one’s ever asked me that before”*. And finally, when she talked for her mother and sister and the way they reacted to Shoshana relating the things her therapist had said: *“ooh that’s very good”, (laughs) “we’ll remember that one”*. The fact that she laughed in between the two quotations added a sense of the way in which she was depicting the influence of her therapist, not just on her mother and sister, but on others: *“he probably has a whole group of people who’d like to take him up on his services”*. At this point there appeared to be an element of hero worship underlying her comment, and also possibly jealousy and rage that he might have other clients too.

She was an insightful participant, and knew that her hormone cycle seemed to play a part in her emotions. However, her interview showed how she was able to use the tools she was given in therapy to cope with those emotional variances, and those tools were able to help her navigate her way through with the least amount of detriment to her relationships both with her husband John and her daughter Isla.

## **6.6 Exploring Shoshana’s object – a memory**

*I hadn’t been seen that way before*

Shoshana was apologetic because she said she had not had time to find something suitable as an object to bring. She seemed embarrassed and yet she

began to speak about experiencing her daughter's gaze, in the first few hours after she had been born, and what this experience meant for her, dropping her voice then gently laughing and her emotion was instantly evident. She said it was this moment that was most resonant for her. Her description was full of pauses as she searched for the words that were meaningful for her to describe it. She was particularly emotional when she drew a parallel to Isla's gaze and to the way her mother would look at her when she was a child, and tell her she loved her:

*Mothering, err, (drops voice, then gently laughs) seeing her eyes for the very first time. (Long pause) And the first night we had together was wonderful, because I was supposed to be feeding her, but nobody told me, so we were just (pause) lying there and it was the first opportunity we had to (pause) just be together and (pause) and she, she looked up at me and I just (pause) it was (long pause), (long long pause). (She sighs and is very emotional) Oh I, (long pause), I I can't possibly describe it, but it (pause) was extremely resonant. And it, I suppose it is one of the former powerful memories, positive memories I have with my mother is that she would always make a real point of taking off her glasses and (very very low voice) telling me that she loved me and (pause) yeah, yeah it was just her, [name removed] gaze and it's so complete. I just, I remember thinking and realising I hadn't been seen that way before, (drops voice) and it was just overwhelming.*

Her sentence: "I hadn't been seen that way before, and it was just overwhelming" seemed to be a particularly beautiful way of describing something so new and personal to her and to Isla, that moment of initial bonding with the first gaze. It is possible this gaze from Isla was the connection that Shoshana had been yearning for throughout her entire life. She then continued to describe the specialness, but also the clarity of meaning for her of that shared moment:

*That was very clear, it was that that kind of, that sense was so, (long pause) crystal clear.*

Shoshana seemed to be describing a sense of 'knowing' between mother and newborn infant, almost as if Isla already knew who Shoshana was, and then went on to say:

*And simultaneously had no idea (laughs). It was, but it is that paradox that, not even paradox, that simultaneity, is so, so (pause) much part of it, its **this complete**, connection and complete newness (pause) and, erm, and there is no conflict. They are simultaneously completely at harmony, (pause) ohhh I've got goose bumps (laughs).*

Clearly her experience still remained resonant, the way her voice changed, and became so soft. She seemed to have drifted back into that memory, as it caused her to have goose bumps still, more than two years later.

## **6.7 Reflections on Shoshana's interview**

I found the way Shoshana described parts of her experience fascinating, particularly her surprise about half way through when she described becoming a mother and yet not feeling anxiety about mothering. The way she described the extremes and the turbulence of her emotions was so measured and carefully constructed, and when re-listening to this section I had a sense of her tempering her experience, possibly for my benefit. It is possible she was choosing her words so carefully because she wanted the words to be as descriptive as possible, but in the least dramatic way. Drama would seem to be part of Shoshana's normal process and yet her interview seemed to lack drama in parts. I wondered if this was because Shoshana found the drama too overwhelming, and wanted to calm it down.

I also had a sense that there was a part of Shoshana that she was not willing to show me. She alluded to this part when describing how she had been suicidal within her lifetime. Maybe this is the part of herself she hides away with her use of gallows laughter.

Of all the participants Shoshana was the most upbeat. This could have been why she used laughter, often at herself. She appeared absolutely ok and seemed quite at ease talking about her experience. This could have been because her therapy had finished about 18 months before the interview. Certainly, to me she seemed to have put her experience into the past.

## **6.8 Conclusion**

It was clear that 'mix' was a potent part of Shoshana's life, a mix of religion, culture and nationality. This mix even occurred within her mental illness, when she was diagnosed with depression as a teenager but subsequently discovered it was anxiety. Mix occurred in the medication she was prescribed as she said she tried various types of medication at various stages of her life. It also occurred in her therapy where she tried various modalities - CBT, mindfulness, compassion therapy, and finally TA. This mix even came into the type of TA she had, because she began in couples therapy, moved into one-to-one, then had some couples sessions again, as and when needed.

This historical 'mix' may have formed a part of her need for constancy so that she sought out the 'same' or 'mirror image' in her therapist. There was a definite sense of 'mix' throughout her narrative, where she used "we" in place of "I" and also in the way she, in the beginning of her interview, mixed up her sentences, leaving parts missing, not finishing sentences, or leaving words unsaid.

There is also a parallel process throughout the interview of disconnection and connection, not being seen and being seen. This felt as if it might have had some connection to Jewish history, and with a sense of connection and disconnection to her own mental health history; to Jewish history; to her family history; to her history with her partner and her need for connection with him; also a needed and yearned-for connection with Isla; and finally her connection with her therapist who needed also to be Jewish. Couples therapy possibly provided that yearned-for connection so the relational style of TA may have provided containment and connection at a primitive, unconscious level.

The two theories she said were the most helpful were the drama triangle and recognising in the moment what she was needing, or what the deficit was, and asking for this to be met by others. She said this had improved the way in which she communicated. She said how helpful having therapy before birth had been because this enabled her to know what was going on for her and gave her the skills to notice that she was actually doing a pretty good job in difficult circumstances, and that this meant she had no need for her historic voice of the inner critic. In fact, throughout her interview, there was no sense of this inner critic at all.

She highlighted the importance of the relationship between her, John and their therapist and the role this played in helping them to interact and communicate with each other more effectively. She put this down to learning about interaction within couples therapy, describing it as amazingly powerful, and added that it was the one thing that they still used all the time as a couple in moments of conflict.

TA addressed the cause of her illness, not the symptoms, and she felt it was this that made the difference within her therapy with John. She described having had therapy many times before, but that TA couples therapy was the most powerful, particularly as it addressed the root cause of her problem, her sense of disconnection, leading to anxiety and then panic. Once she had learned the techniques of connection, both with others and her environment, she said this allowed her to ask for what she needed.

## CHAPTER 7

### Jane's Story

#### 7.1 "*Mortified*" - The trauma of puerperal psychosis

Jane's story of puerperal psychosis shortly after the birth of her first child, is one not often told. Puerperal psychosis is rarely researched and is the extreme of perinatal mental illness. It is often an exclusion criterion within research studies. Jane's story is included because it is important, and not including it would be re-iterating the marginalisation that can occur of women who experience psychosis. Psychosis is usually treated with medication, or in some cases, electroconvulsive therapy. However, Jane was receiving TA psychotherapy at the onset of her psychosis and saw her therapist twice in this period, but they stopped the therapy as she was too unwell. She went back into therapy post-psychosis. She offers a unique insight which is an unusual, valuable resource. Psychotherapists would not normally treat anyone with psychosis and would refer onwards for specialist psychiatric help. It is important that her story is included in this study.

The title for her chapter is her word "*mortified*" as this term captures her experience. Throughout her interview it was clear she was still experiencing the traumatic effects of psychosis, and although she was much better, she had not come to terms with it, and what it meant for her. In parts of the interview it felt like she was back in the experience, and often began to cry. She cried many more times than she laughed, and much more often than the other participants.

Jane's interview was the longest and it was highly detailed. As with the other participants, Jane talked about her psychosis as if it was separate from her. At one point in her narrative she talked about not knowing "*what was part of me, what was the infection*". This gave a sense of her splitting off her psychosis, treating it as 'other' or external to her, rather than being a part of her. This difficulty of coming to terms with actually having experienced psychosis appeared again when she spoke about her initial difficulty in agreeing to participate in the study: "*I suppose in my mind I'm sort of confirming that yeah I'm mentally ill*".

Jane's story was unstructured in places and did not move through her illness with the same temporal movement as the other stories. It travelled backwards and forwards throughout her narrative. This was not noticeable in the interview. The analysis process was difficult and began with formulating some sort of order. Yet a parallel process of confusion and mix-up occurred, so the analysis took longer than all the others.

Jane lives in England with her husband and her son. She is 29 and the interview was at home, while her son was at nursery. Before the birth she worked for the NHS within the mental health team, and went back into work after she had recovered from psychosis. However, her experience of psychosis had a profound effect on her and she had recently left the NHS and moved to a new job working in learning disability services. Half way through the interview Jane said that she had experienced a recent miscarriage and this became a part of her story. She talked about this quite nonchalantly, and had not thought to mention it prior to the interview, nor asked to cancel.

It was unusual for a participant to have first hand knowledge of working for the mental health team within the NHS, particularly as she had spent some time working in the perinatal mental health team. She found experiencing puerperal psychosis herself particularly difficult, with her knowledge about the condition, the medication prescribed, and the way in which a woman with psychosis was viewed. This difficulty is part of her story.

#### 7.1.1 Previous illness

Jane began her interview by talking about an experience that she had, after university, when she had a reaction to an injection, which she said increased her anxiety:

*I'd had anxiety (sighs) things like that [...] where I was really anxious, but .... I'd..... it..... it's a long story but I erm (pause) I had this injection and after this injection I seemed to get this reaction and it yeah, I ended up being really anxious and I don't know if it was the injection or what, but I went really anxious and then suddenly it went (seems bemused)(pause) erm but that very much sounds like what I'm going to talk about today which is, yeah (tails off) but it was quite, quite bad till the point where I would throw up and things like that*

During her description it appeared she had realised the similarities in the way this heightened anxiety manifested itself (from something external – the injection) and her puerperal psychosis, although she didn't say anymore at that time. When speaking, she seemed quite bemused, or confused, and then paused for a period of time, before acknowledging the similarities, then tailing off her speech. For a brief time it felt like she had disconnected and was no longer present. She re-connected when she said about how bad this experience was.

Later on in the interview she came back to this original time and said that she had periods of heightened anxiety as a child of seven and then again when she



was at university after receiving medication due to a particularly bad bout of hay fever:

*I'm not a particularly anxious person now, but we've got a lot of anxiety sort of symptoms in our family, and I actually, I mean again this is going further back, when I was a little girl, about, I think I was about 7, 7 or 8, erm I was really anxious, and that was nothing to do with anything, I was just anxious, but I was getting bullied at the time [...]. [At university] I was really unwell so I don't know if I had some anxiety and having this medication affected it, I don't know, because I'm, it was like I was anxious on acid (laughs), you know, that really like, not like, I could vomit because I was so anxious*

The terminology Jane used “*it was like I was anxious on acid*” offered a vivid sense of how this experience was for her. It was not completely clear what she meant by it and she contradicted herself by saying “*really like, not like*”. From the outset this sense of confusion and contradiction was present, and did not disappear.

Jane then described being diagnosed with chronic fatigue shortly after the bout of anxiety after the hay fever injection:

*I have also previously been diagnosed with chronic fatigue, although I remember somebody saying it's quite an avoidance thing, she didn't believe it was an illness, she thought it was more an avoidance. I don't know, I was quite tired, I used to sleep a lot, errr and that was when I was doing my degree and I've never really explored that at all erm, I don't think I've had the best grounding with things, and that's probably why I've experienced different anxiety and different things over the years, erm and maybe the infection just triggered off something else in me where I became psychotic as well*

Jane appeared to feel judged or discounted, as her experience had been seen as “avoidance” rather than an illness and this appeared to have affected her deeply. She was quite concerned about what others thought of her, and this helped to highlight one of her drivers which she said was ‘Please Others’. At first she said she had little mental illness prior to her psychosis. Yet it became clear that heightened anxiety and chronic fatigue had played a large part in her life. This minimisation of her experience occurred many times throughout her interview, and highlighted just how strong her other driver was, ‘Be Strong’ (Kahler and Capers, 1974).

### 7.1.2 Becoming unwell

Jane was unsure why she had puerperal psychosis, although she said she had a difficult birth experience leading to a cesarean-section. She was in hospital for a week due to complications with both herself and her son, who spent some time in special care. The psychosis began a few days after getting home. One element she believed played a significant role in her psychosis was that her cesarean scar became badly infected:

*I don't know whether it's cos I didn't really like the fact (gallows laugh) that I'd had a cesarean or what but I was a bit squeamish about it, so I tried to clean it but got different information and stuff. So I ended up getting sort of really toxic and I started to get quite, erm anxious about things (pause) started to feel really worried about (pause) my health, dying, and it started to spiral, erm, it was all sorts of different things that I would focus on, erm one being, erm when I was little I couldn't walk until I was about 2 1/2, that's what my mum said, and no-one ever explained why, erm, so I started thinking I had a certain illness and different things, (pause) the difficulty was that once I was labelled as sort of being mentally unwell people weren't particularly focusing on my physical health*

Jane was convinced her infection caused her psychosis. Whatever triggered it, she said the experience was devastating. She acknowledged becoming obsessed about her health, which she called 'health anxiety'. She found stopping breastfeeding her son to start taking antibiotic and anti-psychotic medication devastating.

*I got to the point where I basically went psychotic erm, I, cos of the infection I had to stop breast feeding my little boy which was (pause then begins to cry). I desperately wanted to do that so that was hard, erm, and then the Olanzapine meant that I couldn't at all [breastfeed], erm and I could barely look after him as well, barely look after him because I just had no interest at all because I was just so unwell*

Jane's health anxiety increased into thinking that she had an illness, which spiralled into becoming convinced she was about to die.

### 7.1.3 Experiencing psychosis

Jane remembered her psychosis well, and certainly her description of her illness was detailed. Throughout, one of her most used “I” sentence constructions was “I remember”:

*I remember it all which I hate that I remember it all (pause), not that I heard voices or anything like that, but I couldn't, I could barely sleep, erm I (laughs) my poor husband, he remembers me, him waking up and I was staring, constantly staring at him, erm (pause) and like I, I became really paranoid, like I was being watched and different things (voice faltering) erm, and that's when I had to, cos alongside that they were obviously treating the infection, erm but I had to get involved with perinatal (voice faltering further) because I'd just like gone really. I, not like I am now, I'd completely erm well I was completely psychotic basically (cries) erm and I had to go on Olanzapine,*

It was moving listening to Jane speak about her experience and hearing her voice falter, then break into tears. It was evident that even though two years had passed, her experience was still fresh in her mind. She brought clarity to her experience, and a sense of how frightened she was by her own behaviour. She often used gallows laughter at the beginning of sentences particularly while narrating a difficult memory, but part way through the sentence she would then break down in tears. She seemed confused at some of her behaviour:

*I was just doing all sorts of random things, I threw away my antibiotics one day, I had a really (laughs) you know when your thinking “that's gonna”, you know “that's gonna make me better” and I'd pretended I'd took em and I went upstairs and dropped them down the sink*

She said she was unable to understand why she behaved like that. She also said her sense of time became more fluid during psychosis. Several times in the interview she contradicted herself when talking about how long the psychosis had lasted. This gave a sense of time having altered, that she did not actually know just how long she had been psychotic:

*It felt like a lost time, there was one day actually that I saw the clock and it actually went to different times. It was, but I remember the 20<sup>th</sup> of May (distressed) I went to see my work colleagues and I was ok, I felt really unwell that day, I fell asleep in the car on the way home (gently crying) because I felt that unwell, but I was sort of ok that day, but then the next*

*day that's, it seems like it really kicked in (gently crying) and after that it seemed to be really not quite right, erm. I mean I still, I still remember being paranoid, but I could hold it together to go to work, I remember, cos it was like, right I've got to, ... I went to visit them in work with my little boy.*

Jane did not mean she had to go to work, but that she had taken the baby in to see her work colleagues a few weeks after he was born. This was when the psychosis began to kick in:

*I was, it was like a different person, but I knew I was doing it but I couldn't control it, (pause) erm doing all different random things, thinking that I'd been followed, (pause), so it was pretty shitty, yeah and I feel quite embarrassed about it, (pause) because I suppose in my mind I'm sort of confirming that yeah I'm mentally ill and all this sort of stuff and I think that's really hard for me.*

This embarrassment about her illness continued throughout her interview. In particular, it seemed to become shame when she described meeting her brother-in-law after her psychosis was over. She used gallows laughter to cover how she really felt:

*I remember saying to my brother-in-law "not crazy anymore" and he was like "oh good" (she then laughs) cos I was really embarrassed about it all really embarrassed, erm, but I was I was a lot better then, a lot, lot better. I got, that's why, when I was with perinatal they were quite surprised erm because I've not, in my job I've only met two clients who had psychosis when they had their babies, but not met them at that time, erm but I don't think it was as quick a process as getting well that quickly, erm and that's why they said they felt a lot of it was the infection, because I was really, I felt really toxic.*

It was important for Jane to re-iterate her belief that her psychosis was from the infection, her feeling 'toxic', and that getting better was a "quick process". Later on, Jane described her psychosis again and how it manifested itself:

*the psychosis was like, such an exaggeration of my personality, a complete exaggeration, because I am a bit wary about people and things like that, but I literally like (pause) was just (pause), it was just so exacerbated, [...], it was such an exaggeration of, a complete overload of my thoughts and things like that, but yeah I was convinced I was dying and I'd actually come to terms with it, erm, because I used to have a fear of dying, and I do (long*

*pause) even though I am absolutely fine now I do still have that acceptance that one day I'm going to die, erm (tearful again) and hopefully it will be way off in the future and err, you know, but its weird I still feel that sense that one day you have to die and you can either be frightened of it or you can accept it and yeah, but I remember, I remember that overwhelming feeling of acceptance, (long pause), but then I connect it, I thought maybe the clients I work with, although luckily no client I worked with in mental health actually killed themselves, so erm, worried about that, erm, (pause) maybe they would get to that point of that acceptance, that feeling, erm, it's a strange feeling (pause) almost like (pause) a sort of, say you had a terminal illness and you'd come to terms with it, that was the point I'd got to when I was psychotic.*

Jane said many times that her psychosis was not simply anxiety about her health but it was an absolute conviction that she would die immediately.

#### 7.1.4 Abandoned

The most prevalent theme in Jane's story was abandonment. She felt abandoned primarily by her husband and family through the lack of knowledge they had about mental health. This was difficult for her, particularly as they had no idea how to help her or what to do when faced with her psychosis:

*my husband and his family didn't have a clue, they don't have a clue about mental health at all, erm they thought it [therapy] would help me because they thought I still had health anxiety at that point erm and yeah they were absolutely clueless*

She felt abandoned by the medical staff during her son's birth, culminating in feeling disappointment with the birth itself:

*I imagined having a water birth and doing it all naturally with no pain relief or anything, erm, because that was my complete desire and my little boy ended up breach and erm, I ended up with an emergency cesarean in the end because they left me so long, so we had a very traumatic birth. [...] I had a cesarean... which I was so frightened of. [...] and [afterwards] they rushed me in and put me to sleep which again was my worst fear*

Her mother also perpetuated these feelings as she was not there for Jane after the birth:

*my mum, like she wasn't particularly present when I was ill, erm as soon as I seemed to get ill my mum and dad sort of disappeared, in a sense, even*

*though they didn't, they'd come and see me, but they just didn't want to know, erm.*

*I always say about my mum – after the horse has bolted – that's when she (laughs) she's there after the event,*

*I felt very alone, I, felt very, because I'd had a cesarean so I couldn't drive I couldn't do anything and it was, it was the worst fear that I had*

By “*the worst fear*”, Jane explained that she was frightened about having the cesarean, but also being abandoned at home, unable to go out. After she and her baby left hospital, she began to feel unwell. She had hoped, expected, to receive some help from her mum or mother-in-law:

*I didn't really have anyone around me, I thought my mum might come and help me, I thought my husband's mum might come and help me and I didn't really get anything, erm I mean I spent erm before we came I spent about a week in hospital because, because of my little boy's birth, he ended up having to have antibiotics [...] so he ended up in NICU (Neonatal Intensive Care Unit) and that was a big guilt trip for me because he was in special care and I didn't even have him and then I got ill after that and wasn't being present and yeah it was awful, but to be left on my own was a big thing, expecting my mum to rise up to the occasion and come and help me, and, you know, because I'd had a major operation and been given a baby and you know so I don't know if that contributed because I was just so, you know, I was very isolated, [...] so I was just like I'm getting really confused about it all as well and all your sort of processes going on and you've got this tiny little person and suddenly you're left alone*

This confusion was about describing what had happened at that time, and also possibly the confusion about why nobody came to help her.

#### 7.1.5 Parallel process

Jane spoke about her fear that she would abandon her baby by not being present at his birth. Her mother was put to sleep during Jane's birth and this was something Jane had struggled to come to terms with. Jane was determined to be present. Unfortunately, the baby was breach and she had to have a cesarean section. Although she was awake for the cesarean, she was taken into theatre afterwards, to repair a prolapse:

*my mum had been put to sleep with me and I always found it very selfish that she'd done that (sobs) erm, not wanting to be present at my birth basically, and I wasn't present at my little boy's (sobs), erm, and he ended up in NICU [neonatal intensive care unit] and that was a big guilt trip for me*

This made her feel guilty, particularly as her son was then unwell and had to be taken into NICU, so she was not with him at the beginning of his life:

*I hadn't done it properly, and then I'd repeated what my mum had done (tearful) and so you know, again, he was, I wanted to be a different mum, when I thought that I was already replaying the process.*

Jane said her development of an infection in her scar was a replay of the whole process of her own birth:

*my mum even had an infection and she said "oh it's likely you'll get an infection" and I mean [...] and I'm again being critical of my mum and I don't think my mum was that great.*

Jane's unfulfilled expectations concur with articles in the literature review. Many women talk about their unmet expectations in this way (see section 2.2.5): unfulfilled dreams, disappointment with the delivery, an over-riding sense of not having done it properly (Engqvist et al., 2011).

#### 7.1.6 Guilt – the absent mother

Jane spoke several times about her feelings of guilt, particularly towards her son: from his difficult birth and his subsequent stay in NICU; and because she was not there for him when she experienced psychosis, meaning he had to be looked after by others.

*I've tried to understand about the feelings of guilt and feelings of guilt sort of towards everybody but also towards my little boy because I was very absent and it wasn't (pauses and starts to cry) but yeah I was very absent and now I suppose it's, because you learn about obviously your attachment and things like that.*

During therapy Jane had gained some knowledge about attachment theory, due to an exploration of her relationship with her mother. This knowledge seemed to exacerbate her feelings of guilt:

*doing the therapy beforehand, before my little boy, I explored a lot around attachment with my mum and things like that and, erm, doing the TA and exploring that I feel has helped me be a better mum, to understand things.*

She evidently still felt guilty and was struggling with her strong emotions:

*The impact that might have had and I, I (sobs) and I mean my husband has always said to me "but you were, you were with him, you were holding him", but I wasn't interested really and I know that's aw... awful to say but I wasn't (sobs) and*

E.H. *you were very ill.*

*yeah, oh yeah yeah, sorry (long pause) I thought I won't cry I'll be able to just reel it off*

It felt at the time as if she was talking from her Child ego state, and had forgotten that she was so unwell, and was therefore unable to look after her son.

#### 7.1.7 Shame

Throughout the interview there was a sense of the shame Jane felt about experiencing psychosis. She used the term "embarrassment" repeatedly, possibly in an attempt to minimise her feelings. It seemed as if she felt this shame around everyone, her family, her therapist, her friends and her work colleagues. Her use of the word "mortified" really highlighted the depth of her sense of shame. This was more than embarrassment. She used 'mortified' a few times in her interview, but mostly when talking about her therapist seeing her when she was psychotic:

*I felt really embarrassed, I felt really embarrassed (starts to cry and says to herself to stop it) erm for, you know, my family having to see me like that, having to be, you know, within mental health services, and also like cos I'd built a relationship with my therapist, her seeing me like that and I was just mortified (intake of breath)*

She explained how difficult it was to return to work and admit that she had experienced psychosis and had been under the care of the perinatal mental health team. This seemed to be something particularly shameful for her, having worked within mental health, particularly perinatal mental health and then finding herself on the other side, as a patient:

*I mean I did, in the end I told a couple of people at work, one being my manager, erm, in a way I thought I had to, I had to tell them I'd been involved, and really I didn't, because, you know, er it had no bearing on my*



*work or anything, but erm, it just I felt so guilty that I'd had to be involved and there's been times, because of the work I do, well did, you know, (drops voice) I've literally just left, erm, I had to be involved with the crisis team that I accessed and, erm, there was a time when I've had to, not work with anyone from perinatal with a client, thankfully, but seen that [person], bobbed into our office and things like that and (sighs) yeah hated every second ...*

She did not say that it was this shame about her psychosis that caused her to stop working in mental health. However, this paragraph gave a sense that this had a much stronger bearing on her decision to leave than she was willing to admit.

Jane's husband's reaction to her psychosis underlines her shame and the devastation she felt:

*Even my husband, when they said I was psychotic to him, he was so (begins to cry) frightened of me, so frightened that I would come and hurt him, and my little boy, I know, it really, that's what I mean, they didn't have a clue, and he actually said to me, he actually said he put tshirts at the bottom of his door, because they told us to sleep separately, to let me sleep, and he looked after my little boy and my husband is lovely (very tearful), he's so kind and lovely, but his only experience of psychosis was like the slasher films and things like that, so he thought I would just flip and come and hurt him. That, (pause) that was hard, that's why its been so hard (cries) because, its everybody else's view as well, how you're seen and I know, I know, as much as you think ohh you work in mental health everyone's so open minded, no they are not, (drops voice, but then says determinedly) **they are not.***

This last sentence about the lack of open-mindedness within the mental health team is striking, and Jane's knowledge and experience of this would seem to concur with other research that found a pathologising attitude within the health profession, particularly around puerperal psychosis. The research also highlights the sense of anger felt by women towards the medical profession for perpetuating this pathology and stigma (Robertson & Lyons, 2003), and dissatisfaction with their care by the medical profession (Engqvist et al., 2011).

## **7.2 Therapy**

Working in NHS mental health services gave Jane first hand experience of CBT, as this is often the only type of psychological therapy offered. She spoke about her experience of CBT with her own patients:

*I love psychotherapy, and I would argue that there's not enough at all. I mean this is my personal opinion, but CBT is rubbish, it has its place, and it can be that quick fix, to get people back on their feet, but you need to look underneath about what's going on and explore what's happened to you and [...] part of [...] the process I went through with his birth and everything, has got so much to do with my parents you know, or that lack of parenting.*

Jane chose TA psychotherapy rather than CBT, when she went into private therapy, describing what that was like for her, both before and after her experience of psychosis:

*it's so powerful that, that you know, you can get so much out of it, but you've got to invest in it [...] it's made me be kind to myself as well as being kind to other people, erm and prioritise things as well, [...] I made a massive decision to leave my job, I just didn't want to do it anymore, having my little boy and doing the therapy I was like, "why do I have to put up with this, why do I want to do this?" [...] and I would say to anyone to have therapy. Even the way I deal with people in my day-to-day life I think differently and I think how I can get my needs met, as well as trying to help the situation with them.*

Jane was able to speak about her experience of being in therapy through her psychosis, which gives an indication of how difficult it is for someone with psychosis to engage with reality:

*I remember errr, [therapist] sat in front of me and just, [...] I was paying lip service to her and I was just you know, because I, at that point, as daft as it sounds, (changes voice tone) no it doesn't sound daft because I was psychotic, (changes voice back) erm I was convinced that I was going to die, and she was trying to, I, I remember the session, and she was trying to talk about plans for the future, and I wasn't going to kill myself I just genuinely thought (begins to cry) that I was going to die, erm, and I'd actually come to terms with it (cries more deeply) I remember (is unable to talk for a while), I remember coming to terms with it and thinking well I'm going to die anyway, so I would say to her "yeah you know I'm excited about going to Florida at some time in the future" and I was actually thinking "well I might be dead tomorrow" and I remember that **so** well, erm, I remember sort of having this sense that I was lying to her and knowing I was lying to her and hating that, because I'd built up such a good relationship with her, but also thinking "well I'll be dead tomorrow, so what does it matter"*

### 7.2.1 Gallows laughter

A little later in the interview Jane returned to this meeting with her therapist:

*I remember the session and it was completely pointless, absolutely pointless, of her being there (pause), that's my embarrassment, cos I, I, you know, I really like my therapy with [therapist] and I was mortified that I could be like that with her, so I (laughs) I don't really want to go through that and talk to her about it, erm, yeah, well that's my avoidance.*

She laughed before she said this and it appeared quite a painful memory, one that she was not yet ready to explore in therapy. It seemed to emphasise her shame and how difficult it might be for her to explore that struggle.

Jane switched many times between gallows laughter and crying, often within the space of a sentence. She knew gallows laughter was a part of her process as a defence mechanism to her real feelings:

*I laugh, because my gallows laughter comes out when I'm talking about things that are really bad (pause) (cries) because it makes it feel better sometimes.*

Her gallows laughter came again, when she talked about cancelling one of her sessions with her therapist right in the midst of her psychosis:

*Yeah erm (laughs) because I remember cancelling one, erm and (pause) like my, my therapist, she couldn't understand why I'd cancelled, but I thought I was dying so I was off to A and E (accident and emergency) (laughs) so, as you do, erm, and er yeah she'd, we sort of carried on like over the course, because one thing I was upset about was perinatal [mental health] wanted to liaise with her, but yeah I continued, and I remember one time when she came to see me at home, erm well not at home, I'd gone to live with my in-laws, erm and yeah I felt like she was frightened of me, cos I was that paranoid I thought she was frightened of me. It wasn't really effective at all because really I just needed to get well before I could engage in the therapy, there was no way I could (pause) be bothered really because I was convinced I was dying and that was it really, why would you need therapy?*

It would seem that Jane was confirming that she thought psychological therapy was not helpful during her psychosis, and went on to explain why:

*I just, I couldn't, I didn't have any insight, I didn't, you know have any insight into what I was doing or anything. In a way I was like, erm I felt like I was there but not particularly there.*

This sense of being there but not there resonated with the experience she mentioned in section 7.1.2, about remembering all of her psychosis, knowing what she was doing, but being unable to change her behaviour, almost as if there were two parts to her.

### 7.2.2 Asking for help

One area Jane explored in therapy was her difficulty in asking for help:

*I don't feel like I'm allowed to ask for help, which is my mum, so I can be really anxious about having something wrong with me, but I'm frightened of actually asking for help. So I suppose I could have asked how to look after my scar, I could have asked, you know I could have bothered them more when you know when I was in hospital. I really reproach myself all the time about the birth [...] but its just, everything that has come after, I sort of realised that I don't ask for help, so as much as they have their role in it I think I need to take my role in it and ask more.*

After exploring this in therapy, she now manages to use what she has learned and has changed her behaviour:

*I sort of TA myself sometimes and think about it and explore it for myself, but I did definitely think I'm somebody who, I don't speak up and I don't ask for help and [...] I come across as very much that I can just deal with it and I don't know whether I was quite a model patient when I was in hospital with him, with going to get his antibiotics, I was breast feeding so I was really chuffed with that, you know, I was just dealing with everything.*

This asking for help was an area she talked about much more when exploring her object (Section 7.6).

*It's interesting to explore how other people responded to me as well, erm (pause) because I suppose, coming to terms with the fact that as well, people around me didn't, didn't seem to give me that care that I needed, apart from when I had to ask for it, er (pause) yeah.*

This gave a sense of just how powerful her script was: “being strong”.

### 7.2.3 Jane's script

Jane discovered her script within therapy. She had two drivers, 'Be Strong' and 'Please Others' (Kahler and Capers, 1974), and the combination of the two made it particularly difficult for her to ask for help:

*within social environments, very much, I'll be strong.*

This need to be strong had played a part even in her recent miscarriage:

*when I had my miscarriage, I had tucked it down as far as I could, but I actually kept getting like physical pain in my chest because, and like a breathlessness, and its so powerful how your emotions can do that to you, but I'd be awake and I'd just ... I was dealing with everybody else's stuff and I was like, "why did I come back to work so quickly?" and again that was because I wasn't well enough, and I shouldn't feel anything because I've gone through that process, I've had my injection, and I'm no longer pregnant, then "you can't have any time off", (intake of breath) and that's what I do (laughs), that's my mum (really laughs).*

Her laughter about her own process felt uncomfortable. She was discounting herself, the miscarriage and her feelings about it. She referenced this back to her mother by saying "that's my mum". It also literally showed how easy it was to be pulled into her script of 'being fine'. Her laughter felt incongruent and she possibly realised this as she then continued:

*yeah that be strong, yes as soon as I wasn't having any medical treatment I thought that's it, I've got to go back to work, I'm not allowed to spend any more time off, I've already had three weeks off, "how dare you have three weeks off", err (hmm), that's what I was saying to myself, so I went back, but I was just like, you know (drops voice) I, I, (pause) couldn't (pause) cope.*

This response felt much more congruent, acknowledging how difficult it had been to have the miscarriage, particularly when she finally dropped her voice and acknowledged that she could not cope.

### 7.2.4 Discounting

Jane discounted herself and her own ability a great deal. This discounting was apparent through her use of the word "just" and, as previously mentioned, her use of gallows laughter, particularly when describing something painful or

difficult. She recognised that she discounts herself and acknowledged that her process was to put everyone else's needs in front of her own. This tied in with her difficulty in asking for help:

*I put everybody else first, they're all, I always put everybody else first, I put everybody's feelings and emotions first, before my own.*

As Jane had decided to return to therapy at the time of her interview, it was not surprising that she was still discounting herself.

#### 7.2.5 Miscarriage

Jane's process of abandonment and her anger about the way she had been treated became apparent again when she began to talk at greater depth about her recent miscarriage:

*I had my miscarriage and because I was handling it so well, nobody, they don't offer you any therapy or anything and if, (pause) oh, I know this is (starts to cry) [...] and then a couple of weeks later I was still showing up as pregnant, I, and they tried to say I had got pregnant again and ended up having to have an injection of methotrexic where you can't have a, you can't try for a baby for three months and once my levels were down they just discharged me and its its across the board its not just when you have a baby its everything. Everything, every possibility where they could support you professionally and there is nothing. So we've had a pretty shit time (laughs wryly).*

*I wish someone would have said sorry to me, every time something's happened.*

Jane still seemed angry about the way she had been treated throughout her experiences, of the birth, the psychosis and the miscarriage. She spoke about putting in a complaint about her medical treatment, yet it was not about her own treatment, it was about the way they had treated her son. She then said she had withdrawn the complaint because it was "*pointless, absolutely pointless*".

### 7.2.6 Fear of the future

Unsurprisingly, Jane talked about how she was fearful of having another pregnancy and the possibility of experiencing puerperal psychosis again:

*I do still feel embarrassed and I haven't, I suppose I haven't talked about it as much as maybe I could have done but I suppose I've sort of reconciled it for myself like it was the infection, and I hadn't slept but there is that fear that it, you know could happen again and er it sort of, it's in the back of my mind.*

*working in mental health you see how prejudiced people are, (pause)[...] I don't want to be treated like a psychotic client, and that's my fear.*

*it has really changed my perspective on things a lot, hence why I've left my job and I'm going into something different and*

E.H. [so it has had a profound effect on you?](#)

*yeah, yeah, that and becoming a mum erm because I like working in mental health, I was just, you're an available punch bag sometimes and I didn't want to do it anymore.*

It is almost certain that she was also fearful about going through another miscarriage.

### 7.3 **Other noticeable aspects of the analysis**

Looking for contradictions within Jane's analysis it was possible to see that she did contradict herself when she said "*I am not an anxious person really*", then went on to say that her puerperal psychosis began with "*health anxiety*" and that she had been so anxious as a child she was sometimes sick. It is possible that she was referring to herself now, rather than 'back then', although it was not at all clear within her narrative when she meant she was not anxious.

Jane's interview was conducted at such a pace of speech that there was little time for silence within it. However, it was noticeable that she did use "*erm*" a great deal throughout, and this may have been a way to pause and possibly as a way to buy time to allow her time to think within the interview.

Jane did not use any metaphors within her narrative.

#### 7.4 Listening for Jane's other voices

Throughout the interview and the data analysis there were two prevalent parts of Jane speaking (see Appendix 10). This mirrored Jane's story of psychosis, the part that was her and the 'other' part (the psychosis). Other voices also appeared in her narrative.

From the beginning of her interview the first voice battled not to speak about her experience. This voice stopped Jane from sharing a great deal, giving little detail of her experience at first. It was difficult to engage with this voice, as it felt as if Jane was unwilling, or unable to talk much about her experience. The second voice, which sounded like it came from her Adapted Child ego state was a voice that appeared part way through when Jane was speaking of her re-engagement in therapy, once her psychosis was over. She remembered how embarrassed she felt about her therapist seeing her experiencing psychosis. She began to cry, and as soon as she did, a really critical voice appeared telling herself to "*stop it*", to stop crying. This voice (the third) sounded like an introjected Critical Parent telling herself to be strong and stop crying. This critical voice returned, further on in her story once she had stopped crying, quite matter of factly saying "*I thought I won't cry, I'll just reel it off*". This 'voice' was powerful in Jane's narrative and appeared to be trying to keep her from showing her real self: devastated, frightened and struggling to come to terms with what had happened to her.

Another voice Jane used was the voice of shame which again felt as if it was from her Child ego state, using the word "*mortified*" to describe how she felt about her therapist seeing her with psychosis. This word seemed to offer a sense of the level of her shame more than any other word she used. She acknowledged that she had not addressed her shame in therapy in the way she could have done, because she had "*reconciled it for myself, like it was the infection, and I hadn't slept*". Yet then she talked about how, in her mind, people would be thinking about her becoming psychotic again. This voice of shame is prevalent throughout her interview.

The final two voices Jane used were the voice that sounded like a Nurturing Parent, and the Adult voice she found in therapy. There is very little of this more nurturing voice. It was apparent that Jane found looking after herself, or putting herself first quite difficult. Her pragmatic adult voice appeared when describing her therapy sessions and how these had helped her.



## 7.5 Listening for Jane's "I" poems

Jane's "I" statements were predominantly in the past tense. The most numerous was "I was" which she used more than twice the amount of times she used her second statement which was "I had".

A great deal of her "I" statements were negative, such as:

*I was dying*

*I felt so guilty*

*I was very absent*

*I shied away*

*I sound awful*

*I was so frightened*

*I avoided*

This gave her narration a sense of hopelessness, dejection and helplessness. This was not surprising as Jane mostly reminisced in a negative way about her experience, in particular how traumatic it had been for her and she seemed not to have come to terms with it.

Temporally, her statements moved around a lot and there was no real forward movement in her statements as there were in the other participants'. This was surprising, as towards the latter half of the other stories, the participants changed their speech using more positive statements and also predominantly using the present tense towards the end. Jane did not do this at all, her statements stayed in the past. Also her negativity did not seem to change at all.

## 7.6 The role of psychotherapy in puerperal psychosis

It is plausible that many people may not believe that psychotherapy is appropriate with a woman experiencing puerperal psychosis. Jane's experience brings this into the forefront of discussion. It also highlights the question of when therapy is actually therapeutic.

Shortly after her psychotic period was over Jane re-engaged with therapy:

*I just found [TA] so powerful, I mean, I sobbed, I absolutely sobbed, because I was given permission that it was ok to feel, erm and that's what I love about therapy [...] the bit of TA I've mainly focused on as well about thinking about my relationship with my little boy, my therapist said "you know, there'll be something there about his birth and you know about what's*

*happened and, you don't have to define your relationship with him", and I've, I've, I suppose I've focused on you know trying to think well, that happened and I can either stay with that and feel completely guilty about it, or I can move on and think, you know, I've got my little boy and he's absolutely gorgeous [...] TA has helped me to think about [parenting] differently, [...] doing therapy has really (pause) its changed me as a mum, I maybe haven't explored what went on for me in terms of my mental health at that point when I was unwell, but its changed the way I see things, and I think its made me a better mum compared to what maybe I would have been if I hadn't have done therapy.*

Jane confirmed that therapy was helpful in the aftermath of her psychosis and it gave her permission to grieve for this period. During those two sessions whilst she was psychotic, it may have been useful to her therapist, giving a sense of the depth of Jane's disturbance and the devastation she felt about her experience, as well as knowledge and experience about Jane's process during this time. The experience of the therapist, however, was not part of the study. Research from a therapist's position about psychotherapy during psychosis would be useful. Medication is always the first line of treatment. However, psychotherapy may be able to provide a more holistic form of 'being with' a woman suffering from psychosis. It could also provide an empathic containment of the particularly feared parts of behaviour and self, that a woman may struggle with at this time. As many women with puerperal psychosis speak of their sense of abandonment and isolation (Engquist et al., 2011; Robertson & Lyons, 2003; Heron et al., 2012; McGrath et al., 2013), being able to be with the same person, throughout the experience, seeing them often, may offer the women a sense of relationship and a 'being with' another during the often disturbing psychosis.

Jane said she believed therapy did have a role to play in puerperal psychosis, even though when she was actually experiencing it she was unable to engage properly in it. This was surprising, offering a possible legitimate role for psychotherapy in this period that may prove to be viable, useful and ethical:

*I was just completely unwell and not really in a place to engage in it at all. But I still think it has its place, [...] when someone's got well, and they can start to engage in the therapy, erm because that's something I feel quite strongly about, that people with psychosis seem to get treated so different, to people with general anxiety, depression, even personality disorders, it's so sad, you are just medicated and that's it, and like even, I mean, being part of the work force, working in that environment, but also when I was with perinatal, I mean the woman was lovely, you know she was nice enough, but it wasn't, it wasn't very good at all.*

Jane's story of how helpful this was for her is useful, and may offer possibilities for other women who have experienced this condition. In particular, if women with puerperal psychosis remember what happened to them during the period of psychosis, as Jane evidently did, it is possible that a period of therapy may enable them to explore the way in which their particular psychosis manifested itself and the effect this has had on the woman and the way she now views herself. Psychosis is a frightening experience for both the patient and those around them. Therapy could offer an opportunity to voice this fear with someone who has a sense of understanding, and the possibility to explore it, helping to dissipate some of the fear, and enable a 'coming to terms with'. Jane found it difficult that she could lie to her therapist, pretending that everything was ok, when in fact she knew it was not. The ability to explore this has been useful for Jane in different ways. Jane said it allowed her to acknowledge her embarrassment and this might lead to her being able to voice her shame. It provided the possibility of grieving this lost time, and the difficult feelings she held about experiencing psychosis. She spoke about how she felt she was given permission to grieve in therapy, and how helpful this was for her. It also allowed her the opportunity to explore her relationship with her mother, and how her attachment to her mother played into her adult relationships and caused her to find it difficult to ask for help when she was experiencing difficulties in her life. She finally said that it helped her to realise that she wanted to change her life:

*I want to spend time with my little boy, I want to expand my family if I can, I love being a mum and I want to invest that time, rather than in anything else. Your priorities change don't they? Everything changed for me and I've not been happy going back to my job, all the time I've hated it, absolutely hated it, [...] its been life-changing really, everything that's happened to me, erm its just taken me a little time, since my little boy's come along, for me to realise that I wanted to change things.*

Jane's experience of puerperal psychosis and her experience of TA psychotherapy within the time of psychosis may show that therapy is not a suitable treatment whilst a woman is experiencing psychosis. However, her experience once her psychosis was over gives a different story to her experience. It is possible that psychotherapy may play a role in this devastating and frightening experience, as a treatment adjunct.

## 7.7 Exploring Jane's object - Teddy



Jane's object was a teddy that she and her husband had bought when her son was on the NICU unit . The teddy holds significance for Jane and she said she kept it out of her son's reach at present:

*my little boy is not actually allowed to play with him, (laughs) cos I want to keep it nice, to tell him about it when he is older, erm, we bought it obviously because we were on the unit and it would donate funds, erm to the unit.*

The teddy had a blue jumper with “*I’ve had special care*” embroidered on the front of it. As Jane’s story about her experience began to unfold it became clear the teddy represented both her son, but also Jane’s experience after his birth. Jane acknowledged that she had also needed special care:

*this little teddy, it is quite sentimental because it, it reminds me that he had to be looked after. But when I was thinking about it I was thinking well I had to be looked after and I needed special care, and as much as maybe I didn’t get it at first, in the end, I did. I mean, we went to live with my in-laws, and they were really good with me, erm as much as they were, you know, oblivious to what was going on with me, erm, they were really good and they looked after me and looked after my little boy and so he got some good enough stuff from them that I wasn’t able to give him, at that point*

E.H. *and did you get some good enough stuff?*

*erm (pause) I think I did (begins to cry) I felt looked after, I felt looked after, better than what I would have got from my mum [...]we’d already moved in to live with [my husband’s] mum and dad before I got particularly unwell, (sobs), erm, and then my mum was like (changes voices to one of exasperation) “well I would have stayed at your house, why”, yeah, “I’d have stayed in your spare room” and I was like well, well, you know, I, that wouldn’t have been ok [...] I would have felt too on edge that I had to put on a certain show for my mum, erm (pause) and (pause) yeah I just, I think it was better that I went to their house and we had our own room and, [...] and I remember one day I fell asleep on the balcony and erm on like a deckchair thing, and you know, his mum just let me sleep, because I was so unwell, she just let me sleep and she looked after my little boy, so that (begins to cry again)*

E.H. *so the teddy represents that really really well*

*yes, yes cos I know that I do criticise my mum, [...] but it’s that care, it’s that care that I don’t get from her, I don’t even feel soothed, [...] I don’t get that soothing from her at all.*

This teddy had resonance in Jane’s interview and the embroidery on his jumper spelled out the part of Jane’s experience that she so needed, the need for special care.



## 7.8 Reflections on Jane's interview

Jane's interview began differently to the others. For some reason, I asked her about her history of mental illness. I didn't have time to wonder why I asked her that question, although I thought about it a lot afterwards. However, it had a detrimental effect on Jane and was not conducive to encouraging her to speak. Quite matter of factly, she responded by narrating an experience of severe anxiety after an injection for hay fever once she left university. She then realised the similarities between that experience and her psychosis. This obviously threw her, as she became silent, seemed to be lost, and looked at me as if she was bemused, confused or struggling with this realisation. The interview then became disjointed and difficult, with Jane saying very little, being factual rather than narrating her experience. It was not until Jane talked about her psychosis that her narrative became more fluid. During the analysis process I began to think this must have been due to strong counter-transference, possibly about the unspoken stigma of psychosis.

The strongest feeling I had during Jane's interview was one of bemusement, leaving me with a sense of feeling I was out of touch, not quite there, or confused and at times a little lost. I was struck by the depth of emotion that seemed to lie just underneath the surface, of her experience of devastation about having had psychosis. The knowledge of the effect of her psychosis has helped me to understand the longevity of this condition. I have wondered if a woman would ever 'come to terms with' such an experience.

During the analysis process I had powerful counter-transference, mostly of sadness and I found her tape difficult to listen to. Yet in the interview I had not felt like that at all. In fact I had felt numb, particularly at the beginning when it felt like a huge struggle, almost like walking through treacle trying to get Jane to speak about her experience. She kept me at a distance at first, initially saying just enough about what had happened, but then discounting what she said by using gallows laughter. She also leapt backwards and forwards in her narrative about what had happened in her psychosis, then would suddenly leap backwards to being a baby, then return to talking about the psychosis. This backwards - forwards movement continued throughout. Whereas in the other four interviews, there was a definite temporal movement within the interview, Jane's was different. Early on she spoke about her therapy, then switch to talking about her psychosis, then about her change of job, then back to her childhood. This left me somewhat confused, as the story was jumping from place to place which I found difficult to hold on to. The emotions that Jane narrated also skipped from one extreme to the other. She would laugh at one point in her sentence only to

cry literally a few words later, often sobbing uncontrollably. This left me with a sense that her psychosis had deeply affected her, and continued to affect her.

Her speech throughout the interview was so fast it often seemed as if she had no time to draw breath. This was evident in the transcript when there would be literally whole pages of narrative with no full stops within them. This gave a sense of pressure of speech. It felt that this was her way to help me feel what her experience of psychosis was like. She talked about her sense of embarrassment about her experience and even said that she was doubtful if she could tell me about her psychosis as this would mean she was admitting to having experienced it. This also gave me a sense of the depth of her shame.

I left the interview feeling outrage and anger towards the medical staff that had treated her. This was not my anger, but Jane's, because I stopped shortly after leaving her home to record some field notes, and found myself talking in a pressured, breathless way. As soon as I finished the recording I was able to drive on without thinking about the interview at all. When I began analysing the interview transcript my anger did not re-occur. I mostly felt deep sadness and grief. However, when writing up the analysis I had a sense of being lost again, pausing, thinking and becoming easily distracted. So I would leave the writing up and do something else. I realised that there was a powerful counter-transference, and that it seemed to be about 'time'. Jane spoke about losing her sense of time when she was experiencing psychosis. I lost time almost in a reverie state, staring at the computer not knowing what to write or how to write it. I eventually stopped analysing her transcript and left it part finished for a while, and went back to it several transcripts later. Her transcript was the hardest to analyse. I am still not sure whether this was because of her psychosis, that it was so all-consuming for her that it almost overwhelmed me too. I wondered if being logical and analytical with psychosis just did not easily work.

## **7.9 Conclusion**

Jane's experience was not expected. It was a perspective that offered a different experience, one that could be useful to contemplate for future treatment of women with puerperal psychosis. Puerperal psychosis is easily dismissed as at the extreme of mental health and therefore needing a special form of treatment, one in which there is no place for psychotherapy. However, it would appear that what is lost within the conventional treatment focus, and that of electro convulsive therapy, is the woman's humanity and relational need within that treatment. Medication will always be the first line of treatment, as it should continue to be. However, psychotherapy may offer a possible addition to the conventional treatment, as a useful way for women to explore their experience, helping them navigate their way through the emotions often voiced within this

form of psychosis. Psychotherapy does have research showing it as a suitable treatment has been researched in adult mental illness, yet there is no research at present regarding its use as an adjunct treatment for puerperal psychosis. It may also offer a constancy of an 'other', who is there, throughout the journey, however bizarre that journey is. This would be in direct contrast to most women's sense of abandonment and rejection through psychosis.



## CHAPTER 8

### Julija's story

#### 8.1 The lonely child

Julija's story is of disconnection which began in childhood when she was nine months old and spent time in hospital on her own. This disconnection continued with her parents divorcing when she was seven, splitting the family. From seven onwards Julija's story is of isolation as her mother worked full time, leaving Julija alone a great deal of time. A defining feature of her life is a search for connection:

*I have always wished for somebody to be there, to have someone to be there for me, to hug, to cuddle, to (pause) it was very important.*

This need for connection was also part of her journey in therapy.

Julija went into psychotherapy after the birth of her first child because she was feeling "burnt out". At first, she received Imago therapy privately. However, she discontinued this when she was pregnant with her second child as it was not working for her. She went into TA psychotherapy when her second child was around eight months old. It was in this psychotherapy that she said she discovered that she was feeling a historic form of depression, which she explained as something she had felt throughout her life. Julija's story of psychotherapy was one of acknowledging and understanding, then grieving for herself as this young, lonely child. Julija's interview was more upbeat than the others. This may be because she had been in TA psychotherapy for two years by the time of her interview. She is still in psychotherapy, although now she is in a group therapy, rather than one-to-one.

Julija's story is interesting because although she narrated a story about perinatal mental illness, she also narrated where she believed it came from – her childhood. Julija believed there was a parallel process occurring from the past into her present. When her second son was around seven months old she found herself unable to function properly and sought help from a TA psychotherapist to explore why she felt this way. She said she knew she had been a depressed child and adolescent and that depression had followed her through life, but she was not really sure why. She also experienced fear and anxiety during childhood, particularly around being criticised by others; this also was present in adulthood. Her experience of perinatal illness was of fear and anxiety.

Julija is 33 years old and mother to two boys of six (Tim) and two (Tomaš). She lives with her partner (Luka) in Eastern Europe, and the interview was

conducted in a rented office as Julija preferred not to be interviewed at home. The interview was conducted in English and although she was offered a translator, Julija declined. Her English was fluent and the fact that she was using a language other than her own made little difference to the interview.

### 8.1.1 Previous illness – depression

Julija acknowledged quite early on that she had experienced depression for a long time:

*Depression is something that is certainly part of me, like goes up and down and up and down, it goes up and its better and then it's worse [...]. I think now, when I know so much about depression, I think I've had it, that's why I said that my depression started for sure in that hospital. [...] I couldn't be more sure, it's but on some level it's so strange because its like "oh come on you don't gonna remember anything", but I can, I can so feel it, I'm so certain that that was the point, and because I can remember, you know, at first in my primary school, first second third grade, when I was home alone, not feeling like "oh everything is..." I mean the grades and the things that had to be done they were almost perfect, but beside that I was always afraid to, to, to go, to be socially included, erm it was like always dangerous [...] I now know I was afraid of getting criticism or somebody saying something to me, that is not positive or, erm but I can so remember being 11 years old, watching TV and stuffing myself with food and already bad then, because my parents got divorced when I was 7 and it was a major thing, so we were left, I was left alone with my mum, but mum was working pretty much, during week days, so I was home alone a lot.*

She also spoke about how eating was a form of comfort for her even as a child and she believed that this was because she was anxious and depressed.

*Not only watching [TV], also eating at the same time, like, like yeah sweets and bread and things like that. Even today, yeah I mean I can, I now am aware of it, I, naturally, I've done some work in therapy with regards to that also, but yeah yeah they run together.*

Julija was aware that food had become a coping mechanism that she used when she felt stressed, anxious or depressed, and her battle with food was on-going, and "never-ending". Although she described being unwell as a mixture of anxiety and depression, her narrative described stress and anxiety, rather than depression, stemming from fear of the damage antidepressants may have had on her baby in utero.

### 8.1.2 Becoming unwell

Julija's story of perinatal mental illness began more than a year after the birth of her first baby, once she had returned to work after 11 months maternity leave. She said she had no actual symptoms of being unwell during her first pregnancy or after the birth, but that it all began with what she called "burn out":

*I kind of burned out, I had my first little one and then I was working a lot so in my job, err, it was like evenings, weekends, and so on, I didn't have my annual leave for a year and I had a small baby and I had no time for him and everything just exploded. So I didn't really have a diagnosis like burn out, because I'm still not sure it is like in [country removed] if it even exists, [...] but yes because it was a mixture of depression and anxiety (big sigh) and I went on sick leave, I was totally, yeah, down, trembling, anxious, very anxious. I couldn't go to work at all, so I was for 6 weeks I was like at home.*

After this experience Julija had Imago therapy privately. However, more importantly for Julija, her doctor prescribed her anti-depressants at this time, and about a year and a half later she became pregnant with her second child:

*I got pregnant for the second time, yeah, and it was not planned, and I was, its so crazy because I took the last pill of antidepressants the day, because it was the last day to take it, but the same day I did a "Clearblue" test.*

As soon as Julija knew she was pregnant she immediately became anxious due to the anti-depressants, and was convinced they could have harmed the baby:

*That's when it started, this, because it was also the same time I, I was ending my therapy, with my first Imago therapist, I was just feeling like it was not going places anymore, and [...] I was like annoyed and I had enough, or how do I say, I wasn't enjoying it anymore. But at the same time, this fear started to grow because, er, because of the antidepressants, so I was really like I spent my whole pregnancy, the second time around, with guilt, and then fear, what would be the damage, what if it is, how do you say?*

E.H. [from the antidepressants?](#)

*yes*

E.H. [if they had damaged the baby?](#)

*yes, exactly. If they damaged the baby and also my feelings, because it was really kind of a rollercoaster, and on the one hand I was so happy because we did want to have another baby some day, but at the same time I was so afraid that it would be like with my first born, because my first born was not sleeping at all, during, he was kind of sleeping during the night which was*

*ok, but still I was waking up every 2 hours, but through the day, no sleeping at all, until he was about 1 year old, so I was, it was kind of a suffocating experience for me. I am so not good being 24/7, erm I'm so not good, its very, its yes, stressful, yes and it was hard for me, because then I was getting nervous and then this circle started, I was nervous, I was nagging, I was doing things I'm not so proud of, but then again guilt feelings because of that and it was just a circle, like never ending, so I was not good.*

Julija described her second birth as 'traumatic', and after the birth as a time of emotional extremes:

*It's so hard to explain, but so much joy and so much love erm and then again, my critics, and then it was guilt because of that, because of everything I was feeling, the whole pregnancy.*

She used the term "my critics" to describe what, in TA therapy, would be termed as the Critical Parent ego state.

### 8.1.3 Historical anxiety

Julija experienced anxiety throughout her childhood, particularly, around performance at school and in exams. She was academic and found school easy and always did well in exams yet this did not ease her anxiety at all:

*I remember a lot of times I was anxious, [...] its kind of my thing from when I remember, I mentioned about you know, these things coming up in the future, some cornerstone that I know I will have to pass, erm, when I was in high school and we were preparing for this matura, we say matura, but its like erm (pause) yeah this exam when you finish high school before you go to the university. I know I was so anxious, how will I do, what will I (pause) what if I don't do them good enough, what will happen, but you know not afraid of somebody else but of life in general, what will I, will I handle it, will I do them, erm, always anxious. When I think I have to perform something, and be perfect. [...] so its kind of something that's so, that I'm always carry on my shoulders.*

In therapy, Julija learned this was part of her 'Be Perfect' driver (Kahler and Capers, 1974); in every way she felt she needed to be the best at everything. This need to be perfect affected her life as an adult and as a mother making her feel guilty much of the time. She explained that she would often judge herself as a failure at motherhood, yet she also felt judged by others. Again this stemmed from childhood:

*I was always so afraid, “what about the next year, ohh, this was a piece of cake but how will you deal with it at High School, then you, oh you will see when you go to University”. I was always feeling like everybody else was better, I’m just good, I mean I’m just like hard working, but not intelligent enough, and so I always had that fear, you know, of the next step, but it was quite overwhelming sometimes, not like normal, “you gave a speech, of course you are a bit anxious”, but in a positive way, you want to give a good speech, but I was like this, it was like this overwhelming fear, you know, “oh my god what will happen, and if this happens, I will be, they will reject me, they will not like me. [...] This fear of embarrassment I think it was holding me back, so much in my life. So much and this is one of the major reasons I wanted psychotherapy because I always felt things were holding me back, on my path to be (pause) great.*

Another element was about the harm she might have done to her son Tomáš from taking antidepressants in early pregnancy. This anxiety about harming him, or her older son was all consuming:

*It was always that fear of not handling the situation, or that I will harm someone, but not harm in a physical, I don’t mean in a physical way, but with my kids with Tomáš, even after he was born. [...] But it was like “Oh my god” did I harm him with all of those feelings of anger and sadness during the pregnancy, and also I gained a lot of weight, I was, I can remember being so disgusted with myself the whole pregnancy.*

These internal critical thoughts often spiralled out of control, increasing her anxiety, leading to extreme levels of guilt. Julija’s therapist recognised her fear of harming her son was high:

*So fear of harming Tomáš in the long term, with my feelings and with stuff like the pregnancy, and this is also one thing my therapist addressed, she did say she recognised it herself, “oh so you were like here for not harming him, in the long term” so she put the words to my feelings, and and its priceless, really. I really think this is one of the major things about therapy, somebody putting words, I don’t, I don’t have the words for it, somebody putting it out there and erm, how do you say, to put it in perspective.*

#### 8.1.4 Guilt and Shame

Julija’s ‘Be Perfect’ script was intrinsic to her life, making her feel guilty because she could not be the ‘perfect’ mother:

*And then these guilt feelings, because of course if I'm depressed and I'm grieving I cannot be there for my kids, and I would like to be there, so I'm not spending enough time with them, I'm not cuddling them enough, I'm not playing with them enough, I'm not empathic enough, I'm nagging, I'm angry, erm, all those things, were like then circling, around.*

This inner turmoil led to a sense of guilt and continued in a toxic spiral:

*I was trying to be perfect, so in my, in my life, in my head, in my story it was like "well I have to be perfect for my children" so every time I made a mistake or did something I wasn't so proud of it was like "I'm a bad mum"*

This black and white thinking, only ever having two options of being the good mum, or the bad mum is common among women with perinatal mental health conditions. Societal romanticising depicts mothers as the caring, selfless woman who sacrifices herself for her children. This portrayal of the 'good mother' is the only portrayal of good mothering (Benjamin, 1990). Mauthner (2002) highlights the cultural pressure on motherhood as being the '*epitome of womanhood*' (Mauthner, 2002, p6). Any other style of mothering is demonized with the mother to blame, and the likely cause of a child's emotional, psychological and social problems. This can engender a sense of failure in women when they cannot meet such high cultural expectations. It can also engender shame at not being 'the perfect' mother. Julija seemed to express this cultural pressure that was impossible to achieve.

*Its pretty clear to me that shit happens and yes you can get help, and you are not mentally ill, its not a major, you won't be hospitalised, so its ok to search for help, erm, not shame for that, but yes shame, a lot of shame, about being a bad mum, erm not being good enough.*

Julija acknowledged the probable source of her black and white thinking:

*When I remember mum and me, but (sighs) she was never really trusting me, you know, with my decisions, I felt like she's not trusting me and she always knew what is the best thing for me or for anybody else, except for her, and she was always like very passive, quite judgemental, and she was always watching, she was like kind of everywhere, so my "Be Perfect" was also, a lot has to do with her always like, always watching me. Even now always watching me, and like evaluating, is it ok or not, and when I had Tomáš it was often like "oh you should bring him to the doctor, you should do this, you should (pause), he should wear this like cap, you know, because of the ears and blah blah blah. But she got on my nerves, (laughs) and now I think that somewhere along the way, [...] she got the message, and now*

*she's not even recommending stuff anymore, because I don't, I do or I don't do it, but its based on my decision, not her opinion. [...] But I kind of know how to make these boundaries now, so that I'm not so influenced, but my mum was never really, its not a go-to person for me, sadly, but it is also one thing that I recognised in therapy. So its also one thing that I had to grieve, that I don't have that mum, that kind of mum, and that whatever I do I (pause) maybe we can do some steps forward but not really like a relationship that I would like, or I need.*

### 8.1.5 The partner's experience

Julija recognised her partner, Luka, had also struggled in his transition to fatherhood. His struggle began after becoming unemployed when their first child was a few months old, requiring Julija to support the family on her own. The stress of the extra work she needed to do to keep the family afloat led her to feel burnt out. Julija explained that Luka had felt depression at this time and had struggled with Obsessive Compulsive Disorder (OCD). This had been difficult for them both.

*He's also bad and had that kind of depression, and OCD (big sigh) and he lost his job when I had my first boy, so he really couldn't be there, for us, for me, and so that's when these struggles started, but we are also in couples therapy, so we'll see. But, I'm fighting it. We have been together now for 17 years.*

## 8.2 **Therapy**

Julija decided to go back into therapy when her second son was seven months old. She chose TA therapy because she said she was attracted to it:

*When he was 7 months old I got very, erm, in contact with this pain of mine, that I had from when I was 9 months old, so approximately, yeah when Tomaš was [...] 8 months old, something like that, I, I, all was overlapping, [...] so I got in contact with this sorrow because I was hospitalised, for, for a few weeks, when I was 9 months old and then also when I was 11 months old, [...] but at that time mum could not stay with me, in the hospital, so I was like alone for 3 weeks and then took home, and then again, yeah, and (sighs) I got in touch so, and in those, it was so strong, because I could imagine Tomaš being the same age and now leaving him at the hospital and only seeing him for 2 hours a day, and all the other, all the time out of these two hours I didn't know, what, I mean, I wouldn't know what has been happening to him, how they were treating him, in the night for example, what kind (pause), and I could just imagine myself, that sorrow, that pain*

*was so strong, that's where I, when I looked up therapy, so this is what kind of brought me to TA therapy.*

Although Julija realised she was experiencing strong emotions, she had not realised it was a parallel process from her own experience of being admitted to hospital without her mother as a nine month old baby. In therapy she and her therapist realised this was a somatic experience, from her own experience and her childhood fear. When asked whether it was fear for Tomaš at that time, she responded:

*Oh no. No sorrow, sorrow.*

E.H. *sorrow?*

*yes it was so much compassion, and sorrow.*

E.H. *ok, for yourself?*

*yes basically for myself, yeah because I, I kind of imagined him through through, because he was the same age, I could connect to it easier, I think that was the case,*

E.H. *and that hadn't happened with your first son?*

*no, no, because we were, the subject probably and I also had some therapy before as I told you, so it obviously wasn't the time then, I don't know.*

It was not clear why this did not occur with Julija's first son. However, she described the first 11 months of his life as difficult so her emotions could have become lost in the struggle of bringing him up, knowing she was returning to work shortly.

Julija believed this experience may also have been triggered by a You-Tube clip of a depressed child in hospital in the 1950s that her therapist had mentioned, and which Julija had then watched.

*We were talking about attachment, and [I saw] this depressed er You-tube video of depressive children when they were hospitalised, in the, I don't know, 1950s, I cannot remember which, but I know that I could so see myself there, and it it suddenly made all the sense, also my depression, it was like a depressed child because after, I don't know, a few weeks he [the child on the video] was not even reacting anymore to some tickling, or how do you say, he was just like, erm, depressed without any will to, I cannot find er the suitable words, but all those things that go with depression. And I could so connect and even that baby on the u-tube and Tomaš, my Tomaš took his place, and then I somehow connected to my own story. Because it's so crazy because I don't have the images, but like my body responds to it, so its like somatic memory opened up.*



The You-Tube video resonated at a deep level with Julija and might have provided a catalyst or a way for her to recognise something from her childhood. Whatever it was, and for whatever reason, it seemed to provide some way for Julija to connect with the depressed child she had been.

### 8.2.1 Getting help

Julija talked about her TA therapy and how it had helped her earlier in her interview than the other participants had. In fact, she spent the majority of the time talking about her experience of therapy, rather than her experience of perinatal mental illness.

*[The therapy] helped me to get in contact with this sorrow, that I was talking about, to, to feel it, to, to go there, and erm we, it was kind of I'm not sure if it was imagination erm or, but I did, my therapist led me to that little girl. She said, on one occasion she said maybe, because I was always talking about it like, erm, there's something that is, like er, calling me or to go there something that like a magnet and I would like to go there and she said, I will never forget those words, and she said maybe there is somebody waiting for you, and really I immediately it was like, "oh what does she mean by that?", and then we went there, to her, to this little baby girl Julija that I imagine her, and the sorrow just, I opened up I started to cry, I could feel that, I could really feel that, erm sadness (sighs), and that sorrow, that erm waiting, waiting, waiting, waiting to, erm for somebody to show up, to feel loved, for her mummy to come, to take her to, erm, to hug her, so, it was the first step was like yes, connecting to it, (pause) and then I was actually like, I think I was actually grieving for some time, because I remember I was always checking you know, and asking myself, is it depression? Is it sorrow, is it depression, am I depressed? But looking back, it makes sense because I, I think I had to grieve that part, for her. So I felt down, I felt like very sad, everything was, I was very, erm, not opening up to other people, so intro.....intro.....introspective.*

She described checking herself to see if she was depressed but discovered she was feeling grief, not depression, which she described as overwhelming.

She described why therapy was so important for her, and the importance of her relationship with her therapist, particularly her need to be able to trust her, to share difficult or disturbing thoughts without a fear of being shamed.

*To have somebody, to have a weekly appointment, to go in there when I was grieving, and even talking about different other things, about for instance, other aspects, yes, I think it was very helpful, for me, to know that I have this*

*support, somebody I trust, I can say what I feel, I can say erm what my thoughts are. [...] talking with my therapist, about sharing that with someone, who doesn't judge you, or even lets you know, in some way that you are good enough, that you are not, erm the baddest mum in the world and things like that is really like, (large deep sigh), hard, how do you say, hard and precious [...] it was for me, it was like very important to have someone there.*

This connection between client and therapist, the 'therapeutic relationship', is often talked about as the most vital part of psychotherapy. As Julija had said early on in her interview that she felt judged by others, this non-judgemental relationship was the one in which she could finally feel good enough as a mother. It also provided a relationship in which she did not need to be perfect.

### 8.2.2 Distinguishing between thinking and behaviour

One of the most important things for Julija from therapy was understanding that thinking bad thoughts did not mean she would necessarily perform them.

*A very important thing for me was to distinguish between what I am thinking and what I will do, in the sense of "oh my god I could just" you know, sometimes I really in the middle of the night I go "oh my god, I could just kill somebody really" or I could hurt my child or I, I, I, I don't know I'm not sure, because I will throw him [out] the window, I don't know, and these thoughts are so disturbing, but they came, and to (pause) to (pause) to have a chance to say them out loud, and not get back that I am like the most crazy and the baddest person in the world, but instead of that get like an explanation or a, in terms of "Ok Julija, there's a difference between what you think and what you do", and I know when once she said "you can think about most everything, I mean anything in the world, you can imagine or not even think of anything, but it is important how much you hold on to". It was like (sighs) a relief "oh, so I'm not the only one", erm, and I started basically to become more nurture, nurturing to myself.*

Julija was able to soothe that part of her that was convinced she would harm her children. This soothing helped her and reduced her anxiety. Until this point in therapy, Julija said she was convinced she would actually do something bad. Once she began to see this was not inevitable she was able to nurture herself and listen to what she needed, rather than simply berate herself as bad.

### 8.2.3 Script - perfectionism

Julija said her script was to be the perfect person. Her script manifested itself in many parts of her life. In the therapeutic environment she discovered the need to be the perfect client. She discovered this when she felt brave enough to admit to her therapist that sometimes she did not know how she felt or how to respond to the therapist's questions about feeling:

*My therapist is always like asking "how does it feel for you, where do you feel it? What is this feeling saying?" and I was so stressed in the beginning, I was like "oh my god what now, what do I say now? I don't know?" I mean in my head, "what is the right answers, how come you don't know, you should know" my critic is very erm, how do you say that it's very....*

**E.H. strong?**

*yes and very opinionated (laughs) and very loud, so but, it was like I needed this relationship for, to, to underline this kind of situation, because I did manage to express myself at some point and I said "look there's so, I am so stressed right now because I don't know the answer, I don't know what I should know, where should I feel it, what will you expect, I am afraid I will disappoint you", err tatataa and she went "oh Julija this isn't, you know when I'm asking this question, this is for you, this is more or less for you and 95% it is, they are meant for you, not for me, I don't need the answer, it's like just researching, discovering, what's going on, so that you can, after time passes, that you can recognise it when its going on, what its telling you", so (phew) it was like then immediately I got more relaxed I was kind of learning from my experience, I was learning from this relationship, again, how to be more, more gentle, how to be more erm relaxed, erm and how to say what bothers you or you know, not to be a perfect client, but just to be a client, and express, and I could err express even anger, some to her, about her, anger, yes so these were very like powerful moments for me because I would definitely in the past rather know ..... stand back, yeah and not erm .... And not, how do you say.... And not act on it, or just push it in and "ok so it's supposed to be like that"*

This heralded a change in their therapeutic relationship. Julija admitted that without this intervention it would have been difficult to show frustration in other situations in her life, when she also did not 'know'. Her need to be perfect was so strong she felt she should always know, which of course was impossible. Finally, her therapist offered an alternative possibility that it was ok not to know. Julija said this was a revelation for her and she managed to use this effectively at work and within friendships.

Julija also tried to be the perfect participant within her interview, which was not a surprise as this was such a strong driver. Towards the end of her interview she retrieved a list and looked down it to check that she had covered everything, then said:

*I did make some points, because I didn't want for you to come for nothing. I was thinking today about it and you know not to disappoint you.*

#### 8.2.4 Expressing emotions

Julija felt she learned a great deal from her relationship with her therapist, particularly around how to nurture her own self. This in turn manifested in her behaviour at work, changing a difficult dynamic she had with her boss:

*I was kind of learning from my experience, I was learning from this relationship, again, how to be more, more gentle, how to be more erm relaxed, erm and how to say what bothers you or you know, not to be a perfect client, but just to be a client, and express, and I could err express even anger, some to her, about her, anger, yes so these were very like powerful moments for me because I would definitely in the past rather not (pause) stand back, yeah and not erm (pause). And not, how do you say (pause) and not act on it, or just push it in and "ok so it's supposed to be like that", so it was like kind of empowering, for me to speak up cos when I expressed anger towards her I could in a week or two express anger towards my boss in, in and yeah that's this circle that it's so empowering because you really get this, if it's good therapy, you can get this err, uh we use the term all, often but now I cannot say it in English, err experience the, you know when it's erm a new experience, yes to stand up to myself, it helped me a lot, to set some boundaries and sure I'm still on the way there, but it's getting better and better.*

*in the therapy sessions I came in anxious but I never came out, went out with this feeling, it always, I'm not sure but she always managed to get somewhere with me.*

*I wouldn't even say I was ever anxious now.*

Group therapy also helped her express her emotions, particularly when the group was talking about imposter syndrome in each of their professional careers:

*One group member was just talking about not being deserving to call herself a psychologist, about this fear, and it touched me so strongly really, I was like my heart was pumping, the same situation as always, I was becoming red, with red dots and I was, like my throat was hurting, this, this happens a lot when I am stressed because I now know from my therapy that I .... Some things want to get out but I am stuffing them in, so she was talking about that and I came in such contact with my erm my story of not being deserving to be called a mum (pause)*

E.H. yes

*and I did say that in therapy, in the group process and I like fell apart, I was crying from..... like I've never cried before, in my life, from from, I don't know from my toes probably, it felt so raw, so strong, and to be able to say that, out loud, and then to get those feedbacks, those strokes, it serves such a, a a, healing process.*

This sense of not deserving to be called a mother is highlighted in the literature review in Chapter 2. Again, this could be due to the expectation of being the perfect mother and that anything other than being perfect does not feel like an option for some women.

#### 8.2.5 Permission

Another important aspect of Julija's therapy was receiving permission to behave in the way she was, without criticising herself. Her therapist helped her understand that part of her that sought sanctuary in food, or took time away from her children. Consequently, she learned how to push a 'pause' button after thinking something, and before she actually performed whatever it was that she was thinking. She said this allowed her to think about what she was eating and why, whether it fulfilled a purpose:

*I was talking all those things through in therapy and yeah, it helped me be like more, erm yes you know Julija, you're ok to stuff, stuff with food, blah blah, but again to be more gentle to myself, to take it slow, to breathe [...] she was like trying to, to get me there, to be able to, to push the pause button. Even before I take a chocolate, or before I, I started to scream to my kids or, all those different things, but to pause. And on the other hand, like allowing me to not pause if its not the right, err circumstances, "if you cannot do it, it's ok". Because, otherwise now I should push the pause button and I didn't and another row. It's like, react (laughs). So now I'm bad because I should, and I didn't and blah blah blah, so it's a never-ending story.*

*So this permission, yes to give my kids to their grandparents, and to just lay on the sofa, and to not do anything, she was giving me that. So she was giving me like permissions, yes its ok not to do anything if you need rest. So these things were such a blessing, I so needed to hear that, those those things, and to be home on sick leave, when I feel sick. Because it's a guilt trip over there also, because I was like even if I have a fever, I, I think I need to apologise myself, and to make myself in my job to be, so that I have a permission to be at home. But all these things, I think I started to, to manage myself better, in these situations.*

Pushing the 'pause' button is not exactly a TA theory. However, it has been used in TA therapy as a means to allow a client time to act rather than to react. It can be powerful in helping clients to understand that they have choices in their actions.

#### 8.2.6 Acceptance

Once Julija was able to give herself permission, and to push the pause button when necessary, she was able to have a greater acceptance of herself and who she was, rather than simply berating herself or disliking herself:

*To accept my failures, or to accept myself in the way to be more, erm, gentle to myself, to be more gentle to the role of mum.*

She said this helped her let go of the need to be so perfect and helped her accept that good enough was simply good enough:

*So to distinguish "yes this time I can be good enough, I don't have to be perfect all the time" this is certainly something that was, was, the therapy was doing for me. Our contract, our relationship with my therapist is definitely, I have surely become more, erm, more, more accepting of myself, as a woman, as a mum, as a person,*

When asked if she thought she would have got better without therapy she responded:

*No not in, not ok as the way I am now, I mean, these struggles which certainly have an impact on me and on my family, yeah I really believe that, I just would be depressed and nagging and unsatisfied (pause). No, no, no never. Time passes and yeah and so, but like I said, you know, its like I was saying about this picture [her collage], saying in the group what I was going*

*through, I mean, the feeling went on, went by, but it didn't because it stayed within me, it just stayed unspoken, and not processed, so its just another thing to suffocate, to, to, to push and then to explore, I don't know in 15 years, I'm not sure, but the way I see it, is yes certainly, I mean, something would stay there, but something not good, not a good feeling, not a process thing, so when I expressed it, when I got recognised for it, the thing, I think it started to heal from that moment on. When somebody else said "oh, yes, you are in such a distress", and I was like "ah ok, I am, so it is legitimate to have pain around it, or, so if that wasn't said it would just be, if that wasn't said by my therapist it would be one feeling to be suffocated but I really don't believe it would be for, I don't know, it could go on until the end of life but I am surely better off recognising it and talking about it, expressing it surely? I am a better person for it for sure, I mean more strong, with less content that is still like somewhere probably deep down, struggling to get out,*

She seemed to be expressing a need to be recognised and to have her distress affirmed through that recognition. Recognition hunger is a theory from Berne (1961) who believed this hunger to be one of the most important, beginning in infancy with a baby's need to be recognised through physical contact, and feeding. Recognition was important for her as it gave her distress legitimacy. It helped her to understand that she was not alone, or isolated, that her distress was visible and understood by her therapist, and also by the other participants in her group therapy. This was the beginning of her healing process. Without therapy she would not have received this legitimacy, and may well have continued to hide her distress and remain silent.

### 8.2.7 Group therapy

Julija transferred into group therapy with the same TA therapist about seven months into her therapy. This was due to a change from full-time to part-time work and the reduction in her salary, which meant one-to-one therapy became too expensive. Instead, her therapist offered a place in a therapy group. This was not a perinatal group, but a group of clients who either wanted or preferred group therapy, or who, like Julija, found one-to-one therapy prohibitively expensive:

*I had to take the part time job. [...] it was the only thing on the table, to accept the part time job or to stay at home without any job, but the part time job means also the part time salary, so I couldn't afford it at the time, and so she invited me because it was just opening up for two places and she said "Julija maybe that would be ok for you, to at least stay in some kind of treatment, to have a connection with it". So yes, I said immediately great I will take that opportunity, and erm now I'm, yes for a good year now I have*

*been in group therapy and it's a very interesting experience. Because normally I would say that in one-to-one you can go to more depth, and it's easier to express myself, because I have this, erm this "ok the therapist is meant to be there to understand, to be empathic, is meant not to judge." Whereas in group therapy I'm (pause) the therapist is there, but also the group members who are not therapists, so I will surely say that its harder to express myself, but its, I feel like I don't have enough time, to do some really in depth work, but on the other hand it is so interesting because I came in contact to (pause) these very strong feelings, and it was in group therapy, not individual, and also when I think about it, I am crying more in group therapy, than in individual, so its very like, I'm not that sure, it has its, how do you say, its pluses and minuses, the both things. Because you know the number of strokes (laughs) that you get in group therapy is (pause)*

E.H. *more?*

*(laughs) yes, so its kind of a blessing.*

Julija was asked whether she was able to say which type of therapy she preferred, group or one-to-one therapy:

*Just one group therapy, half an hour, one hour, priceless. To have people there to, to support you, to show you how they see you, and its very different from how you see yourself, and to be able to express those deepest, deepest feelings, and deserving this and shame because we did that, it was so a blessing, so yes I kind of dig both of them, it would, I think it would be best for me to, to, to take both of them, at the same time, so to have weekly TA therapy one-to-one, and at the same time group therapy. And sometimes I miss this one-on-one because I have some, like acute things that I would like to, because now I already know "ok I am stressed, I really need to talk this through", and we are, we have arranged it like that I can call her, we search for a, a block of time, and we can go through it, when I'm in distress, that's our way, but I don't have like weekly appointments, yeah so, but as I said I sometimes miss it because, you know, to have one hour for myself, because in a group of course you never know who is in more distress, less distress, and then my story is of course they are more distressed, they have to have their time and not to steal their time, but on the other hand I like to talk, I don't have problems opening up, erm, I'm kind of opportunistic in that way. I don't want to waste, like time and I don't have a problem, because even when they are working, I'm always working I think, because their stories are opening up my own important things that I even wasn't aware, or just something they say makes so much sense to me and so I I'm so, I'm always so "wow" you know that wow feeling, and with the therapist you cannot do that, she is not sharing her life, and her stories and you know, its all about me and so yes I get different things from it*



Julija clearly saw a contrast between these two types of therapy. Group therapy is not always useful for women with perinatal mental illness because of the shame and stigma that might be engendered. However, a mixture of one-to-one and group therapy might offer the 'best of both worlds', beginning with one-to-one therapy, to gain containment and soothing. Moving on to group therapy might provide a sense of connection, which could be useful to counteract the sense of disconnection and isolation women often feel.

### 8.2.8 Theory or therapist

Julija seemed to state that it was both the therapist and the theory that helped her, rather than simply one element:

*We were never discussing in therapy really in theoretical concepts of TA. I can now see what she was doing, I mean, I can see it, but we were never like ok that's my script, ok those are ego states, we were not really discussing the concepts themselves and erm, like I said she's quite experienced and she, she, I think she goes with the flow, very much, so I can really not say that any of these things wasn't working for me, I think I can see value in practically everything. There was never a time when I left her office and thought oh my god this was really a waste of time, or this did not work, this is not working or not really.*

Possibly both elements need to be there for the therapy to be successful. TA is simple to explain and uses everyday terminology that is easy to grasp. Equally, robust evidence indicates that the relationship between client and therapist is more fundamental to the success than the modality per se (Charura & Paul, 2014; Clarkson, 1995; Lambert et al., 2004; Paul & Haugh, 2008; Stiles et al., 2006).

### **8.3 Other noticeable aspects of the analysis**

The lack of contradiction, omission and revision was noticeable within Julija's narrative. This may have been because she had made notes prior to her interview, to ensure that she covered everything that she wanted to say, and had clearly been thinking about her narrative. This note making was interesting as she was the only participant to do this, and it is entirely plausible that this was an unconscious demonstration of her Be Perfect driver. There was also little silence within the interview and this could possibly be part of the same actuating mechanism, her driver forcing her to be prepared so that there would be no silence, perhaps. However, the lack of family members in her narrative was apparent. Her father did not appear in her interview much at all, which was

possibly unsurprising as her parents had divorced when she was seven. But her sister was also absent. This seems odd as her sister would probably have been around during the period Julija described when she was alone for periods of time because of her mother's need to work.

#### **8.4 Listening for Julija's other voices**

There were five distinct voices in Julija's narrative (see Appendix 10). The first voice was of fear and anxiety. This may have come from her sense of disconnection. Julija noted her somatic experience to her fear which was her body trembling through anxiety, and an inability to attend work due to the severity of her symptoms. This fear returned on discovering she was pregnant with her second child while taking medication for depression. Her fear was about the harm this might have had on her baby. This first voice disappeared when she began to talk about her therapy.

Julija's second voice was of a depressed Child, which she recognised from childhood. She found this voice in therapy, helping her to understand how it must have been for her as a tiny child, separated from her mother, when in hospital. She seemed to connect with this voice of depression. In therapy this voice was given permission to grieve, to acknowledge everything that had happened and to feel sorrow for the child she once was. This voice overlapped with the third voice, the voice of guilt and shame. This voice struggled with her behaviour, with her perfectionism and the way she judged herself as failing as a mother.

Julija's fourth voice no longer wanted to feel depressed, sad, or self-critical. This voice sought therapy, engaged in it and used it as a means of change. This voice understood that her thinking and behaviour were not connected so that even if her thoughts were dark, it did not mean she would act upon them. She found she was able to express herself congruently, particularly her anger. She began to re-connect with herself and her surroundings, her partner and her children. And she was able to understand that her yearning for the mother she wanted would never be fulfilled and that she could let this go. This voice overlapped with Julija's fifth voice, the Adult, which understood she was recognised by her therapist, that she could have and retain connection. This voice learned to accept who she was, that it did not matter if she felt she was failing, and could nurture and care for herself, so she could nurture and care for her family.

## 8.5 Listening for Julija's "I" poems

Julija's interview was one of the most positive, and this was reflected in her "I" statements which moved temporally, with the most numerous positive statements and which were often in the present tense such as "I am", and "I can". In the first quarter of the interview she used the past tense in preference to other tenses, and she also used enhancing words such as "totally", "immediately", and the word "so", to enhance other statements such as "so much", "so little". Yet in the second quarter, she moved into using the present tense, and the enhancers reduced. Towards the final quarter of the interview the future tense appeared, and the enhancers disappeared. Her use of discounting words such as "just" and "kind of" also disappeared by the middle of her interview and were virtually non-existent in the last half.

Using a non-native language did not diminish the richness in her language. However, she did use the construction "I mean" as a way of clarifying herself far more than the other four participants. Also her lack of metaphors could also have been due to not using her native language.

## 8.6 Exploring Julija's object - Collage

Maternstvo	-	Motherhood
Potanje	-	Travel
Zaupanje	-	Trust
Sprejemanje	-	Acceptance
Smeh	-	Laughter
Zaščita	-	Protection
Podpora	-	Support
Strah	-	Fear
Družina	-	Family
Povezanost	-	Connection
Bližina	-	Closeness
Toplina	-	Warmth

Julija had made a collage in a group therapy session, which she brought to her interview because it told her story of perinatal mental illness. The faces in the collage have been blurred to protect privacy.

*So in group therapy we were kind of instructed to bring our photos and then we spent one therapy session to prepare our posters, drawing so that we could [pause] and then a few therapy sessions went by with our*

*presentations of these posters and of our stories, basically. So its very, erm I'm not sure where to start but with regard to this perinatal distress I had, I have to say it was about this poster, and presenting it, it was the most crucial thing for me was just this, erm, these feelings because when I had Tim (points to top right hand picture of her when she was pregnant), he is my first born, you can see its like a heart and a smiley, meaning he was so wanted and so, we were really looking forward to him and I was so happy during the pregnancy and everything, everything went smoothly and the labour and it was really an amazing experience.*

She pointed to the picture of her pregnant underneath:

*but then I pointed out this sadness during erm, during my erm my second pregnancy with Tomaž, erm because, and I told them about this fear of harming him with antidepressants, and he was also, he was overdue, I went three days overdue, and I remember my last three days, I was just lying in the sofa when I could and crying my eyes out because I was so afraid if, if he's in distress, in the belly, why doesn't he want to come out, I, I just, will he be ok, is everything ok with him, [...] I was just like, oh my god, and those three days were so painful, really, it was so stressful, and it was full of fear and sorrow and, and anticipation and everything and when I expressed that my therapist said "Oh Julija" it was like a question, "you are in such distress" and it was like I immediately started crying because it was "ahhah, ok so it makes sense", I mean, it is something to be stressed or that somebody was recognising my, my distress, my worries or, even if alone, my feelings at that time, because I have never spoken about that with anyone, I always thought "oh well, probably everybody goes through that", I mean, it's silly because people are saying like, I mean, you know, my mum is like "oh don't worry about the antidepressants, you should not be thinking about it, tatata, tatata". I know, I totally know on a cognitive level, but, you know, under the surface emotionally I was dying really those 3 days were really a hell for me, and for somebody to recognise it (pause), like that, so empathically, so erm attuned, would that be the word?*

E.H. *yes*

*was alone by itself, an experience which stays.*

Motherhood

Travel

Trust

Acceptance

Laughter

Protection

Support



Fear

Family

Connection

Closeness

Warmth

For Julija there was a clear contrast between the two pictures of her pregnant. In the first picture she was happy and looking forward to the birth of her first child. Although the second picture depicts a pregnant mother waiting for their child's birth, for Julija they were different. Her therapist recognised her distress in the second photo, offering a level of attunement she had not received before. This sense of recognition seemed like something she had yearned for and may have been what she had missed from her mother in childhood. Her parents played a small role in her narrative. The only times she talked about her mother were when she described her time in hospital as a baby, and her mother's absence due to work, when Julija was a child. This gave a sense of how disconnected she was from her mother. This was corroborated by the way her mother dismissed and discounted her distress and fear about taking medication in the early stages of her second pregnancy. It was telling that Julija had not spoken about this time before, which showed how she felt about it. It seemed to highlight the shame and fear she felt, about taking antidepressants when she was pregnant, as well as her sense that her fear would not be recognised or accepted so she remained silent.

The rest of Julija's collage was about happier times, and included people who were important to her and who helped her through her struggle, and the words that resonated with her during her experience. The words and their translations are listed above.

Julija pointed to the picture of her partner and two sons where they seem to be a happy and contented family:

*You know these are [language removed] words but it is family, warmth, connection, and closeness.*

She then focused on the two photos at the top right hand corner of the collage grouped under the heading 'BFF'. The right hand photo is Julija with her sister, the other, her two best friends:

*And I have a sister, here in the BFF corner, this is actually best friends forever, this is my sister, she is older than me, and its like kind of been my wish, my secret wish that they would be connected, that they would be friends, it means so much to me because my sister was such a support for me, yeah in my life, and its like erm, protection, support, laughter, trust, and er acceptance, and these are my best friends, my colleague, my best friend from 6 years old, so almost 30 years we have been best friends.*

She then points to the centre of the picture by the word *potanje* meaning travel:

*So this is the way I presented, kind of my erm my circle, my life, my what is important for me, and like sun and sea and the green*

Finally in the middle of the bottom of the collage there is a large question mark, which she said was about the future - what's next for her, which she didn't know, but was excited about.

### **8.7 Reflections on Julija's interview**

Julija left me with the impression that she was completely over her perinatal mental illness, and had moved on to other areas of exploration in therapy. This would fit with her story of therapy no longer being about the perinatal period, but more on present aspects of life. It was as if she had truly put it into the past. Of all the five participants, she seemed to be at ease with herself and with that time, and her interview was also easy and flowed naturally, even though she was not speaking in her native language.

Her narrative followed a temporal sequence and this might have been due to her acceptance of her experience. She seemed able to look back on that time and narrate it sequentially. It may be this acceptance that played a part in my own counter-transference. When I finished Julija's interview I felt like it was gone, or let go. It did not sit with me in the same way as the first three interviews, all of which left some resonance.

The strongest theme of Julija's interview was of her guilt. At first she said she did not feel shame. I was surprised at this. However, later in her interview she suddenly said that she had felt a great deal of shame during her second pregnancy, from taking anti-depressants when she was pregnant, and she said her shame was because she needed to take them. It felt, at the time, that she had initially forgotten how ashamed she was, but once she began to remember that shame she was able to articulate how intense it was for her.

I found it surprising how some members of her family were missing from her story. In particular, her first son and her partner did not feature in her interview at all until she talked about her collage of photos. Her story seemed to be mainly focused on her second son, his age when she went into therapy, and the positive effect of her therapy. Her father also was not mentioned at all until right towards the end of her interview, again due to her collage, when she pointed to the one picture in which both her parents were included. I wondered whether these people were left out of her story because they were not the main 'players'.

I also wondered whether her partner was left out because she felt the need to be strong and tried very hard to cope on her own, particularly after the experience of having the responsibility of being the sole earner, trying to keep the family afloat when her partner had depression.

## **8.8 Conclusion**

Julija's story is historical, and the way in which she experienced perinatal mental illness seemed to be with a sense of disconnection, yet a yearning for a long-term, family connection, the one thing she was not able to have as a child. Her story was one of fear of not being good enough, leading her to try even harder and to strive to achieve perfection in everything she did. As she could not achieve perfection in motherhood, or in life, she demonized herself as 'bad'.

Her story of therapy is of receiving the longed-for recognition, the permission and also the acceptance she needed to be able to let go of her inner critic, her perfectionism and her sense of being the 'bad' mother. This she gained through a combination of one-to-one and then group therapy. Both styles of therapy offered different things. The one-to-one therapy gave her the opportunity and time to express her emotions, to gain the recognition she craved, and the permission to nurture and care for herself. Group therapy gave her the possibility to challenge her thoughts from childhood about judgement from others, allowing her anxiety to dissipate. Julija described her therapy as "*hard*", "*powerful*" and "*precious*".



## CHAPTER 9

### Sarah's story

#### 9.1 "This feeling isn't me"

Sarah's story is different to the other participants' stories. She experienced perinatal mental illness after the birth of her first child, Sally, 40 years ago. She also did not receive TA psychotherapy until later, after all three of her children had been born. She explained that there was virtually no help for perinatal mental illness at that time. She hid her illness because she was afraid of losing her husband and children. She remained silent until after the birth of her second child, when she finally had to admit her difficulties and said her husband was very understanding, committed and helpful with the children from then on. At first Sarah received weekly help from the National Society of Prevention to Cruelty in Children (NSPCC). However, this came to an end after about a year. So, with the help of her husband and parents she went for psychoanalysis twice a week. At the time this was the only available help. Her doctor had initially referred her to a psychologist but Sarah found him "*utterly useless*". She acknowledged that the psychoanalysis did initially help her. But it was in TA therapy that she began to uncover and understand what had happened between her and her daughter during this time. TA gave her the structure to improve her relationship with her daughter.

As her story is from so long ago, Sarah provided a different perspective on the story of perinatal mental health, one of looking back from a distance. The other four participants, having experienced this within the last two years, showed a sense of still being caught up in the process of what had happened to them. Sarah's distance has allowed her to look back and reflect on that time, the impact on her relationship with her daughter, and the entire family, and the way TA therapy helped her both with understanding at that time, but also with moving forwards. She said it did not matter that the TA therapy was some years after the difficulties she experienced, as a great deal of time was spent exploring that time, the processes involved and Sarah's dysfunctional relationship with her daughter. The title of Sarah's story is a sentence towards the end of her interview when she was remembering how she felt after Sally was born. She said her feelings at that time simply were not hers.

Sarah lives in England and has three grown up children, Sally, George and Charlie. Her husband Dominic had recently died. The interview was conducted at her home in May 2017.

### 9.1.1 Becoming unwell

Sarah said she had no symptoms of illness during her pregnancy with Sally. It was immediately after the birth that Sarah became unwell. She described her illness as an antipathy towards Sally:

*I thought there has to be something wrong with me that I feel like this. This is not normal to feel like this about a baby, I just thought I've obviously got a screw loose somewhere. It happened like that (snaps fingers)*

#### E.H. Overnight?

*Immediately, I mean, I was thrilled to be having a baby, I was so excited about being pregnant. Erm. And then when she was born I thought "Oh my god what's the matter with me" (pause). I've got this terrible reaction to this helpless child (pause).*

When asked if the birth had been traumatic she was quite pragmatic:

*Not particularly, erm (long pause) I erm, they induced me, which wasn't particularly nice. Because they put up drips and stuff because I started bleeding, so they had to do something and so erm she was born very quickly and rather painfully, well I suppose its always painful isn't it? With that drip. But no, no, not at all.*

During the interview Sarah wondered about her antipathy towards Sally and offered the gender of her baby as a factor. It is plausible that 40 years ago gender may have played a role. Culturally, in many countries, a baby's gender can play a large part in perinatal mental illness, particularly the birth of a girl. Whether this actually played a part for Sarah is unknown. Sarah also never quite knew what to call her illness. She said that she was told it was not depression, as it did not fit the medical determinants. However, when she read an article calling it distress, this finally fitted her experience. Research shows that women often do not feel depressed at this time, and so the diagnosis of postnatal depression does not necessarily fit their experience. If this is the case they feel they do not know what it is that is wrong with them. If the treatment is focused solely towards depression they also feel the treatment offered does not meet their needs (Button et al., 2017; O'Mahen et al., 2015; O'Mahoney et al., 2012).

### 9.1.2 Shame and stigma

Very early on Sarah talked about her shame because of the way she had felt towards Sally as a baby. This played a large part in why she was unable to tell anyone, particularly her husband:

*Of course the huge fear for me was that if I told Dominic, my husband, I thought he'd leave me. [...] That's what I thought. So I thought I can't tell him, I can't tell anybody, I've just got to get on with this, horrendous, whatever it is you might call it. [My fear was] that I would be horrendously shamed. I would feel a terrible shame, which is of course what I **did** feel, massively ashamed. Oh it was like a stigmata, as well as a stigma.*

When Sarah was asked to clarify what she meant by the word stigmata, she said:

*The fact it was something from outside [...] that's being wounded, you are wounded by a stigmata aren't you?*

E.H. [so were you wounded?](#)

*Oh yes, and she was. That's my huge sadness. And I knew it was terrible for Sally, I just knew it.*

Sarah returned to her shame and stigma and what that was like for her to experience:

*Huge shame. Oh yes (drops voice). I attached stigma to myself, I thought this is frightful. What a terrible thing. But I have this sense that it came from the outside, although I knew it didn't and I am really kind of confused by that. Cos I thought this really isn't me, that's how it felt. This feeling isn't me. And I feel that very strongly, this feeling isn't me*

E.H. [And you still feel that now?](#)

*Yes, well its gone now, thank god, it was a horrible feeling.*

### 9.1.3 Extremes of feelings

Sarah experienced strong feelings of antipathy and fear, and she talked about them coming from an external factor:

*I mean it was kind of like somebody had almost shot me actually. I don't know where it came from. It was cruel.*

She clearly felt it was not her feelings, or anything internal, but came from outside of her.

*Those were my 2 huge fears.*

E.H. [That they'd take Sally away from you?](#)

*Yes that they might. Dominic would leave me. That was my hugest fear. No I don't actually think they would take her away from me, funnily enough. That never entered my head, funnily enough, but that **he** would take them away, take George away.*

The thought of losing George, her second child, seemed to affect Sarah more than the thought of losing Sally. Loss of her son, Sarah believed, would result from Dominic taking the children from her, rather than Social Services stepping in and placing the children into care.

Sarah was asked if she had experienced anything similar when she was pregnant with George:

*Do you know, I don't remember being terrified, but I do remember feeling worried. Of course looking at it now, I can imagine I must have been terrified, but you know, when you are 28, you're young.*

And with her third child Charlie:

*I didn't even think about it. Because it had gone, I didn't feel like that with George, and so it was gone.*

It is possible that with each subsequent birth some of her initial experience might have been brought to the surface again. However, for Sarah this did not happen.

#### 9.1.4 Asking for help

At first Sarah approached the NSPCC for help. They sent a woman once a week and Sarah felt this was someone to talk to, until the woman was no longer able to come:

*I suddenly got a letter saying she was very ill and she wasn't going to come and see me anymore. And I can remember that ghastly feeling, and it may have precipitated actually erm, I thought I can't do this anymore, I'm going to have to tell Dominic, but if he leaves me and the children are taken away from me then I'll have to put up with it.*

By this time Sarah had given birth to her second baby George, and she said she knew she could not keep it secret anymore, that she had to tell her husband:

*And I knew it was terrible for Sally, I just knew it, and anyway I thought I can't do this to the children, so I told him, and that was a heck of a risk actually and erm he was amazing, amazing really, and said "I always knew there was something wrong", and I said "why the hell didn't you say anything". He said "I suppose I was too frightened". And I suppose having*

*told him, I then told my sister, yes that's right. Who then went off and told my mother. Before that happened, Dominic and I tried to find somebody or other, we saw this useless psychologist and erm, then they found me this person, who actually was a child psychiatrist. I imagine a psychoanalyst. I don't know what she was. She was enormously helpful, and erm she, she kind of, funnily enough from what I can remember cos it was so long ago, taught me strategies about how to manage and you know she reiterated them. But of course Sally had done nothing wrong, she was just a baby, just a small child and the most important thing was to be respectful and courteous to her and I couldn't manage anything else. So that's what I've always been driven to do, erm, is the kind of message "You're ok".*

Once Sarah had confided in Dominic, she said he was enormously helpful and supported her to gain whatever help she needed, looking after the children when she attended her psychoanalysis appointments.

#### 9.1.5 The consequences

Sarah spoke about the consequences on her relationship with Sally. When asked to clarify this she sighed deeply, then said:

*All through her life. Completely, ohh (pause) (she sounds and looks in pain).*

Sarah explained that her relationship with Sally was damaged irreparably as mother and daughter and was still strained today, even though Sarah never gave up hope that this might change. She had asked if Sally would have joint therapy with her but Sally refused.

Once George was born, Sarah did not experience antipathy towards him at all. However, when talking about George, she expressed more about her thoughts on gender, and the role of hormones in perinatal mental illness:

*I didn't have the same reaction to him at all. And my reaction to him was one of huge love and great relief, funnily enough, these two emotions.*

E.H. *it's curious that you had it with Sally but not with George, I'm sure you've wondered about that*

*Maybe she's a girl and she's an identity with me. Does it usually happen with girls rather than boys? Mine was a huge antipathy which has obviously got to do with hatred of myself. That is what I think it was all about. Who knows? [...] Its almost like that transition to motherhood. I think motherhood brings up all sorts of issues about yourself. Erm I mean I know it does. I mean that's a fact, we know. [...] And perhaps if people like me had been given hormones it might have helped, as a sort of aide.*

*I mean Dominic was marvellous, in that he accepted it, but he didn't understand it. But he accepted it, so that was hugely helpful and he accepted me and he was a very accepting man, erm, he didn't judge people for anything really. But he didn't understand what all this was about. [...] I'm sure he was terrified. It was an extraordinary madness really, I mean this was in 1981 that I told him. Because Sally will be 40 this year. So yep. So I think that's what, it was that which of course as we all know is hugely powerful, if no-one's ever been understood.*

This sentence “it was an extraordinary madness” resonated with the experiences of two other participants, Lucy and Jane.

A little later Sarah talked again about her illness and how it felt like an external attack, even though she knew it was an internal mechanism:

*My felt sense is it makes no sense, why was I almost like attacked by this phenomenon. Yes there is all sorts in my childhood, but then there is all sorts in lots of people's childhoods. It doesn't mean so they're going to be assaulted by this.*

She clarified more about this sense of feeling “attacked”:

*It does have a kind of feeling that it was something out of me, but obviously it wasn't. But it has that kind of (pause) it's so foreign.*

*E.H. The fact that its not from within? Its from without? As if it almost overtakes you?*

*Not almost, it does! Well to the extent, I mean they did say, well you know you, you're not depressed, you are (pause) and you are very jolly and all the rest of it, and I might portray myself as that, but I can tell you, in the inside I feel absolutely overwhelmed by it. But I managed to hold it. So when you say almost, I can see that you could be referring to that. That you pull the wool over people's eyes, and they just don't notice.*

Sarah then talked about how long it took for her feelings of antipathy towards Sally to dissipate:

*I think it dissipated over time, erm it was helped by a lot of things, by her getting older, [...] She's devoted to her little brother, extraordinarily, because I absolutely adored that child, because it was kind of pure. There was nothing about (pause) he was a sort of textbook baby and I thought “God I've been given what I deserve, you know, I've got this correct feeling that you have towards a baby”, and it always amazed me that she adored him.*

E.H. **You thought she might be jealous?**

*I thought she would be, why not? I thought she'd hate him.*

E.H. **But she didn't**

*Oh no, extraordinary isn't it. So that helped. And he her too.*

E.H. **So he adored her?**

*Oh yes, like a little mother. She didn't have a mother, so let's have him, Sort of projection in a way of what she needed she put on him. [...]I'd loaded onto him, what should have been hers, or some of hers. And he got it all. Because she didn't get any.*

## **9.2 Therapy**

### **9.2.1 The differences between psychoanalysis and TA**

Sarah initially went to a psychoanalyst for help. It was not until after the birth of her third child that she moved into TA therapy. She talked about the difference between the two therapies:

*So I went into TA therapy. [TA Therapist] was much better (she laughs), I have to say. She was much better.*

E.H. **What was different?**

*Oh these ridiculous boundaries, and I mean that has kind of set (pause), I don't know how I ever did it, I had to go and see her twice a week and on her terms and conditions and I paid whatever, it was an enormous amount of money. I couldn't afford it. My parents funded it, which was really good of them, because we couldn't have afforded it. [...]There was no, there was no dialogue about anything. It was how she had it. Just like my mother. I can feel myself getting angry thinking about it. Rigid and I was having a baby and she came back off holiday and I went to see her 5 days after he was born. Because, otherwise I would have had to have paid. I actually found it abusive. [...] when I went to [TA therapist] that was the first thing I asked, what her contract was, fees and attendance and all the rest of it.*

E.H. **Did you speak about that time with Sally?**

*Oh good Lord yes, endlessly it was a very big part.*

### **9.2.2 The power of TA**

Sarah spoke of her positive experience of TA. It helped her to understand and improve her relationship with Sally, even though Sarah acknowledged that the relationship was damaged irreparably:

*What I've found about TA and what I've found enormously helpful from TA is that there is such a wealth of information and models about the person,*

*and so that to me is (pause). And I find it fascinating because I really like puzzles.*

E.H. *It gave you more information about you and the way you ticked? That sort of information?*

*Me and actually Sally, definitely me, yes. Well (sighs) she doesn't want to, and I respect her, she doesn't want to get into any of that, its too painful. She won't. And ok, she won't. But we operate, not in a way I'd like to but we operate. And we would never have done so. I often think what the heck would have happened, if I hadn't done all this psychotherapy? I was absolutely determined to sort this problem out. (Long pause). I had to.*

*Of course it's had an enormous impact on her, you can see that and, you know, that's why I believe so much in the therapy, because I've seen it in action. You know I've lived with it. I've seen it evolve, I've seen it develop, I've seen, not just me, but Dominic and our relationship and I've seen the impact, I think on my son George, erm, because he had to witness this psychologically.*

*I just think it gave me a hugely greater understanding. Of not only the process, Sally, or my assessment of her, erm, it made me feel more stable in something that I just didn't understand, from which there were no answers. I'd love there to be an answer, with what we've just been talking about, this stigma, or stigmata, and the fact it was something from outside.*

This last paragraph showed that Sarah still felt, at some level, that she had been 'attacked' by perinatal mental illness, that it was external to her and in her mind it was a 'stigmata'.

### **9.3 Other noticeable aspects of the analysis**

There were no omissions and revisions within Sarah's narrative. However, she did contradict herself towards the end of the interview about her son George, because she said at first that she adored him as a baby and child: "*I absolutely adored him*". But later on in the interview she said that she was not besotted with him. She did this when drawing a parallel to her daughter Sally's intense emotions about her own son, and how Sarah's feelings about George had not been so intense.

There was also little silence within the interview, although at times she did seem to drift away from the interview and become a little distant. This may have been because her experience had been so many years ago and this drifting could have been a time for her to re-connect with her experience. Her interview was also



short and concise and it was difficult to keep her on track, talking about her experience, rather than her suppositions about perinatal mental illness. She also did not use any metaphors. However, it was interesting that she used the term “stigmata” when talking about the stigma of mental illness, and this may have been to emphasise the point she was making about how her illness had literally harmed her daughter, causing their relationship to falter, having a long term detrimental effect on them both, which had never recovered.

#### **9.4 Listening for Sarah’s other voices**

Sarah had five separate voices speaking within her narrative (Appendix 11). The first three could be associated with the Child ego state. The first was a voice of fear and shame and knew there was something wrong, but was terrified that if she admitted to being unwell her husband would leave her and take her children. The second Child voice was one of confusion, who could not understand why she felt antipathy towards her first child, yet adored her second, who wondered if she had a hormonal problem, and whether it was because of the baby’s gender that she felt this way: *“it was a wicked awful witch and it had gone”*. The third Child voice was that of sadness, particularly about the consequences for her daughter, which have continued through life: *“it has had an enormous impact on her”*.

Sarah’s fourth voice was her Nurturing Parent ego state seeking help. This voice knew she could no longer carry on and accepted that she was ill. This was the voice that eventually admitted to Dominic just how unwell she really was.

Sarah’s final voice was from her Adult ego state and enabled her to reflect on how TA therapy had helped her, with its wealth of information, strategies and framework that she could use to understand her internal process: *“it gave me the stability I needed”*.

#### **9.5 Listening for Sarah’s “I” poems**

Sarah talked mainly in the present tense, although the first few minutes of her interview were in the past. She also did not really show the temporal movement of her experience through the use of tenses. This made her “I” poems different to the other participants.

Her most-used “I” sentence construction was *“I have”*, followed by *“I think”*. Looking over her “I” sentences she used fewer than the other participants, apart from Shoshana, and this may have been due to how many other members of her family had played a part in her story. None of the other participants talked in such an inclusive way about their extended families. This may have been due to

the length of time from illness to interview - Sarah has had a great deal of time to think about what happened to her. Yet she still remains confused about her illness, where it came from and why.

Throughout her narrative Sarah used many heighteners, in particular “*awful*”, “*horrendous*”, “*terrible*”, “*massively*”, “*enormously*”, “*amazing*”. When she described her illness she used negative heighteners. Yet, when she described her son George she used positive heighteners. She didn’t use these positive heighteners for her two other children.

## 9.6 Lack of an object

Sarah did not bring an object. It was not a pre-requisite of the interview and it had no bearing on it at all. However, within her interview she talked about the resonance of her son George’s first gaze at her, shortly after he was born. Her memory was similar to Shoshana’s, surprisingly similar:

*I remember when he was born he looked at me. And this was my imagination, he looked at me and I thought this baby understands me. “What! Don’t be ridiculous!” (laughs), this baby knows. And I remember because they left me in those days and they brought the doctor in to stitch me up and they left me, [...] they left me and they put him in his plastic cot, down below the delivery table and I looked at him, I can see him now, this look, and I was desperate to pick him up, but terrified, because I felt very fragile and thought if I try to, I could fall into his cot or if I did I might drop him, so I just looked at him, we just looked at one another. Why I had this huge feeling of relief.*

E.H. [A big fear?](#)

*I had an enormous fear that actually, and funnily enough when I had number 3 I didn’t have any fear at all. It had gone (pause), I suppose because I knew that I hadn’t felt like that with George so I would never feel like that again. And of course what’s ironic is that all those feelings that I had towards or about Sally have all gone.*

E.H. [How long did they last for?](#)

*Oh a long time because of course she activated them. Because you can imagine how she would have behaved and can’t you? You can imagine it, so it all got reactivated.*

E.H. [So it was a dual process?](#)

*Oh god yes, that’s what is so desperately sad and of course Dominic didn’t really help because he did a heck of a lot of rescuing.*

It was not surprising that Sarah had not brought any object to her interview as her experience had been so long ago. The parallel to Shoshana's memory was striking, and for that reason it has also been included in the study.

### **9.7 Reflections on Sarah's interview**

A few parts of Sarah's interview were different from those of the other participants. Thinking about who was missing in the interview I noticed that Sarah spoke about her whole family, although her third child, Charlie, did not figure as often as Sally and George. My sense of Charlie was that he had been 'normal' and therefore not involved in her illness, and perhaps this was why he was missing in her dialogue. Dominic, her husband, featured a great deal, and appeared important in her journey to getting help and recovery. She also talked a lot about her extended family - her parents, her sister and her relations. No other participant talked in this way about their extended family, so I wondered if this might be due to the length of time that had passed. I also excluded a part of her interview that was not relevant to the research. It was about difficulties in her psychoanalysis and how angry this had made her.

An aspect of Sarah's story that resonated most for me was the length of time it took her to find psychological help. She stayed silent for more than two years. It also took a long time for her to gain understanding, which she said did not happen until she had TA psychotherapy. This may have been because it happened 40 years ago, when stigma and shame of mental illness was high, and there was little help or care.

I was also curious about her continued sense that her illness was external to her and the way she spoke in the present tense about it "attacking" her. Throughout the interview it felt as if this was her view, even towards the end of the interview, when she acknowledged having been through many years of analysis and therapy. She also said she was still confused about why it had happened, and had found no reason behind it. She did not say if she had experienced any other type of mental illness in the past, even though I asked. However, she did surmise something historically in the family - a great aunt who had experienced schizophrenia. This led me to think she was still ashamed at some level.

I came away from the interview feeling confused. At first I was unsure what information Sarah had given me. She digressed into her family history when trying to draw a possible parallel with her great aunt's schizophrenia and her own illness and it was difficult to keep her on track. Her great aunt's schizophrenia seemed to lurk in the background of her thoughts, because she surmised, part way through her interview, that there was no cause of perinatal mental illness, that it just was: *"A bit like schizophrenia, we all want to have some*

*bench mark or yard stick in order to measure it.*" Her feelings about her illness seemed not to have left her, and I wondered if this was because she still felt she had no answers about where it came from, or possibly had not come to terms with the fact that this was an internal experience from within her.

## **9.8 Conclusion**

Sarah's description of her illness was almost as if it were a foreign object, something external that had "attacked" her. This is similar to Lucy's and Jane's descriptions. All three participants recognised their illness was internal, yet for Sarah it still seemed she was not quite sure. It was as if her rational brain was telling her it was internal, but her irrational Child ego state still felt attacked by some malevolent external force.

She was the only participant to mention the possible role of hormones in her illness, although Shoshana alluded to them because she said that her panic attacks came when her periods returned after the birth of her baby. As there is still no conclusive evidence whether these types of mental illness are caused by hormonal fluctuations, or whether hormones play some role, possibly in heightening the depth and breadth of the illness, it is impossible to say whether Sarah and Shoshana are right.

Sarah confirmed that she experienced both shame and stigma during her illness and that they both played a large part in her silence and her inability to seek help. She continued to experience the illness with no real help for about two years. It was not until her second child was born and that she told her husband that she found suitable medical help, firstly through a psychoanalyst and then a TA psychotherapist. The role TA played was to give her understanding about the repercussions of her illness particularly on her daughter Sally, and to enhance the strategies she could use to help bolster that relationship. Sarah acknowledged the relationship was still not how she would have hoped, even today. This offers a sense of how damaging this condition can be to the infant and the life-long repercussions that may exist for that infant, even if the mother has had treatment at some stage. Possibly, sadly for Sarah and Sally, that treatment was much too late, and so the damage was already done.

Sarah contacted me to offer her support for my research because she said she had a strong belief in TA psychotherapy. It had offered her so much after her experience, helping her relationship not only with Sally, but also with Dominic. Sarah's experience of TA psychotherapy shows longevity in her positive outcome. I would hope that other women would be able to have a similar experience, and in 40 years time be able to confirm that the psychotherapy they received was beneficial as it was for Sarah.

I was unable to offer Sarah any hope that I had an answer for her continuing question of why she had experienced it. I hope that some day, I will be able to give her that answer.

## CHAPTER 10

### Reflexivity

#### 10.1 Introduction

This reflexivity chapter has enabled me to reflect on some issues I discovered during the process of completing this study. The first was the importance for the participant voices to remain central to the research. Therefore, all my reflections have been contained in this chapter, apart from those in the participant analysis, which have been kept within their appropriate chapters.

##### 10.1.1 Lack of TA research

TA research is in its infancy and although some research is starting to be published it is almost always through institutions such as universities where TA psychotherapy is taught and practiced within a university or college psychotherapy service. The lack of TA research was an ethical dilemma due to the significance of using an ‘untested’ psychotherapeutic treatment for a new client base, particularly to treat women at such a vulnerable time.

Unsurprisingly, I was questioned about this moral and ethical dilemma. It was useful that the literature was expanding for the use of TA in depression and anxiety within an adult population. As a TA psychotherapist I believe research into all aspects of the use of TA is vital and necessary. Research needs to begin somewhere, and I took this dilemma into consideration when devising the study design. Focusing on listening to women’s experiences was a good beginning for research of a burgeoning psychotherapeutic treatment. I am biased about this treatment and see TA as a positive development for perinatal mental health disorders. Therefore, it is important for me to showcase the versatility and flexibility of TA within this research study.

#### 10.2 Methodology

##### 10.2.1 An eclectic path

From the outset, there has been a persistent need for a pluralistic approach, as well as a persistent vein of eliciting difference within this study. In particular, difference in the narratives of the women in this study, in their experiences of illness, in the circumstances of their illness, and the difference in the styles of their treatment (one-to-one, couples, or group psychotherapy). I incorporated a creative technique as a possible means to evoke this. I initially chose a mixed methods style of research, but this proved too difficult due to ethical considerations and time constraints. I therefore examined primary sources and returned to the heart of philosophies, and philosophical debates underpinning

psychotherapy research. I explored those elements important in psychotherapy such as epistemic justification, autonomy, value and the self (Erwin, 1997). I reflected on how this could influence my own study, and was influenced by Partington (2001) who suggested researchers find and explain an approach that is appropriate to the requirements of the research and its context, rather than favouring ontological and epistemological norms. This seemed a more congruent pursuit of knowledge, and led to an exploration of philosophical pluralism, drawing at first on multiple different philosophies such as Feminism, Feminist Standpoint theory, Phenomenology, Hermeneutics, Post structuralism, and Social Constructionism. I then chose to combine Feminism and Social Constructionism as both were able to reflect the different aspects of my research and to account for the women's experiences. Similarly, I followed the suggestion by Emmett (1972) to adopt a style that is a 'matter of convenience' employing approaches relevant to the subject matter, the informants and the method of enquiry. This led to a more in-depth exploration of creative techniques in the arts, media, nursing and social work research. It also made me re-think the study focus.

Barriers to treatment were recurring themes throughout the literature review, as were help-seeking behaviours, which seemed to be bringing women into private psychotherapy, rather than seeking help within the NHS. This developed into a stronger focus for the research project, highlighting the difficulties women had in voicing their experiences and asking for help. The literature also showed a deficit in women's voices, particularly women speaking about their experiences of treatment.

### 10.2.2 Congruence

The work of Arthur Frank (1995), in particular "*stories repair the damage that illness has done*" (p54-55) has had a significant impact on my thinking as I wanted to hear these stories of illness, not only as a possible form of repair, but as a way of allowing others to hear them. I also wanted to respect the voices and experiences of my participants and my choice of data analysis offered me a meaningful and productive way to do this. I knew that part of each of my participants' stories could be hidden and might not be accessible by interview. I use creativity in psychotherapy with clients and supervisees, and I was keen to see if using a more creative technique of data collection might bring out hitherto hidden elements.

This research is novel and unique. In particular, the choice of using creative methods to enhance the narrative form of experience, and possibly unlock the "unthought known" (Bollas, 1987) has meant that there has been little in the way of template. There is no specific literature about combining both elements, and

there is little written about this type of research. However, a paper on feminist collaborative research showed me the possibility of using multiple types of data analysis (Morrow, 2007). I have combined the two different data sets with a single style of analysis, the Listening Guide. Accordingly, I believe I am making a new contribution to method. Finding the right way to analyse my data was difficult. Methodology, theory and philosophy within the social sciences continually evolve. This research contributes to this evolutionary process by offering another way of analysing visual data.

This research is iterative-inductive and it began by acknowledging the gaps in the literature. It is ground-up research, concentrating on women affected by perinatal mental illness, rather than top-down, focusing on the use of expert input into the development of policy, regulations, and guidelines. It is iterative because there is a constant re-reading, re-searching, re-participation, re-observation, re-writing, re-reflecting which has continued throughout. It is, as O'Reilly (2012) narrates, more of a voyage of discovery, less of an examination.

### 10.2.3 The dual role of psychotherapist and researcher

A significant challenge throughout has been my dual roles of psychotherapist, treating women with perinatal mental illness, and researcher. Due to ethical concerns I was unable to research my own clients, which I experienced as a loss. There was also a risk that my professional life could affect the information the participants gave me within their interviews, because they knew I was a TA psychotherapist. However, it was impossible to keep this information away from them, because each came through either their own TA psychotherapist who discussed the research with them, or through knowing another participant within the research. Two participants responded to an article I wrote about my research which asked for participants to contact me.

At times participants' knowledge of my role in psychotherapy was useful to them as all of the participants used TA terminology throughout their interviews. This mitigated the necessity for them to explain what they meant by some of the terminology. However, it was difficult when participants asked my opinion about particular aspects of perinatal mental illness. Several participants tried to draw me into disclosing other participant's experiences, possibly to break down their sense of isolation. There was also the pull to step into the role of therapist, particularly when a participant became upset. Listening back to the interviews, I would say I achieved the researcher role more effectively with some participants than others. The participant with puerperal psychosis, Jane, was particularly affected within her interview. At the end, rather than take up the offer of a debrief session, which all participants were offered as part of their participation, she said she wanted to go back into therapy, as she realised her experience had



affected her more deeply than she had thought. Listening to her interview I realised I managed the boundaries well with her and I was not drawn to give her therapy, but simply to sit and listen to her story.

Reflexivity is at the forefront of ethical practice, letting the participants and the readers know who I am as a researcher, as a psychotherapist, and what my moral and ethical stance is. It is impossible to hide. Arguably, all human experience is to some extent biased by subjectivity. As such, I am biased and my work is biased. My work is also highly subjective and I aim to make it as explicit and transparent as possible. My knowledge as a professional clinical psychotherapist influences me and brings with it a form of expectation. It is important to keep this in mind and to acknowledge how this research has affected me.

There is nothing new about being a researcher-practitioner. I would argue that I am fully part of the narrative process within the interview with my participant, as it is my interest in their story that may influence the process of the storytelling itself. I am less interested in the more traditional description and theory of life itself, than actively being a part of the process with my participant. Co-creative TA (Summers & Tudor, 2000; Tudor & Summers, 2014) emphasises the 'co' as in mutual, joint, transactional, inter-relational, co-operative, partnership. In this narrative inquiry, my stance is more to be a 'part of', or a 'co' researcher with my participant. This influences my analysis and impacts the presentation of my findings.

The research interview is not a neutral exchange (Fontana and Frey, 2005), nor is it narrative neutral. Irigaray (1993) urges us to "*analyse very rigorously the forms that authorise*" (p172). She argues that those who are marginalised in society and are not privileged within these 'authorised' discourses will not be seen, and that the other widely available, but invisible and illegible languages, need to be listened to 'with another ear', because:

*'If we go on speaking the same language together we are going to reproduce the same history'* (Irigaray, 1985, 205).

I was not interested in hearing only positive stories within this study. I was willing to expand the boundaries of the research, and be inclusive rather than reductive, including both Jane (the participant with puerperal psychosis), and Sarah (the participant who had therapy 40 years previously). This has been positive for the study. Both have offered experiences not normally heard in a research study.

#### 10.2.4 Intertwining methodologies

This research study has had a theme of pluralism: of theories (Feminist and Social Constructionist), and of data collection (creative and interview). This seems to parallel the fact that psychological distress is not just one type of condition, it includes (m)any other mental illness that a woman experiences within the perinatal period.

This type of 'experience-centred' (Squire, 2005; 2007) narrative research allows the life experiences and the objects that are a part of this data, to constitute the 'narrative' (Bruner, 1990). Experience-centred research stresses that individual and internal representations vary greatly over time and across circumstances "so that a single phenomenon may produce very different stories, even from the same person" (Squire et al., 2013). I am interested in that part of narrative that is focused on what the individual actually says about her own thinking and feeling (Chamberlyne et al., 2002; Hollway, 2015; Hollway & Jefferson, 2000; Labov, 1997). I also have an interest in the more psychoanalytic elements of experience (see Craib, 2004). The form of narrative research that I have chosen is multi-layered, as an individual is multifaceted and multi-layered. It is an analysis style which draws on Deleuze's thinking of selfhood as continuously, multifariously constructed and then reconstructed (Deleuze, 1966, 1968). The concept, developed by Deleuze and Guattari, is of the development of one's thinking as a rhizome, an underground root system, with many branches, an open decentralized network, with multiple entryways, and a multiplicity of connection (Deleuze and Guattari, 1976). This allows us to broaden our sense of knowledge, and understand there may never be one truth, or one construction of knowledge, that it is multi-layered, multi-faceted, and multi-voiced and that each telling of a story will lead to a different connection, a different version, a different speaking, a different part of us speaking. People continually tell themselves and each other stories, due to the human need for structure and stability, and through those stories they derive meaning. These stories can be ruptured, and in those ruptures new stories or parts of stories may evolve:

*"Every attempt to transform this multiplicity to a unity (to one version) leads to a reduction, to the exclusion of other possible and perhaps even important versions." (Sermijn et al., 2008, p112).*

#### 10.2.5 Finding my own identity

This study has been as much about my struggle, searching for and then finding my research identity, as the participants narrating their lost identity and how they found it again through psychotherapy. Part of me struggled with letting my research be confined by feminism. I am female, a mother, and I am also a

working mother therefore I view this research through my own personal lens. My professional work is in a caring profession, as a psychotherapist, which is particularly female-dominated. My journey into feminist literature and philosophy has taken me in many different directions.

Childbirth is inherently female, but I was unsure it needed to be viewed through a 'feminist' lens. By a feminist lens, I mean the significant amounts of feminist literature that view childbirth through a sociological lens (Oakley, 1980); a status of passage from child to woman (Layne, 1990); or through the discourses on pregnancy, childbirth, breast feeding and infant bonding, which view motherhood as a project with required instruction and monitoring, surveillance and intervention for "good mothering" (Abramowitz, 1996; Arnup, 1994; Ladd-Taylor & Umansky, 1998; Margolis, 2001; Rapp, 1999; Reid et al, 2008, Wall, 2001). Or other discourse on the 'selfless mother' (Hays, 1996; McMahan, 1995) or who view 'selfless motherhood' as an unnatural event which is not instinctive (Badinter, 1981). Pregnancy and childbirth are, in my mind, pathologised and there seems to be a politics of childbirth. Many women say they enter pregnancy with a belief that their birth will be 'natural' with no medication or pain relief, no need for a caesarean-section, in the environment that they choose and with the woman in control. However, the vast majority of women say they did not have this 'natural' experience (Byron & Downe, 2015).

Throughout this research my two roles of psychotherapist and researcher have had periods of separation, blurring and merging together. This has been true of many parts of the research, feminism being a case in point. I shied away from using feminism as my methodology, possibly because it seemed so obvious, but also because it seemed so angry. Yet, on reading many of the academic texts I became angry and outraged. As a psychotherapist my role is not to hold a definitive stance, it is to listen and hear, not judge or advise. Yet in this research I felt I had to take a standpoint, and that I was being asked to be bold and place my head above the parapet. This was, and will always remain, uncomfortable for me to speak and be heard.

Over the duration of this project I have become influenced by feminism (Butler, 1993/2011, 1997, Bloom, 1998; Fine, 1992/2002; Forna, 1999; Harding, 1987; Hartsock, 1983; Oakley, 1980; Reinharz, 1992; Ruddick, 1989; Weedon, 1987, 1997), by social constructionism and poststructuralist theory (Derrida, 2000; Foucault, 1988; Gergen, 1999; Gergen & Gergen, 2003; Josselson, 2011; 2013). I am also influenced by the epistemologies of psychoanalysis and the psychoanalytic way of knowing which comes from the mother: Ettinger's matrixial knowing, the earliest form of communication (Ettinger, 2006, 2010), Winnicott's transitional space (see 1953, 1956/1984, 1960, 1963, 1971/2005), Bollas's unthought known (Bollas, 1987), Lorenzer's scenic understanding

(1977, 1986), and the reverie, containment and communicative projective identification in which Bion locates the origin of knowledge (Bion, 1962a, 1967). All of these forms of psychoanalytic communication are pre-symbolic, non-lexical, and are embodied forms of communication, which do not disappear once we reach adulthood. Choosing a methodology that fitted this style of communication and this form of knowledge was vital, yet difficult.

### **10.3 Methods**

#### **10.3.1 The interview**

Each participant was interviewed only once in this research. This was a decision made at the outset, and in hindsight, my experience as a therapist almost certainly influenced this choice and the way I conducted the interview. Each interview lasted on average 90 minutes, which is longer than an average therapy session. At first I was unsure how long the interviews would last, so with the first participant I decided to see how the interview progressed naturally. I had no pre-conception of how long this would be, other than knowing that it would unlikely last for hours, due to the nature of the subject. I knew that some women might find the interview difficult and it was my aim to make the environment feel as safe and comfortable as possible. I knew I would be able to sense when the interview was coming to an end, and when the participant had finished narrating. This was from my therapy experience, and I did not worry that I would prolong the interview or knowingly cause distress.

I kept in mind Bourdieu's (1999) theory on interviewing, in particular: *"It is not simply a question [of] collecting 'natural discourse' as little affected as possible by cultural asymmetry; it is also essential to construct this discourse scientifically, in such a way that it yields the elements necessary for its own explanation"* (p611). I perceived myself as having little skill, as such, at interviewing, as I had not conducted a research project before. However, I realised my own skills as a therapist were in fact 'interviewing' skills - to listen actively and attentively, with no thought to respond, no need necessarily to question, with an aim simply to hear.

#### **10.3.2 Free Association Narrative Interviewing**

This style of interviewing is different. It has no set questions or guidance, apart from that given by Hollway and Jefferson in their book 'Doing Qualitative Research Differently' (2000). At first this was daunting. I wondered whether my participants would actually talk within their interview, and whether this would be to a depth I was hoping for. I also wondered how the interview would progress without any formal structure. Having faith in the process was difficult

for the first interview. However, the depth of material I gained by this process was more than I had expected, as well as being of a richer nature.

All the participants, apart from Jane, had no difficulty at all in speaking from the outset. I was surprised by how much they all seemed to want to tell their story, and how important it seemed to be to them that I was listening, intently.

The lack of a formal interview structure was a positive within this study. This seemed to encourage the women to speak more freely with me, and it certainly encouraged them to tell me the story they wanted me to hear. I tried to keep any interjections needed for clarification purposes to the absolute minimum as I did not want to interrupt the flow of narrative. Listening back to the interviews it felt that my interjections were only those required at the time.

As there is no set of questions, there is no formal structure to follow and this may feel daunting to future researchers, who are interested in different styles of interview. Yet, I chose this interview style deliberately due to the nature of the depth of stigma and shame within perinatal mental illness. I believe it was necessary to allow the women to feel as free as possible to speak, not to be led in anyway by my desire for any particular knowledge. In hindsight, the choice of interview style was the right choice for this research project. I believe I would have gained little in the way of new narrative if I had chosen a standard interview technique style of set questions.

### 10.3.3 The creative object

As a psychotherapist it was important for me to elicit the non-verbal, possibly unconscious elements within the narrative, in order to see if meaning could be made from this. The non-spoken is often considered as powerful as the spoken word in psychotherapy, with emphasis on unconscious processes and how these affect and influence the therapeutic process. 'Hearing' the non-spoken element of these women's experiences has been as important as hearing the spoken narrative within this study. Language, and in particular words, have different meanings to different people, and I agree with the ideas of Gadamer (2006) that language has a self-concealing as well as a revealing nature. Meaning emerges through the non-spoken as well as the spoken word. Therefore, it was important for me to give a role to the unconscious within the data collection process to discover whether meaning could be extracted from it.

### 10.3.4 The analysis

Throughout the analysis process, when listening back to each tape recording, I tracked my thoughts and feelings, my questions, my interpretations of the

(multi-layered) voices of the participants, of their behaviours, and also my confusions and my questions. I was curious to know whether my participants ventriloquated or appropriated (Bakhtin, 1981) voices, that devalued the participant, or allowed me to know of any appropriation of power within the interview. This would allow any hidden dimension of power to be brought out and highlighted. I was also interested in how each participant contextualised themselves and their many different selves, such as wife, mother, businesswoman, daughter, and how these were portrayed within the narrative.

#### **10.4 Summary**

From the outset my aim has been to highlight the depth and breadth of this illness, the difficulties with diagnosis, the lack of treatment options, the plausibility of TA as a suitable treatment, and the devastating effect the illness can have on the woman, the infant, and the wider family. I also wanted to highlight the women's voices about treatment, in a way that had not been heard before. I also had a deep belief in the usefulness of TA for this condition because it is different from CBT and offers a relational approach and a form of trust that women with this illness are seeking (Myors et al. 2014; Katz & Hetherington, 2006). TA aims to unravel the cause of illness in order to help the client gain greater insight and in this way find strategies of self-regulation and resilience. Once achieved this may mean no further treatment is required, as the client is more able to regulate their emotions and strive towards maintaining homeostasis. In my mind helping the client achieve this objective is the aim in TA therapy. Berne's fundamental philosophical principles are that people are OK, and have the potential of self-actualization. TA fosters cooperation and mutuality within relationships as well as teaching clients about decision-making and the ability we each have to change our life plan (Woollams & Brown, 1978).

*"If we accept depression statistics as the most accessible index of unhappiness ..., it would seem that the commonest unhappiness in the adult Western world is that experienced by women during the usual childbearing years."*

Cain, 2009, p 126

This quote acknowledges how large this 'unhappiness' truly is, and would be even more pertinent if updated to include the prevalence of anxiety, stress and puerperal psychosis.

## CHAPTER 11

### Discussion

#### 11.1 Introduction

When asked, women say they would prefer to receive psychotherapy rather than psychotropic medication for perinatal mental illness (Battle et al., 2013; Dennis & Chung-Lee, 2006; Goodman, 2009; O'Mahen & Flynn, 2008; Pearlstein et al., 2006). Supportive counselling was also experienced by women in a study by Coates et al. (2017) as a key strength in a perinatal infant mental health service in Australia. Yet psychotherapy is not freely available as a form of treatment in the NHS, in the UK. Previous literature shows that few women with perinatal mental illness receive any kind of treatment (Goodman & Tyer-Viola, 2010; Horowitz & Cousins, 2006; Marcus et al., 2003). For the few who are receiving treatment, they are not asked how they experience it. There is little literature on perinatal mental illness, and there is no consensus on its causes, symptoms, aetiology, nor its treatment. A small number of studies have been conducted on women's lived experience of illness, but these are almost always restricted to the postnatal period and to depression only, and some research has been published on barriers and facilitators to treatment. Virtually no research has been conducted on women's experiences of puerperal psychosis and its treatment. Yet research shows that perinatal mental illness is common.

The aims of this research study were to explore clients' experiences of perinatal mental illness and their Transactional Analysis psychotherapy treatment. The literature review (Chapter 2) demonstrated that the client voice is almost always absent in research, particularly in terms of exploring client experience of treatment. A qualitative study of the client's voice would increase knowledge of the factors that facilitate engagement in treatment and highlight barriers to treatment. Acceptability is a primary factor in engagement in perinatal mental health (O'Mahen et al., 2015). Exploring the client's voice would also increase knowledge of women's experiences of their treatment, and the acceptability of TA psychotherapy for this condition. From the participants' narratives it is clear that the aim of the study has been achieved and we now know that all participants found TA to be acceptable and suitable as a treatment.

The primary objective was to listen to women, and to hear their experiences, regardless of what their experiences were. An exploration of barriers to treatment in relation to different time points within the perinatal period was also a main objective. This study actively sought difference in the voices rather than generalizability, which would have been the antithesis of the research aims. Secondary objectives were to explore potential links to prior mental health conditions and the part these might play. All of the objectives of the study have

been fulfilled, although there were limitations to the findings about barriers to treatment at various time points. This discussion examines the extent to which the aims and objectives have been met.

This discussion synthesises the data from the participants initially into the women’s experiences of perinatal mental illness and the common themes (section 11.2), then into their experiences of TA psychotherapy (section 11.3). It continues with the separate objectives (section 11.4 to 11.7). Aspects of the method relevant to the findings are also included (section 11.8). Findings that were not part of the aims and objectives but are also of relevance have been included. These were elements about shared language (section 11.9) and the usefulness of the language of TA theory (section 11.10). The chapter finishes with sections on a possible needed change in terminology, limitations, strengths, contributions to knowledge and future research.

## 11.2 Common themes

Table 11.2 Themes drawn from the participants’ stories

<b>Theme</b>	<b>Lucy</b>	<b>Shoshana</b>	<b>Jane</b>	<b>Julija</b>	<b>Sarah</b>
‘Attacked’	X		X		X
Disconnection	X	X	X	X	X
Health anxiety	X		X		
Madness	X		X		X
Emotional extremes	X	X	X	X	X
Seeking help at crisis level		X	X	X	X



Masks	X	X	X		X
-------	---	---	---	--	---

The women’s stories share common themes within their narrative of their experience of perinatal mental illness, which highlight issues regarding access to perinatal mental health services and engagement with treatment.

### 11.2.1 ‘Attacked’

Three of the participants, (Lucy, Jane and Sarah), expressed a sensation of being ‘attacked’ by their illness, as if it was something external to them and that this ‘(some) thing’ was not them. Jane and Sarah still appeared, at a deep psychological level, to express their experience in this way, even though at a cognitive, logical level they knew, through therapy, that this was in fact an internal process.

Sarah: *“It does have a kind of feeling that it was something out of me, but obviously it wasn’t. But it has that kind of (pause) it’s so foreign”.*

Sarah: *“it makes no sense, why was I almost like attacked by this phenomenon”.*

Sarah still seemed unsure of what had happened to her, forty years on, and was searching for reassurance or for an answer within her interview. It is significant that she spoke of it, in the examples given above, using a mixture of past and present tense, which gives a sense of it still being unresolved for her. Lucy also talked about being attacked by her illness, and even described it as ‘attaching itself’ to her. Her inability to be able to control it was the factor that she said she found most ‘scary’. However, Lucy did seem to have come to terms with it being an internal process, and said that reframing her distress in this way in therapy had been helpful for her.

Jane attributed her psychosis to her infected scar and continued to re-iterate this belief. She did not seem to have come to terms with her psychosis, and was still searching for explanations about why this had happened to her. This highlights the level of trauma that can occur from puerperal psychosis and how the devastation felt from experiencing this condition can be long term. This sense of being ‘attacked’ was also mentioned in research by Stone & Kokanovic (2016). They used Judith Butler’s (2001) “besieged by an enigmatic alterity” (p74) as a way of explicating this sense of attack by a hostile other, rather than an acknowledgement of it being a hostile internal object (Heimann et al., 1989).

### 11.2.2 Disconnection

All five stories contained a theme of disconnection, particularly when the participants' mental illness was at its height. Therapy seemed to be a time of reconnection with themselves, their babies and the outer world. All five also gave a sense of their feelings of being abandoned in the illness. This was apparent in many parts of their lives, from intimate relationships, familial relationships, relationships with their baby, medical relationships and relationships with friends and the wider world. This sense of abandonment is supported by Stone & Kokanovic (2016) who also highlight the disconnection and abandonment women feel with perinatal mental illness, and their subsequent relational act of seeking connection through speaking of their illness. Raymond et al. (2014) in their focus group study of women in an underserved urban population also found that isolation, abandonment and loneliness were significant problems for their participants.

Disconnection and the sense of being overwhelmed, seems to manifest itself through silence within this illness, with women not able to, or choosing not to voice their difficulties. Sarah spoke about not talking to anyone until her second baby was born. She experienced mental illness for nearly three years with no help and in silence, even though her husband and family confessed they had noticed something was wrong. She acknowledged that she had "*pulled the wool over their eyes*". Yet Lucy also said she was unable to talk about her experience to anyone until she had undergone therapy. She also said she spent time with her mother and stepfather during the most heightened part of her mental illness yet she said she had not subsequently explored this experience with her mother. The way she narrated this experience almost suggested that her entire family assumed it would all pass, and did not seem to think to help her access medical or therapeutic intervention. Jane spoke about her own script of not asking for help and acting to everyone as if nothing was wrong even though she had psychosis. She talked about people never being around when she needed them, and this was clear in her narration of living those few weeks of her psychosis with her mother and father-in-law. She acknowledged how ill she was at the time, yet it appeared that no-one really understood the severity of her illness. When they did begin to understand, they were frightened of her, following stereotypical explanations from the medical team.

The women experienced a sense of abandonment, some from intimate partners (Lucy, Jane, and Julija), parents and family (Lucy, Jane, Julija and Sarah), and also from the medical profession who seemed to offer little help to any of the participants (Shoshana, Jane, Julija and Sarah). There was also the need to show a 'brave face' to the world and continue as if all was well. This behaviour is supported in other research studies. Tobin et al. (2018) found that in particular

women of immigrant or refugee status hid their illness due to the fear of their status, and of their baby being removed from them. Bennett et al. (2007) found that women in their study described 'putting on a happy face' as a way of keeping their level of denial and delusion going.

### 11.2.3 Health anxiety

In this study, the term 'health anxiety' was used by both Lucy and Jane to describe their mental illness. Although neither of them speak of this terminology as given to them by their doctor or midwife, this may have been the way their symptoms were medically described. Both became fixated with their health and this gave them growing concern as their illness progressed. This concern transferred into increasing levels of anxiety, culminating in panic attacks for Lucy and psychosis for Jane. For Jane, this manifested itself in a conviction of believing she was about to die, when she was experiencing psychosis. Lucy did not express her health anxiety in such a heightened way, yet she did talk about how she felt she could not go on. For Lucy, this did not seem to be suicidal ideation, it felt more like Lucy expressing that her body and mind could not cope with the level of anxiety she was experiencing at that time. There does not appear to be any literature that acknowledges or explores health anxiety as a symptom of perinatal mental illness. Yet, the findings from Lucy and Jane suggest that health anxiety may well be a symptom.

### 11.2.4 Madness

Three of the participants (Lucy, Jane and Sarah) talked about feeling a kind of 'madness' within their symptoms. Lucy and Sarah expressed it as:

Lucy: *"the madness of thinking"*

Sarah: *"an extraordinary madness"*.

Jane acknowledged that her behaviour was highly distorted and abnormal and used the term 'psychotic' within her narrative. Lucy's and Jane's interviews revealed similarities in behaviour and the way they both spoke in a pressured way, extremely fast, and in Jane's case with few pauses for breath. This felt at the time like their way of showing just how this "madness" manifested itself within them. Sarah's interview, however, was not pressured or hurried, and the length of time between Sarah's experience and her interview may have had some bearing on this. She also acknowledged that she had received a great deal of therapy over many years for her perinatal mental illness. Such feelings of 'madness' or being 'psychotic' support other research, which discovered similar themes and were often narrated as intrusive thoughts and visions. Stone and Kokanovic (2016) found that these intrusive thoughts were described by the

women as distressing and different qualitatively to other types of thoughts, and were experienced as intruding as the women claimed not to have consciously generated them. Beck (2002) in her metasynthesis also found that women experienced intrusive thoughts, which often continued to the point where the women found them intolerable, leading to compulsive behaviour. In her research she found that women were unable to control these thoughts and would often question their ability to mother and their fear of harming the baby or being harmed themselves, or would worry unnecessarily about the baby. Bennett et al. (2007) found women also used the term “going crazy” as a descriptive way of expressing a sense of total loss of control that they felt when depressed during pregnancy. Tobin et al. (2018) found that some of the refugee and immigrant women in their research used the terms crazy and ‘loco’ to describe their symptoms.

#### 11.2.5 Emotional extremes

All five participants described emotional extremes within their narratives. These led to them feeling overwhelmed by their emotions and unable to cope. The only exception was Jane who did not talk about her extremes of emotions as such, but talked about her psychosis, which is the most extreme on a continuum of emotion. Lucy’s experience resonates with Jane’s with many similarities in their experiences, yet Lucy was not diagnosed with psychosis. Her narrative and the pressured way she spoke in her interview, however, suggested that Lucy’s experience could have been on the borderline of psychosis.

Some examples of the extremes of emotions expressed in the narratives are: fear, anxiety, madness, abandonment, antipathy, devastation, perfectionism, grief, frustration, guilt, shame, stigma, trauma, burn out, and isolation.

Feelings of being overwhelmed are corroborated in other research studies into perinatal mental illness. Abrams & Curran (2009) found that the core symptom of postpartum depression was “mothering is overwhelming” (p359). Coates et al. (2014) in their phenomenological research into postnatal distress found that being overwhelmed was part of the psychological process that maintained and characterised their distress. Gao et al. (2010) also found the first-time mothers in their research felt overwhelmed, due to physical and emotional exhaustion. Chan et al. (2009) in their comparative study on the experiences of Hong Kong Chinese women and Australian women, found that the women experienced emotional extremes such as shame, fear, anxiety, guilt, panic, suicide, dual reality and homicide. Bennett et al. (2007) in their research into how women make sense of their depression in the antenatal period found women used extremes of language to express their sense of despair at their illness.

### 11.2.6 Seeking help at crisis level

All five participants demonstrated different ways of seeking help at crisis level. Jane, in particular, fitted this description, yet she was the one participant with professional knowledge of perinatal mental illness and psychosis. She struggled to ask for help because of her sense of shame and stigma. This prolonged her silence, and her need to externally project a façade of being ok, when she was not. This was also a factor in her difficulty in asking for the help she needed through her miscarriage and with her son's difficulties after he was born. This was due to a sense of failure as a mother. Slade et al. (2010) highlight that women struggle to admit they need help due to an implied sense of failure.

Sarah also chose to remain silent and not seek help until she absolutely had to admit her illness to her husband. She was afraid that this would cause her husband to abandon her and take their children away. This fear was so intense that it was a precipitating factor in keeping Sarah silent for three years. Fear of losing a child due to mental illness is supported in a great deal of research (see Bennett et al., 2017; Bilszta et al., 2010; Boots Family Trust Alliance et al., 2013; Byatt et al., 2013; Edwards & Timmons, 2005; Jarrett, 2016; Knudson-Martin & Silverstein, 2009; Mollard, 2014; Nakku, 2016; O'Mahen et al., 2015; Staneva et al., 2015; Stone & Kokanovic, 2016; Tobin et al., 2018). Also an inability to disclose feelings due to cultural obstacles, or difficulty in admitting their illness to family and friends is highlighted in research by Button et al. (2017).

Julija had sought help when she was unwell after her first child. However, she did not seek help for perinatal mental illness, she sought help for burn out when it was at a level that prevented her from working for about six weeks. She initially attended Imago therapy, although she said that it was not altogether satisfactory for her. She also did not initially seek out help for the guilt and shame she felt after taking medication when pregnant with her second son. It was not until he was nine months old that she went back into therapy. This may well have been due to a sense of shame and stigma. Button et al. (2017) found that if women perceived that speaking about their difficulties would engender such feelings they would remain silent. Foulkes (2011) also highlighted how women would not seek help due to stigma, but also how women feared medication and the effect this would have.

Lucy sought help relatively promptly in her second pregnancy and saw a CBT therapist, although she felt that the help it offered her was limited. Once she stopped seeing the CBT therapist, she began to see her TA therapist soon afterwards, so she did not struggle to seek help. She did acknowledge that she was also unwell in her first pregnancy, yet she had not sought help at that time.

Shoshana also seemed to fit the criteria as she only went back into therapy after experiencing a significant panic attack about two months after giving birth.

From the literature in Chapter 2 it is known that women have an inability to seek help, unless at crisis level. Bilszta et al. (2010) in their qualitative study highlight significant beliefs and attitudes as barriers to care, such as denial and lack of understanding of the seriousness of symptoms. These beliefs and attitudes have an effect on a woman's ability to seek help. Tobin et al. (2018) in their research on refugee and immigrant women's experiences found that guilt, fear and shame prevented women from seeking help, which was further compounded by a feeling that they should be able to cope. These women only sought help when their symptoms became so bad that they had to admit to them to a close relative or friend, who invariably encouraged the seeking of help. Tobin et al. (2010) also found an unacceptability of medication for their symptoms, which they found led to "hidden non-adherence" (p98). Factors behind this are covered more extensively in the section on barriers to treatment (11.4).

#### 11.2.7 Masks

Two participants specifically talked of using 'masks' to hide their illness (Lucy and Sarah). However, Jane and Shoshana also alluded to 'masking' their illness. Lucy's object, a poem called 'Masks', was particularly resonant. Sarah spoke about the need for a mask "*to pull the wool over people's eyes*". For both, this was very much a need to hide the real self, with all the stigma and shame, embarrassment and guilt, pretending to be someone else and hiding behind a persona. Three other studies also highlight how women wear a mask with this illness: Bennett et al. (2007), Chan et al. (2009) and Patel et al. (2013). Bennett et al. (2007) found that women were in denial and tried to hide their illness by putting on a happy face. Chan et al. (2009) found that in particular the Australian women in their research put on a mask in order to try to keep up the 'Madonna' image to hide the truth of their illness.

Jane also spoke about pretending to be ok, when in fact she really was not ok. Shoshana did not directly speak about masking herself, yet when she talked about feeling suicidal, "*it happens*", it seemed she was discounting just how difficult her experience had been, to the point of her feeling suicidal. This was glossed over by Shoshana within her interview, and it was only afterwards that the sense of the depth of her struggle materialised. The mask was also of gallows laughter, which all of the participants used at least once in their interview. Feeling as if the only option left is one of suicide was also found in research by Chan et al. (2009).

### 11.3 TA psychotherapy

All the participants said they found their therapy useful. Those aspects that the participants highlighted as particularly relevant, which were TA specific are highlighted below. Several participants also spoke of the way in which these elements blurred together and impacted each other.

TA is a style of psychotherapy with no pre-conceived treatment plan, the therapy is suited to the individual. This personalisation is useful and a critical factor in engagement in treatment for perinatal mental illness. TA also looks backwards into the past to give meaning to the present. Each participant spoke of the way in which their therapist explored the past, using past relationships and historical mental illness as a way of 'unlocking' the present perinatal mental illness. In this respect, past history became a critical part of treating the illness.

#### 11.3.1 Addressing the cause of illness

All the participants said they found the way TA addressed the cause of their illness, rather than the symptoms, was one of the most important aspects in the success of their therapy. This suggests that symptomatic relief, although useful, may not be the prime reason for women to choose psychotherapy. Several of the participants actually stated that symptomatic relief was not enough. This may highlight why CBT, which targets symptomatic relief, is not always found to be satisfactory by women for this type of illness, as was attested by three of the participants, (Lucy, Shoshana and Jane) all of whom had received CBT prior to TA.

Lucy and Shoshana both spoke about the differences they experienced between CBT and TA therapy, stating why CBT did not work and why TA was more helpful for them. Jane also felt strongly about the difference between CBT and TA, even describing CBT as "*rubbish*". She said that in TA therapy she discovered: "*you need to look underneath, about what's going on [...] and probably part of my erm [...] the process I went through [...] has got so much to do with my parents, or that lack of parenting, and it's just, it's so powerful*". In acknowledgement of the change this had made to her she said: "*it's made me be kind to myself as well as to other people*", "*I think differently*", "*TA has helped me to think about [things] differently*", "*its made me a better mum compared to what maybe I would have been if I hadn't done the therapy*".

Shoshana also mentioned that TA addressed the cause not the symptoms, unlike CBT. Shoshana said several times how helpful her TA therapy had been: "*we both found it extremely valuable and I think, I think we both feel quite a lot of gratitude actually towards [the therapist]*".

Julija spoke about her need to go back into her past, because it was this that she believed was the cause of her mental illness not only in the perinatal period, but throughout her life as well. Her second son reached the age she was when she was hospitalised as a child and she experienced intense sorrow but did not understand why. She said that her therapist helped her grieve for the child she was at that time, in hospital alone without her mother: *“the therapist led me back to that little girl”*. She also said that with her TA therapy the anxiety she had experienced throughout her life then diminished: *“I wouldn’t even say I was ever anxious now”*.

### 11.3.2 Identifying needs

Another element of the therapeutic process highlighted as helpful by all participants was being encouraged to identify what they needed in the moment and then being encouraged to ask for it, which is a fundamental part of the TA therapeutic process.

Shoshana recognised that understanding her needs and being able to address them were a fundamental way of unlocking her relationships: *“Identifying what I needed in the moment and helping with the steps I needed to take to get it”*.

Julija also spoke of how she had learned to give herself permission in the moment to ask for what she needed.

### 11.3.3 Relationships

Another significant factor that all the participants talked about was the positive effect their therapy had on their intimate and familial relationships.

Lucy said that TA addressed her sense of lost identity and enabled her to find out who she was again. But it was the change in her relationships with her husband and mother that she talked about the most, and these changes appeared to be the most significant elements of her therapy. It is her final statement that substantiated the significance of TA for her:

*“[It’s been] massively powerful, it’s given me a new way to look at the world really and myself, which I just really needed”*.

For Shoshana it was the relational element of TA that was most helpful: *“[it was] massively helpful to be in a session with John”*. Discussing her relational interactions in therapy helped her unlock her relationships and was the basis for a deeper, more personalised relationship with her husband. She described the



process of this as breaking down her narrative around anxiety and relating it back to past experiences, which hinged around her relationship with her parents and their fights during her childhood.

Julija said that she found the relationship she had with her therapist helped her to learn how to be in other relationships. She gave an example of being angry with her therapist and how this helped her to unlock her need to express anger with her boss at work.

Sarah's experience was that her TA therapy had allowed her to understand the underlying causes of her relationship difficulties with her daughter Sally. For Sarah it was the wealth of information in TA that she found so helpful which helped her to make sense of her relationship with Sarah, and to find a way they could operate more effectively together: *"I just think it gave me a hugely greater understanding"*.

#### 11.3.4 Durability

This study suggests that TA is a style of treatment that can offer a sense of endurance in treatment, as all participants were interviewed several years after their experience. This gives some sense of the durability of change effect in TA psychotherapy, although this would need to be corroborated with further studies.

Lucy and Shoshana highlighted the durability of their therapy, with Shoshana saying that addressing the cause of her illness had led her to a more significant and sustainable level of relief: *"I haven't had anything like that huge panic [...] that really has been a huge shift"*. For both it had been several years since their experience of perinatal mental illness and their therapy for this, although Lucy is still in group therapy, but stated that this was not about her illness. Julija also had found the therapy durable, and is also still in group therapy, but again said the her illness was not a part of this group therapy. For Sarah the durability was the most significant factor as the positive effect had endured for 40 years

#### 11.3.5 A good therapist

Another factor expressed was the way in which each of the participants valued their therapist and the process of therapy. In particular, Lucy stated her therapy was *"massively powerful"*. Shoshana and Sarah both said that their therapist was better than previous, and both of their comments are attestive of the skill of the therapist:

Shoshana *I've seen a lot of therapists, and by far and away he's the best I've ever seen*

Sarah *She was much better [than the psychoanalyst] I have to say. She was much better*

For Julija it was the recognition she received from her therapist that was so crucial to her and allowed her to let go of her need for perfectionism. She described her therapy as “hard”, “powerful” and “precious”.

### 11.3.6 Transgenerational trauma

The mother-infant bond is one of the most intimate bonds within humans and is now shown to be crucial to the development of the infant's brain and sense of identity (Schore, 2003). It is possible that this lack of bond, inability to bond, or a mother's perceived lack of bond with their baby reinforces and heightens the mother's sense of mental illness. If the mother was not mothered herself due to her own mother being unwell in the perinatal period, a system of trans-generational scripting may have passed from grandmother to mother and could now be passed onto the infant. Within TA this is identified within the theory of trans-generational trauma (Noriega Gayol, 2016), which identifies how scripts could be handed down from one generation to the next, for example alcoholism (p312) and possibly perinatal mental illness. Advances in neuroscience and epigenetics are beginning to scientifically suggest the mechanisms for this passing down through the generations of illness and affective states. Yet they are both still in their infancy and so conclusions might be premature.

## 11.4 **Known barriers to treatment**

Stigma, shame and silence are known to be significant barriers to treatment within perinatal mental illness and were voiced by all five participants within this study. They are also prevalent within the majority of research studies identified within the literature review. The way in which the findings within this study relate to the existing literature are discussed below.

### 11.4.1 Stigma

Only one participant (Sarah) specifically named the stigma she felt. Yet all the participants, although not directly naming stigma, spoke of behaviour which corresponded to research on stigma in perinatal mental health.

Sarah *“Certainly 40 years ago I attached stigma to myself, I thought this is frightful. What a terrible thing”.*

Sarah saw perinatal mental illness as a 'stigmata', because it left a 'wound' on both her and her daughter Sally, which neither have recovered from. This highlights the way in which she described being 'attacked' by her illness:

*"Oh well that's being wounded, you are wounded by a stigmata aren't you?"*

This corresponds with the way Goffman (1990) refers to a human with stigma as someone who is so marked as to have a 'blemished' and essentially 'polluted' status.

Two other participants (Jane and Julija), alluded to stigma in their interviews. It was clear that Jane was affected deeply by the stigma she perceived from her husband and family, and her work colleagues. She talked about her difficulty in asking for help, her sense of abandonment by her family and the medical profession and her sense of isolation and fear. Her stigma was so strong that she eventually left her job working in mental health in the NHS. This sense of stigmatisation is corroborated in many other research studies. Bilszta et al. (2010) also found that perinatal distress was viewed as stigmatising by women experiencing it. Tobin et al. (2018) found that the stigma of being mentally unwell was so great within immigrant and refugee women that it prevented the women in their research to admit to being unwell even to their close friends and relatives. Myors et al. (2015) found that stigma was a significant factor in the ambivalence women felt towards asking for help, even though they might know they needed it. Goodman (2009) found that perceived stigma was one of the strongest barriers to women obtaining professional help for depression and anxiety.

Julija also did not specifically name stigma within her narrative, but she named her need for perfectionism in the way she mothered. Her perceived lack of attaining this perfection led to her behaving in ways that correlate with stigmatisation. Staneva and colleagues (2015) found that many women described motherhood as being situated in a position of perfection, which those women found unattainable. This may be due to the 'myths' around motherhood, perpetuated in society (Bilszta, 2010; Knudson-Knight & Silverstein, 2009; Tammentie et al., 2004). Childbirth is supposedly a joyous occasion. Popular interpretations portrayed are of smiling, giggling, clean babies, with responsive, happy and contented mothers interacting with their infants. The joy of motherhood is a myth continuously perpetuated throughout society with expectations that couples will want children, and that those children will be loved and cared for in the best possible manner. If a woman is unable to perceive her life as a mother as living up to such expectations, she is quite likely to feel a sense of stigma and shame about not attaining such perfectionism, and

remain silent and unable to reveal her illness. Tobin et al. (2018) also found that women felt they should 'know' how to cope with their baby, and felt shame and stigma from admitting they were struggling to cope.

Lucy highlighted another element of stigma, which is spoken of in other research studies. She spoke of her need to "*get away from*" which she narrated early in her story. This was a need to escape from people, but also to escape from her own thoughts and emotions, which heightened her anxiety and increased her sense of panic, leading to her panic attacks. Staneva et al. (2015) noticed that the difference between the real and perceived experience often left women needing to "*get away from*" (p568), causing them to isolate themselves physically, emotionally and socially. Stone & Kokanovic (2016) also highlight this need to escape. This is highlighted by qualitative research into experiences of depression and anxiety in the perinatal period, which found women needing to isolate themselves, with thoughts of "*leaving and escaping*" (Highet et al., 2014, p182), as well as feelings of hopelessness and helplessness. Again, Lucy spoke of her hopelessness within her narrative. These types of emotions, and the corresponding behaviours emanating from them, are supported within other qualitative research (Bennett et al., 2007; Chan et al., 2009; Patel et al., 2013). It is this isolating behaviour that may be the most crucial factor stopping a woman from speaking out, seeking help, remaining compliant within treatment, and getting better. Even though the participants may not have talked about stigma specifically, the way in which they talked about their mental illness, being unable to speak about it, remaining silent, and isolating themselves indicates a level of shame they felt, which may be due to the stigma of perinatal mental illness.

Stigma is a significant barrier to treatment (Edwards & Timmons, 2005; Staneva et al., 2015; Tobin et al., 2018), and is thought to lead women to non-disclosure of their symptoms and to self-silencing (Coates et al., 2014). It affects self esteem, disrupts family relationships, and causes people to limit their ability to socialise, find a job and house themselves and "*many people with mental health problems choose not to engage or maintain contact with mental health services due to stigma and discrimination*" (WHO, 2013, EUR/RC63/11 p 2). Stigma and discrimination are part of the WHO priority areas to address in relation to mental health, not just perinatal mental health, as they remain significant barriers for seeking help. There is a need for a significant cultural shift in the way that mental illness is perceived and treated, for this stigma to begin to subside.

However, research by Phillips & Thomas (2015) may show the beginning of change in the cultural shift of stigma in perinatal mental health. They found that mothers they interviewed were generally positive about talking about their mental health. If women are beginning to find it easier to voice their experiences

it is a welcome change. The participants within this study seemed able to speak about their illness. However, it was not easy for each of them to do so.

#### 11.4.2 Shame

Three participants (Jane, Julija and Sarah) talked about the shame they felt of being unwell. Lucy, although not actually calling it shame, alludes to this feeling in many parts of her story. For example, she describes about the mask she wore to prevent anyone knowing how she was feeling inside, and how she remained silent and isolated herself from friends and family, as she said she was unable to admit how she was feeling during this time. Jane spoke about feeling guilt and shame in several parts of her story. It appeared to be that her sense of shame was heightened by her experience of returning to work in the NHS in mental health. She said she felt significant shame around admitting her illness and found it difficult to speak about it with colleagues. However, she said it was also the way she was treated by colleagues and throughout her experience of giving birth and going through puerperal psychosis that enhanced this shame. This has had such an effect on her that she is now unwilling to admit her experience, in case she is labelled and treated as 'psychotic'. This should be a concern for those working within the NHS and aligns with the findings of other qualitative studies, which found a lack of training and knowledge within mental health professionals, GPs, midwives and health visitors (Button et al., 2017; Byatt et al., 2013; Foulkes, 2011; Jarrett, 2016; O'Mahen et al., 2015; O'Mahoney et al., 2012; Nakku, 2016; Slade et al., 2010). There is a need for consistent and thorough training and education among health care providers, particularly those working within mental health. This is important to eradicate stereotyping and out-dated views and behaviour which should not be acceptable within any healthcare system.

Shoshana was the only participant who did not talk about shame within her narrative. This may be due to her familial experience of therapy. She said her parents went to both personal and couples therapy throughout her childhood, therefore she may have an acceptance that mental illness can be a part of life. It is also possible that her culture and religion played a part in this acceptance.

DeYoung (2014) approaches shame from a relational and neurobiological perspective and believes that shame is actually physical, that it hurts and that the pain of shame can be unbearable. In her research on shame she discovered that people push it away as fast as possible and cover it with more tolerable states of being. However, when a person covers their shame, they are actually compensating, by using masks, or '*sleights of mind*' (DeYoung, 2014). Those people are pretending to be something or someone that they are not. DeYoung (2014) believes that people do this because they believe that there is actually

something wrong with them: *“Shame is an experience of one’s felt sense of self disintegrating in relation to a dysregulating other.”* (DeYoung, 2014, p xiii)

By using the term ‘dysregulating other’ DeYoung (2014) implies that shame is a relational experience. She believes it does not happen to a person alone, it depends upon the ‘other’ who responds in a negative way, causing the human psyche to feel an intense, unpleasant experience of non-acceptance. This, she believes, can cause the psyche to fragment. DeYoung (2014) sees this as relational trauma which then engenders self-protection mechanisms within the person, such as impaired capacity for connection (Heller & LaPierre, 2012). This experience of self as mis-attuned to, or mis-attuning may cause humans to believe things about themselves that are faulty or not real. It is shame about self that causes a human to cover up, or mask their real self. Heller and LaPierre (2012) show how early trauma, such as feeling unwelcomed, rejected, unlovable, bad, wrong and sometimes not quite human gives rise to conscious and unconscious shame-based identification (p 125). For women in the perinatal period this is of primary importance, because the infant of a mother with mental illness could grow up to feel rejected, unlovable, bad, or wrong, because of the mother’s significant ill-health.

#### 11.4.3 Silence

Silence was a barrier for four of the participants (Sarah, Lucy, Jane and Julija). Sarah remained silent about her illness for a period of three years. Jane also remained silent about how she was feeling throughout her experience of a traumatic birth and for four weeks afterwards. Jane said that her family were ‘clueless’ about the depth of her illness. She found it difficult to share her experience within her work environment and so remained silent, only speaking to her boss about it towards the end of her time working within mental health in the NHS. She also found herself unable to complain about the way she had been treated both in her experience of childbirth and miscarriage. Julija told very few people about her fear of the damage antidepressants may have done to her second child. Unfortunately, she did tell her mother who dismissed her fears and told her not to be overdramatic. Lucy initially hid her illness from her mother and her husband. She felt her husband did not fully understand how unwell she was until he finally accompanied her to the GP who confirmed her illness. Only Shoshana did not remain silent, seeking help immediately she had her first major panic attack after giving birth.

Silence is a part of perinatal mental illness highlighted in the literature in Chapter 2. Derrida (2000) invites researchers to interpret silence within their research by saying *“What I don’t want to say or cannot, the unsaid, the forbidden, what is passed over in silence, what is separated off... - all these should be*

*interpreted"* (p12). The silent elements of this research were important to be interpreted, as within the literature and in this study silence contributed to the length of time women took to seek help. Mauthner (1999) states: "*Postpartum depression occurs when women are unable to experience, express and validate their feelings and needs within supportive, accepting and non-judgmental interpersonal relationships and cultural context"* (p. 160). In much of the literature reviewed silence is a significant problem, with women silencing themselves due to stigma, shame, guilt and embarrassment as well as due to a fear of losing their infant (Boots Family Trust Alliance et al., 2013; Buultjens & Liamputtong, 2007; Tobin et al., 2018). Silence is a prevalent feature of perinatal mental illness and a compounding problem for diagnosis.

Jack (1991; 1999) wrote an influential model on silencing the self (STS) after a longitudinal study of the description of the experience of clinically depressed women. These women detailed how they actively silenced themselves in order to maintain their relationships, to maintain their own physical or psychological safety and also to avoid conflict, (Jack, 1991; 1999; 2003). She found that this self-silencing was in fact a deeply cultural process, which led to women feeling a loss of self, and feeling lost within their own lives. The narrative from Jack's research was of silencing self due to depression caused by a sense of norms, prescribed values, and images of how women should be, from a male-centred world, leading these women into a position of shame, desperation, and anger from their sense of entrapment and self-betrayal.

As silence is such a fundamental part of perinatal distress, it seems plausible that there may be a similar form of self-silencing occurring. Jack uses many aspects of psychological theories – attachment theory, relational theory, and cognitive theory, to substantiate her argument of the vulnerability of women to depression, through a lack of intimacy (1991, 1999). Disconnection and isolation, again language that is used in perinatal distress, were precipitating and maintaining factors in her work on depression. She highlights the interconnectedness of personal, cognitive, social, and biological, and the particular threat relational disconnection constitutes to the self, helping to show how relational disconnectedness, mother to infant, may also exacerbate perinatal mental illness, and increase an infant's susceptibility to life-long mental illness. Staneva et al. (2015) in their meta-synthesis of qualitative research support this concept of self-silencing, particularly if the woman felt isolated or misunderstood by their partner. This silence then had a profound impact on the woman's emotional state through pregnancy, birth and postnatally.

Shoshana did not remain silent in her illness. She said she was able to speak to her husband, her family and also her GP with no shame or stigma. This was a surprise and may well have been due to having received therapy before and

throughout her pregnancy. Button et al. (2017) found that if a woman had previously experienced mental illness this helped them to ask for help. It also may have been due to Shoshana's religion and culture, both of which promote the family. She spoke of how close she was to her mother and sister and even spoke of sharing information about her therapist with them.

### **11.5 Facilitative factors for engagement in treatment**

The relational dyad of client and therapist was central to the success of therapy for all participants in this study. Length of time with that therapist, or a relationship prior to perinatal mental illness, did not seem to change the potency of this dyad. One participant (Shoshana) already had a significant relationship with her therapist, due to her attending couples therapy with her husband before and during pregnancy. Shoshana said this relationship was important and facilitative for her. Jane also had a relationship with her therapist prior to experiencing puerperal psychosis. Although, in Jane's case, this prior relationship enhanced her shame, as she struggled with the knowledge of her behaviour towards her therapist during her psychosis. Lucy, Julija and Sarah did not have a relationship with their therapist prior to their mental illness. However, all participants highlighted the importance of their therapeutic relationship, and the influence it had on their therapy. They all narrated the sense of relief they felt once they embarked on their therapeutic journey. Coates et al. (2009) also found that the therapeutic alliance was fundamental to enabling the women in their study to make the personal changes necessary to help them in their perinatal mental illness. Myers et al. (2015) found that it was a relational model of care, providing the sense of trust in the therapeutic relationship that was a facilitative factor in a women's engagement. Trust as a facilitative factor is also highlighted by Dennis & Chung-Lee (2006).

The style of TA therapy did not seem to be particularly significant as a facilitative factor. This was because all types – one-to-one, couples and group therapy - were all experienced by various participants, and the type did not seem to indicate a change in the significance of the outcome. All types were deemed to be helpful.

The relevance of the modality of therapy may or may not have played a part in compliance in treatment, but this was not an aim of this study. However, TA may have provided an environment in which the specificity of perinatal mental illness, an important factor in a woman's engagement in therapy as mentioned earlier, was incorporated and met. All of the participants said that TA had helped them. It is also plausible that any style of psychotherapy may work well, as long as it places the therapist/client relationship at the heart and addresses the specificity that the client needs.



Language and the ability to narrate experience is particularly human, yet perinatal mental illness seems at times to be non-narratable (Butler, 2001). This suggests that the transformation of identity in maternity is held at both a conscious and a pre-conscious (non-narratable) level. This study was not a psychoanalytic study, and it was not an aim to unpick this. Yet narration is relational and it is in relationship that women seem able to find an audience or an 'other' to co-create or co-constitute their selves to give them meaning. The participants were able to narrate their experience to their therapist because they wanted to be heard and knew at some level that this might allow them to get better. The participants could also continue this 'co-creation' within their interview. Language seemed to hold significance in two ways within this study. The first was the way the participants used rich and descriptive words for their illness to highlight the extremes of their fear and emotion, such as: *"horrendous"*, *"horrific"*, *"extremes"*, *"awful"*, *"terrifying"*, *"madness"*, *"enormous fear"*, *"traumatic"*, *"so much sorrow"*, *"crazy"*, *"toxic"*, *"mortified"*, *"neglected"*, *"devastated"*. All of their descriptions help to highlight the depth and breadth of experiences and offer a sense of why it is so important to treat this illness.

The second significance was the TA language used within the interviews. This indicated that TA offered an easily understandable, 'shared' language which the participants found useful to make sense of their experiences. It offered a new, more expansive language, which the participants speak of as facilitating their process of change. This is explored more deeply in section 11.9.

### **11.6 Specific time points of illness**

The majority of study participants experienced few symptoms during pregnancy, with three out of the five experiencing no symptoms until the postnatal period (Shoshana, Sarah, and Jane). Two of the participants (Lucy and Julija) did experience symptoms within the antenatal period, and these continued into the postnatal period. A greater understanding of illness at different time points would be helpful to target women at the most beneficial time of their illness, possibly even prior to illness, as a connection to past history is now being evidenced (Bowen et al., 2009; Faisal-Curry et al., 2009; Rubertsson et al., 2014).

### **11.7 Past history of mental illness**

The final objective was to gain a greater understanding about prior mental health conditions and what part these play in women's perinatal mental ill health. This would add to the existing knowledge. The majority of the participants in this study experienced mental illness or trauma in their past. Sarah was the one exception, yet she alluded to it within her narrative by saying:

*“Yes there is all sorts in my childhood, but then there is all sorts in lots of people’s childhoods”*. The type of mental illness or trauma differed between participants. Nevertheless, it was significant that the majority had this past history, and that the historical mental illness seemed to correlate to the manifestation of mental illness in the perinatal period. Research from Coates et al. (2009) supports this finding as their qualitative research study of women accessing a perinatal and infant mental health service in Australia found that 41% of their participants disclosed having had prior mental health conditions, although researching prior mental illness was not an aim or objective of their research. Other research by Ugarizza (2002) also found that women admitted to having had similar symptoms in the past. Choi et al. (2017) discovered a link between childhood trauma and postnatal depression and Patton et al. (2015) also showed that many women with perinatal depression had mental health conditions prior to pregnancy. With the present study also highlighting a link, it would now seem pertinent to increase the scope of perinatal research and study the incidence of a past history.

Shoshana’s interview also highlighted the possibility of historical childhood trauma being resurrected in the partner or father, as well as the mother. Her husband John experienced what Shoshana depicted as a *“flooding back”* of negative childhood emotions, such as anxiety and depression, when his daughter was six months old. Research into the significance of childhood trauma for both partners would be helpful in order to highlight any significant findings.

## **11.8 Method**

One of the motivating factors in this study was to understand what it was like for each participant to live with perinatal mental illness and in particular, the way in which their treatment might or might not have met their needs. Both of these motivating factors were met. Another gain from the study was the participant’s dialogue between self - *“who am I with this illness”* - and society - *“who do others think I am with this illness”*. This is not new in the context of perinatal mental illness. What is new is to gain knowledge of how the TA psychotherapeutic process helped to alter and evolve this sense of *“I”*.

### **11.8.1 The creative method**

A positive part of the method was the contribution the ‘object’ gave to this sense of *“I”* and how this contributed a visual and often vivid way for the participant to show the audience (the researcher) who she was and the impact this had on the study data. Lucy’s poem *“Mask”* was a particularly vivid depiction of how she felt during her experience of illness. Without this poem it is probable that she would not have shared how strong her experience of wearing a mask was. Even though

it was several years since her illness it was clear this still impacted her, by her narration of the poem and workshop. Her choice of one line in the poem captures the literature findings of women's experiences, in particular the fear women have of being 'found out' or recognised: *"I panic at the thought of my weakness and fear of being exposed"*.

The memories, shared by both Shoshana and Sarah of their infant's first gaze, are particularly poignant and unusual. They narrate the sense of a new born infant knowing and yet not knowing its mother in that very first instance of bonding. The intensity of the gaze, which both participants mentioned, was also pertinent, and may highlight the perception of a lack of such a gaze or recognition from their own mothers. This 'lack' was voiced by Shoshana: *"I'd never been seen that way before"*. The mother-infant gaze is known to be powerful, allowing for a transfer of positive hormones that aid the bonding between mother and infant. For both women that first gaze was an important moment in their intimacy with their newborn. It may have been a first moment of connection they both sought. It is doubtful whether these participants would have shared something so intimate if the interview had not included the creative element, allowing them to offer their memory as their object.

Jane's teddy bear also held resonance for this study and was a graphic and striking object. It was the jumper on the teddy that held such resonance because it stated Jane's yearned for need: *"I've had special care"*. Jane did not go into a mother and infant in-patient psychiatric unit when she experienced puerperal psychosis. Instead she stayed at home even though she was psychotic. She clearly stated how isolated and abandoned she felt within her illness, mainly due to her family misunderstanding and not comprehending the depth of her illness. It was only when she and her husband were able to stay with her parents-in-law that she said she finally received some care. It is easy to underestimate the depth of puerperal psychosis, how frightening it is for both the mother and her family. In her narrative Jane clearly stated that she had not at first received the level of care she needed.

Julija's collage was also pertinent to perinatal mental illness as it pictorially depicts her story of her experience. She had originally made the poster for a group therapy session and said that presenting it to the group had been a crucial experience for her because the group participants and therapist recognised her distress and fear, and this recognition was Julija's need above all else. In particular, it was the empathic attunement from the group that was so crucial.

### 11.8.2 Analysis

The Listening Guide style of analysis offered many advantages to the study. In particular, it was pertinent because it encourages the researcher to enter a journey of discovery, to listen underneath the narrative in order to seek out marginalisation and oppression, or to be able to hear those who are rarely studied (Gilligan, 2015). All aims of this study. It is a method of analysis that invites a deeper listening, tuning in to the rhythms of narrative, what is left out of the narrative, as well as emotional hotspots and metaphors. Woodcock (2012) added to Gilligan's method by also encouraging the researcher to look for contradictions, omissions and revisions as well as silence and silences within the narrative. This allowed aspects of the analysis to become apparent, such as:

- How Jane contradicted herself when she said *"I am not an anxious person really"*, then went on to say that her puerperal psychosis began with *"health anxiety"*.
- The members of Julija's family missing from her narrative. Her father did not appear in her interview much at all. Lucy's husband and her first child, are virtually absent too.
- The revisions Shoshana made throughout her narrative, revising "I" to "we" such as: *"then I, we occasionally did a few sessions separately"*

The second part was an in-depth analysis of the "I" statements in each interview. This made it easy to determine the most significant statements, the ones that were used most often and those used sparingly. This helped to emphasise Lucy's statement of *"the madness of thinking"*, as her most prevalent "I" statement was *"I think"*. These "I" statements also helped to highlight the temporal movement of the participants' narratives and highlighted when there was no forward movement, for example Jane whose statements were chaotic, moving backwards and forwards between various aspects of her story, which was disjointed and difficult to follow. This seemed to echo her experience of how traumatic puerperal psychosis had been. Indeed her most prevalent "I" statement was *"I was"* which gave her narration a sense of being caught up in the past of hopelessness, dejection and helplessness. This was surprising, as the other participants changed their speech towards more positive statements and the present tense in the latter half of their interviews. These "I" statements also brought out Shoshana's depiction of suicide showing how she dissociated herself from her feelings. Pinpointing this in her statements gave depth and clarity to her feelings of suicidality. The "I" poems also highlighted how positive Julija's and Sarah's narratives were. Both used the present tense more than the past, and this showed how both of them had come through their illness and seemed to be over their experience, looking forwards in their lives.

The third element in the analysis, listening for the “other voices” in the narrative offered an insight into a TA theory called Ego states. This analysis style provided a way of searching for and ‘hearing’ a person’s different ego states speaking. This was novel and had not been researched before. This enhances TA theory and actively highlights the different voices within a person’s psyche. It would be useful to study this more fully to ascertain the elements that will enhance theory.

### 11.8.3 Reflexivity

Reflexivity causes vigorous debate. It has been heralded as the way to give qualitative research integrity, and yet others talk of the ‘myth of neutrality’, the ‘God position’ or the ‘myth of authenticity’ (Speedy, 2008). Therapist-practitioners, as Speedy (2008) points out, already fill their professional lives with attention to discourse - what is said, what is not said, what is left unsaid, what is said between - this is their daily life. They uncover meaning by “*excavating the traces of other discourses contained therein*” (Speedy, 2008). Reflexivity is a part of therapy.

Reflexivity in this study has been used to open up the space between and within dialogue. Creativity, and the creative object have sought to bring out, open up, and find space within the narrative, which would not have been found without this element. The readers have not been ‘told’ what to think about the participants and the narratives have been left in their original form, with large chunks shared to keep transparency within the dialogue. This is to invite the reader to make up their mind, rather than rely on the researcher’s interpretations. For some researchers, coherence of narrative is their criterion for good narrative research (Riessman, 2013). Yet coherence of narrative relies on the participant being coherent in their story. Within this study all participants, apart from Julija, lost coherence at times, as did the researcher. In particular, Jane’s story was more like a chaos narrative (Frank, 1995) and manages to convey the level of trauma she felt from experiencing psychosis. If coherence of narrative, continuity and temporal sequencing are considered the framework for a good narrative study then this study did not meet the criteria. Some experiences were not spoken, other voices came from the creative objects. Any interpretations are ‘provisional’ and ‘incomplete’ (Rosaldo, 1989, p 8).

### **11.9 TA - a shared language**

When he began TA Berne’s intention was to have an interpersonal system of open communication between therapist and client, a two-person psychology, with a theory base that could be shared by both. He deliberately devised a system of language that was easily understandable, de-mystifying and clarifying

(Tilney, 1998). It is this shared-language that the participants found facilitative. The immediacy of TA theoretical language seems evident from the findings generated in this study. All of the participants used specific TA language within their narratives, which indicates that TA language is easy to grasp and useful, fulfilling Berne's intention. The specific theories are detailed below.

Lucy used the theory of ego states throughout her narrative, talking about all three (Parent, Adult and Child) ego states and spoke from each one in her narrative. Early on she talked also about her script behaviour and her 'Hurry Up' and 'Please Others' drivers. Other elements used were game theory, permissions and also symbiosis when talking about her relationship with her mother. She compared CBT and TA therapy, saying that CBT did not help her because "*I was not in a place where I could think cognitively as my head was skew whiff*". Prior to her TA therapy she said she could not stop her negative thoughts, in particular thoughts about health anxiety and the fear that she might die from it, saying "*I couldn't soothe myself*". However, she said that TA provided her the framework to understand what was happening to her, which in turn helped her to get what she needed.

Shoshana actually spoke of talking about transactional analysis fundamentals and concepts during the course of therapy. She said how powerful she found the theory of the Drama Triangle and how useful it was to her. She was able to describe the way in which she utilised this theory in her everyday life, even though her therapy had since ended. Sarah also alluded to her knowledge of the Drama Triangle when she talked about the way her husband would 'rescue' her daughter Sally, if she was misbehaving.

Jane acknowledged that she used gallows laughter, particularly at one point in her interview when she laughed about something and then went on to cry. Shoshana and Lucy also used gallows laughter within their interviews but did not specifically name it. Jane specified her driver behaviour as 'Be Strong' and 'Please Others', saying: "*I put everyone first*". She also talked about an injunction she had which was 'Don't Feel' when talking about accessing the grief she felt about her miscarriage: "*I was given permission that is was ok to feel*". She spoke about using the elements of TA she had learned in therapy, and how these elements impacted her everyday life, by saying: "*I sort of TA myself*".

Julija spoke about her 'Be Perfect' driver and how useful it was for her to discover this and the coping strategies her therapist gave her to help with it. Although not exactly a TA theory, she also described learning how to use the 'pause' button to help her cope with her need to be perfect all the time. The 'pause' button is not a theory that has been researched or written about within

TA literature. Yet in TA training it is a tool that is sometimes taught as a way of slowing down a process, and can be useful both for a therapist, as well as a client.

Sarah was the one participant who did not use TA language in quite such an overt way, although she did talk about Berne's life position "I'm ok, you're ok" (Ernst, 1971) when referring to the way in which she treated her daughter.

Transgenerational trauma is a part of TA therapy most often researched by Gloria Noriega (2004, 2016). Both Sarah and Jane talked about this theory, with Sarah alluding to it "*Of course we've examined endlessly [my mother]. And I've asked my mother if she felt that about me, and she said "absolutely not". I've often wondered what my mother felt about me. I mean she's never been able to articulate it, so it's been difficult*" and Jane actually specifically talked about it: "*I hadn't done it properly, and then I'd repeated what my mum had done (tearful)*".

Recognition hunger, although not actually stated, was alluded to by Julija, Shoshana and Sarah. Julija alluded to her need to have recognition from her therapist within her narrative, and how important it was for her to finally receive this recognition. Shoshana and Sarah, in their memories of the first gaze they had with their newborn babies both alluded to the importance of this recognition.

Finally, all participants 'performed' the TA theory of discounting throughout their interviews. This became more apparent within the analysis process when looking at the "I" statements. This style of analysis highlighted how often discounting was used and this was surprising, particularly the use of the word 'just', which is used so often in everyday language that it often goes unnoticed. Some of this discounting changed within the interview and it was noticeable that some participants stopped it altogether when they began to talk about their therapy.

### **11.10 Puerperal psychosis**

Puerperal psychosis might also be considered to be included in the types of mental illness suitable for treatment with psychotherapy, although for puerperal psychosis this would almost certainly only ever remain an adjunct to medication or ECT. Jane clearly stated that she found TA psychotherapy useful, but only once her psychosis had passed. Psychotherapy may be of benefit to women in the aftermath of this devastating illness, providing a non-judgemental and compassionate container for those women to explore the extremes of their mental illness. It may also be argued, from Jane's experience, that psychotherapy during psychosis could also be beneficial as a non-judgmental, witnessing 'other',

although this would need to be thoroughly researched. This also highlights a different question of when therapy is therapeutic for a client.

### **11.11 Style of treatment – group/one-to-one/couples**

Two of the participants experienced both one-to-one and group therapy (Lucy and Julija). Both of them did not seem to favour either of the therapies, and spoke favourably about both. Lucy talked about the acceptance and support she received from the group experience: *“I got a massive lot of acceptance from the group. And that has been a big thing for me, you can expose, you know, the bits of yourself that you are uncomfortable with and still experience acceptance and support”*. However, she did not say whether she preferred group or one-to-one therapy. Julija stated that she would actually prefer to have both styles because in her mind they gave her different things. Group therapy gave her the ability to learn from the group and to gain group recognition. This was important for her as she stated that recognition hunger played a significant part in her process, and this was what she yearned for most: *“Just one group therapy, half an hour, one, hour, priceless....to have people there to support you”*.

For Shoshana the most important thing was to be in therapy with her husband John. Even though they both had individual therapy as well as couples therapy at times within their therapeutic journey, couples therapy seemed to be the most helpful for her: *“[it was] massively helpful to be in a session with John”*.

### **11.12 ‘Postnatal depression’: A change needed in terminology?**

Many women are unwell within the perinatal period and this suggests it may no longer be appropriate or accurate to label this illness as ‘postnatal depression’. This terminology may be deemed as too simplistic as it does not take into account the many women who experience mental illness within pregnancy. The term may also be experienced as unhelpful and confusing, particularly to those women who do not have depression but do have stress and anxiety. Within this study only one participant (Lucy) talked about experiencing depression as part of her perinatal illness and this was reported by her as a response to heightened anxiety. Mental illness within the perinatal period encompasses many types of illness - stress, anxiety, distress, psychosis, depression, and melancholia. This suggests it may be more appropriate to encompass the entire perinatal period and the entire range of mental illness by re-naming it as ‘perinatal distress’. This would capture the many vivid and different experiences of mental illness women have at this time.

However, it can also be argued that by solving one problem, changing the terminology, this may lead to other problems. There is the added argument,



from some feminists, that health professionals may be too quick to diagnose depression, therefore pathologising women, when childbirth is argued to be a huge, yet normal, life event and is bound to have negative implications because of this. Difficulties also do not necessarily only occur with the first pregnancy and birth. Each time a new baby arrives a change in the family dynamics is required and this can be a time of tension and difficulty, needing a period of adjustment.

### **11.13 Study strengths and limitations**

The small sample used within this study was both a strength and limitation. Having only five participants enabled the study to deeply explore each participant's experiences, providing a richer data set. It was a limitation because the findings are not generalisable, although generalisability was never a study aim. The limit of time also affected the scale of the study. If time had not been an issue, a larger sample of participants could have been recruited. However, it would never have been a large sample, as finding participants proved difficult because so few TA psychotherapists work with this type of condition. This was known at the study's outset and influenced its nature and design. In particular, the style of research needed to work with the small sample. Limiting questions, tests and measures were also not used within the research. This study was not about the efficacy of TA psychotherapy but about its acceptability to women with perinatal mental illness. This was due to the importance of acceptability for women's engagement in treatment (O'Mahen et al., 2015). All the study participants did believe their therapy was effective.

Qualitative research is often seen as anecdotal, subjective and 'interpretivist'. Indeed, the reflexive researcher needs to be a part of the research. Using a creative method of data collection may also be problematic, although the objects the participants shared prompted a co-created narrative that would not have happened using interviewing only. In this way, the creative element supplemented and supported the narrative data. It also permitted a reflexive element. Two participants used a memory as their creative object, which might prompt discussion about how to render non-visible objects visual. Both participants used a highly descriptive, almost sensory means of describing their memory, bringing ontological and epistemological concerns of what exactly denotes memory, the visual form, and indeed an 'object'. In order not to stray too far into the subjective or into 'material culture' or the 'anthropology of the senses' (Classen, 1993; Howes, 1991; Mason, 2002; Tilley, 1999), I have attempted to keep this exploration of the object grounded in the interview and in the style of data analysis. However, this does not mean that the visual data was treated as of less importance and has been subjected to the same critical scrutiny as the narrative data.

It could also be argued that there is bias and over-involvement (Sweeney et al., 2009) in this study. However, the researcher's experience as a clinical psychotherapist offered a positive element, in the context of knowledge of harm and the subtleties and nuances that can bring it about. Also the knowledge of active listening, attention to the other, the building and maintaining of rapport and relationship, and staying with and dealing with emotional sensitivity and affect were also positive elements. Some may continue to view the data analysis as biased.

The researcher may also be described as the 'instrument for analysis' (Starks and Trinidad, 2007) with all the preconceptions this might entail. In this respect, reflexivity has been used to examine the research decisions from theoretical preconceptions through to analysing and presenting the study data. Reflexivity is closely entwined with ethics, and in feminist research is considered to be a political practice (Squire et al., 2014). Narrative research is more interested in examining the individual rather than the generaliseable and relies on dependability of the data rather than validity: trustworthiness and strength of analysis (Webster & Mertova, 2007). Reissman (1993) notes that validity relies on objectivist and measurable assumptions, which do not have a place in narrative inquiry. To fulfil Polkinghorne's (1988) sense of reliability - trustworthiness of transcripts or notes - a full participant transcript is held within the appendices. All transcripts were checked by the researcher's three academic supervisors for validity and transparency purposes. However, further independent auditing may be seen to be preferable. This has been cross-referenced to each section of analysis for this participant, Lucy, within her specific Chapter (5). This offers a level of transparency of both interview script and researcher participation within the interview. It was not possible, to provide full transcripts for all participants within the appendices due to limited word count. In response to claims of validity, no claims have been made that are concrete and participant stories may not correspond to 'truth' or an exact recount of actual events. Each participant also has a table of 'other voices', also available within the appendices. Lucy's table is numbered to correspond to the line in the transcript containing the piece of narrative demonstrating the alternate 'voice'. These tables also offer transparency in the procedure of determining what part of the narrative constituted each 'voice'.

There was a limitation to the findings regarding the importance of specific time points within perinatal mental illness and the suitability of therapy at those various time points. Both Shoshana and Jane received psychotherapy prior to, and throughout their pregnancy. Both had a period of time when they did not receive therapy, for Jane this was the period after she was diagnosed with psychosis. Jane did see her therapist twice within that period, but they both

agreed that Jane did not have enough insight into her illness at that time for therapy to be effective as she was too unwell with psychosis. Shoshana had a break of two months, from her daughter's birth up until the point at which she experienced a panic attack when her daughter was two months old. Both Jane and Shoshana said they found their therapy useful. However, they did not state whether they found it more useful to have been in therapy prior to pregnancy or not. Therefore, it is impossible to conclude that TA therapy prior to pregnancy is more effective than receiving it once experiencing perinatal mental illness.

Free Association Narrative Interviewing offered a lack of a formal interview structure that was a positive within this study. This seemed to encourage the women to speak more freely with me, and it certainly encouraged them to tell me the story they wanted me to hear. I tried to keep any interjections needed for clarification purposes to the absolute minimum as I did not want to interrupt the flow of narrative. Listening back to the interviews it felt that my interjections were only those required at the time.

As there is no set of questions, there is no formal structure to follow and this may feel daunting to future researchers, who are interested in different styles of interview. Yet, I chose this interview style deliberately due to the nature of the depth of stigma and shame within perinatal mental illness. I believe it was necessary to allow the women to feel as free as possible to speak, not to be led in anyway by my desire for any particular knowledge. In hindsight, the choice of interview style was the right choice for this research project. I believe I would have gained little in the way of new narrative if I had chosen a standard interview technique style of set questions.

The Listening Guide Analysis allowed me to listen at depth to the narrative of my participants, and to track changes in their process through an in-depth study of their 'I' statements. This was unusual but also useful, as it highlighted changes in the narrative, in terms of tense, the use of particular repeating words such as 'just', and it highlighted the temporal movement of the narrative for each participant. This was important as it highlighted when one participant, Jane, had no temporal movement. I do not believe this would have been noticeable without this style of in-depth analysis. However, the method did have drawbacks. For instance, the suggestion is to look for emotional hotspots, metaphors, gaps, ruptures, images, contradictions, symbols, who is there, who is not there. All of these were useful. However, when I began to write up the participant narratives, I found the narrative broke down into chunks because I kept looking for various items, such as emotional hotspots, and metaphors, rather than concentrating solely on the narrative. I therefore stopped focusing on this part of the analysis, and concentrated on what was being said. This honoured the voice of the participant, keeping their narrative whole, in the

temporal manner it was narrated to me. This felt more suitable. I deliberately did not choose a style of analysis that looked in depth for themes, and would have needed a coding element. This would have meant each voice merging with the others. Rather than having 5 separate participant voices, each segregated within their own chapter, in order to highlight difference, such a thematic style would have instead highlighted sameness. This was not an aim of the study.

#### **11.14 Contributions to knowledge**

This study has several contributions to knowledge and to method.

- This is the first study of its kind to ask women about their experiences of their therapy.
- This is the first study to explore TA psychotherapy in relation to its use in perinatal mental health.
- This is the first TA research study that uses narrative analysis.
- This is the first study on perinatal mental illness to use narrative analysis.
- This is the first qualitative TA research study.
- The use of creative objects as part of the data collection process is unique in psychotherapy research. This enabled a specific narrative to be collected and collated which would not have been possible without this element.
- The use of FANI for data collection, in combination with the Listening Guide analysis style is unique. The aim was to highlight difference within the participants' narratives. Using these two techniques, in combination, has produced a rich, detailed, and unique data set.
- The Listening Guide style of analysis highlighted specific elements of TA therapy. The element of the 'other voices' in each participant's narrative offered a way that seemed to highlight Ego State theory in TA. Therefore, this is a unique contribution to TA theory.
- This is the first study to highlight psychotherapy as a possible adjunct treatment for puerperal psychosis. There is no research on this type of treatment for puerperal psychosis. This woman's experience has been a valuable resource. It may offer hope to women with psychosis who struggle with the lack of suitable, holistic treatment, or who struggle with receiving strong psychotropic medication or ECT. These women may prefer to be treated using a combination of medication and psychotherapy.
- The durability of TA therapy has not been studied before. Although durability was not an aim of this study, it was clear that four participants found TA to be durable (Lucy, Shoshana, Julija and Sarah). For Lucy, Shoshana and Julija this durability was around 2 years. For Sarah it was 40 years.

- The immediacy of and usefulness of TA language and the ability for it to be shared between therapist and client seemed to be evident within this study. This has not been explored before and although it was not explored at length within this study it has implications for future research.
- Couples therapy as a suitable style of therapy for perinatal mental illness has not been researched prior to this study. Although only one participant had undergone this style of therapy it would warrant further research.

### **11.15 Future research**

A much larger prospective study listening to women's experiences of psychotherapy (irrespective of modality) was beyond the scope of this study. Such a study would enhance knowledge across all modalities of treatment and would give more generalisable knowledge on barriers to treatment, factors in treatment engagement, as well as factors across all modalities which work and those that are not so helpful. It is possible that theories from different modalities may be useful in combination to treat this wide-reaching illness. This would enhance treatment planning within larger-scale programmes such as in public sector care, like the NHS.

A mixed methods study/process-outcome study/systematic case study of participants may also be appropriate as a next step in research as this would be able to give both qualitative and quantitative data, which may enhance knowledge of the effectiveness of TA psychotherapy within this client group

Future research to explore the link between past history of mental illness and perinatal illness would also be useful. This link would have direct implications for patients and the medical profession. If a link is substantiated it may help women to know their susceptibility prior to pregnancy. For the medical profession the implications would be on screening, prevention programmes and the successful targeting of tight resources. There would also be implications for practice – both for TA psychotherapy practice (this could become an area to focus on in therapy) and for maternal mental health practice.

A future study into the durability of TA would also be a useful study. This study suggests that TA offers a type of psychotherapy that can offer such durability but this needs to be corroborated with further research.

A future study of psychotherapy as an adjunct treatment for puerperal psychosis would be useful.

Finally, research into the partner's experience and the impact of perinatal mental illness on their experience, as well as the significance of childhood trauma on their experience would be useful.

My future aim is to collect both quantitative and qualitative data, to incorporate a process-outcome study, and target prior mental illness, durability of TA and the use of TA as an adjunct treatment for puerperal psychosis. This would enable the efficacy of TA to be measured.

## CHAPTER 12

### Conclusions and Implications for Practice

#### 12.1 Introduction

This study has demonstrated that perinatal mental illness is a highly complex, personal and significant type of mental illness, which has far-reaching and devastating consequences. It has also shown that perinatal mental illness is much more than just depression. At present there is no consensus on the aetiology, the prevalence, the longevity, and the diagnosis of this illness and there is little in the way of specific treatment other than psychotropic medication.

#### 12.2 Conclusions

This study found several common themes the participants' used to voice their experience of perinatal mental illness. These themes were: 'attacked', disconnection, health anxiety, madness, emotional extremes, seeking help at crisis level, and masks. All of these themes add to our understanding of the symptoms women may experience, and the way these may influence their help seeking behaviours. All of these themes, apart from health anxiety have been found within other studies. Health anxiety does not appear to have been found in any prior study.

This study shows that TA psychotherapy was a treatment option for perinatal mental illness the participants found to be useful, and effective, within the short and long term. This durability of therapy is important. All participants found the treatment acceptable and remained engaged within their psychotherapy. There are many reasons why this might have been the case. TA may offer a way that fits a woman's experience, and can target the specificities of the illness.

The participant's expressed several particular ways in which they found TA psychotherapy useful and these were: addressing the cause of illness (rather than the symptoms); identifying their needs and helping them to seek out ways to meet those needs; the way in which TA addressed deficits in relationship, by putting the relationship at the core of the therapy; the durability of TA; and the value of the therapist.

Barriers to treatment have been researched before and this study adds to knowledge by confirming that the most significant barriers are stigma and shame, which lead women to remain silent and not seek help. The lack of accepted aetiological pathway, and the continued disagreement on causes are significant factors in the continued stigmatisation of perinatal illness.

There is confusion among women, particularly if their experience of illness does not match the biological determinants used for diagnosis by health practitioners. This confusion is a significant barrier to seeking help.

This study found the relational dyad to be a facilitative factor in treatment. This has been found in other studies and so this study adds to knowledge. The length of time of this relationship, or having a relationship prior to perinatal mental illness did not appear to have any significant impact on the potency of this relationship. The quality of the TA therapist was also highlighted by two participants (Shoshana and Sarah) and played a significant role in their journey to health and the continued durability of their treatment.

It is evident from the participants in this study that TA psychotherapy offered a plausible alternative to CBT and psychotropic medication for their perinatal mental illness.

This study suggests that TA psychotherapy is useful in whatever format the woman experiences it: couples therapy, one-to-one therapy or group therapy. It appears that the richness and breadth of TA therapy may be an advantage for perinatal mental illness. The fact that TA has always been a group therapy may offer economic advantages for this modality of treatment.

The secondary objective, regarding the link to past mental health conditions, was a significant finding from this study. All of the participants in this study had some form of prior mental illness, which highlights the need for more extensive research into the strength of this link and the significance this might have. Another significant finding was that perinatal mental illness may also trigger childhood trauma in the partner, and this would warrant more research.

The use of two methods for data collection purposes – client interview and creative object – enhanced each other and added to the richness and depth of data gathered. This would not have been possible without the creative object.

The use of the Listening Guide method of data analysis offered many advantages. It allowed for a deeper listening to the narrative and showed the temporal movement of narrative, which in turn helped to highlight the participant's process and indicated the level of recovery. It provided evidence to the participant's statements, such as Lucy's "*madness of thinking*". It also allowed the level of Jane's trauma to be evident and highlighted the dissociation Shoshana felt which was linked to her feeling suicidal.



Language held significance in two ways in this study: psychotherapy offered the women a way of co-creating the language of perinatal mental illness and this co-creative process continued within the interview process. The rich, descriptive language they used highlighted the extremes of fear and emotions they felt and helped to highlight the depth and breadth of this illness and why it is important to treat it. The second significance of language was the TA language used.

TA offered a 'shared' language that was easy for the participants to understand, de-mystified the process, and clarified what was happening to them. The immediacy of the language and theory were significant factors in the participants' journeys and provided the specificity for the participants', which helped all of them to come through their mental illness. For four of the participants TA provided the framework for them to take away and use in their future lives, which may negate their need to go back into therapy. In particular for Sarah her therapy had endured for an extremely long time, 40 years. The only participant who had not yet come entirely to terms with her experience was Jane, and this is unsurprising due to the depth of trauma she experienced during and after her psychosis. However, Jane acknowledged how she found TA therapy helpful in her everyday life: *"I sort of TA myself"*.

Specific TA theories used by the participants were ego states, script behaviour, driver behaviour, game theory, permissions, symbiosis, the drama triangle, gallows laughter, the 'pause' button, life position, transgenerational trauma and recognition hunger. All the participants 'performed' the theory of discounting. This evidences how TA theory clearly de-mystified the process for the participants, and how the theory was used by them to make sense of their experiences. TA theory offered the specificity they sought, and that many women require, to engage in and remain in therapy, as the focus is on listening to and treating the person, not the symptoms. It can also address any relational deficit that a woman may be experiencing within what can be a difficult transition to motherhood.

This study showed that TA psychotherapy could offer an adjunct treatment role for puerperal psychosis. Although this would need to be researched extensively prior to use. Once the psychosis was over, Jane found that TA offered her a beneficial way to explore her experience and to help her come to terms with the severity of her symptoms.

### **12.3 Recommendations**

An effective treatment that can be prescribed on the NHS needs to be found. Treatment may be more beneficial if it addressed the cause rather than symptoms, with a wide enough aetiology to encompass all types of mental

illness, not simply depression or anxiety. At present, treatments target only the symptoms of perinatal illness, which is not economically, morally or ethically appropriate. This study has shown that this condition also includes other types of mental illness such as stress, anxiety and puerperal psychosis. It is also known that depression itself is a relapsing-remitting illness, bringing the possibility that a single course of treatment is simply not adequate.

As this study shows, this condition incorporates many aspects of mental illness such as stress, anxiety, the struggle with the change in identity, fear, trauma, and psychosis, not only depression. It is also now known that at least 50% of women experience illness within the antenatal period and continue to experience it postnatally (APA, 2013). The continued use of the term 'postnatal depression' now seems inappropriate. A more useful term encapsulating the entire breadth and depth of this illness is perinatal distress. This may enable those women who are unwell but who do not experience depression to understand that they are experiencing this condition. This may also encourage them to seek out help earlier, with the benefits this would entail.

The maintenance of the long-term effects of treatment need to be taken into consideration and future long-term follow-up needs to become a part of the original treatment plan within the NHS. As yet, this is not offered.

The research basis of perinatal mental illness needs to be expanded, for researchers, health practitioners and scientists to gain a consensus of agreement about this illness and to determine its causes.

Treatment, although costly, may prove economically viable, if a true cost-benefit analysis could be completed. At present, this has not been researched. Such an analysis would need to take into account the costs to the infant of life-long susceptibility to illness, as well as the deleterious effects on the larger family involved in caring for someone with this condition.

At present, this condition is not a part of the standard syllabus in any UK-based TA training institute. It would be useful to include perinatal mental illness within the syllabus in order to disseminate knowledge about the condition as well as how it can be treated.

#### **12.4 Practice implications**

The findings from this study have significant implications for practice. These are split into three different areas arising from this study:

1. Transactional Analysis psychotherapy practice

2. Maternal mental health practice implications
3. Implications for midwifery and health visiting

#### 12.4.1 TA psychotherapy practice implications

Currently, no protocol exists for using TA psychotherapy within perinatal mental health. This would be a useful addition of theoretical knowledge for TA psychotherapists. Trainees are not taught about perinatal mental illness, nor puerperal psychosis, yet many women say they would choose psychotherapy if it was a treatment option. It is plausible that some of the students entering psychotherapy as a profession have experience of perinatal mental illness, either for themselves or with family or friends. These students may be interested in this area of specialisation, yet as it is not on the curriculum, they possibly have no idea that it is possible to work in this area. At present, this condition is not taught within any UK-based TA training institute, nor is it offered as a CPD opportunity. For the future, both areas may be able to be addressed. Bearing in mind the quantity of women experiencing some form of mental illness during the perinatal period, it would seem useful to consider it as an addition to a CPD programme.

A protocol would need to provide a psycho-educational element, as knowledge of the condition seems to be lacking, and should include all elements of mental illness in pregnancy, childbirth and postnatally. This would need to include birth trauma, miscarriage, death of an infant, and all the many types of mental illness such as stress, anxiety, depression, psychosis, and clinical disorders that may influence or heighten susceptibility in the perinatal period. Other elements that would be useful to include would be: a working knowledge of medication used within this client group; ethical considerations, such as working with pregnant women, and also the plausibility of working with women when they are accompanied by a small infant; the relational dyad and why it can be a critical factor for this client group; elements of theory that are useful, as well as theories that might not be quite so useful and why; working one-to-one and within a group style.

Additionally, within the protocol it would be useful to have a section on the use of couples work within perinatal mental illness. This could have significant benefit not only to the mother, but also to the partner and the infant, and wider family. It would allow the partner to have an increased understanding in the illness, what is helpful within the partnership, and also would enhance knowledge in recognising relapses. The partner would also be a suitable 'voice' when a woman finds herself isolated and unable to express her illness, seeking out, and asking for help. It may also be appropriate for couples therapy if the partner is the one experiencing perinatal mental illness.

A protocol would be aimed at psychotherapists, helping to broaden their knowledge of this condition, and offering suitable skill sets that can be learned in order to offer suitable, efficient treatment.

#### 12.4.2 Maternal mental health practice implications

As mentioned above, this illness would benefit from being re-named, as at present the terminology used within the health professions of 'postnatal depression' may be continuing to hamper diagnosis. It creates misunderstanding, both in the general population, and within the medical profession.

There is an acknowledgment of the lack of treatment offered within the NHS (Mental Health Taskforce, 2016; PHE 2017). Treatment available has often meant long waiting lists. Due to the wide-reaching consequences of this illness there is a need for more treatment to be offered. Although, most recently this is now beginning to be addressed with an increase in new perinatal mental health services provided in the UK. All five participants stated their needs were not met by their health professional (GP, midwife or health visitor). They were offered a mixture of care, either CBT (Lucy), a CBT approach (Shoshana) or psychology (Sarah) or medication in the form of antidepressants (Lucy and Julija) that they stated did not address the specificity of their illness and therefore had not offered them the help required. At present, there is also a lack of evidence of the benefits of CBT for this illness and three participants (Lucy, Shoshana and Jane) stated why CBT did not work. Broadening the scope of treatment by incorporating wider ranges of treatment would address the difficulties women state around specificity. Specificity is evidenced as crucial in the decision to seek help and gain treatment.

Funding allocation currently still remains a difficulty within the NHS (NAO, 2016) and may prove to be a difficulty for research. Funding for the NHS is a combined amount with no monies earmarked for specific services and with limited data on spending for mental health services. Funding of specialist training and services would need to be addressed in order to meet the needs of the women who are not treated at present. The funding and the research are intrinsically linked. Research into the aetiology and preferred methods of diagnosis need to be incorporated with the funding necessary for treatment. It is not helpful to diagnose women if there are limited treatment strategies available to offer.

A broader understanding of this illness within the health service is highlighted as necessary by the participants. There seems to be a gap in knowledge about

perinatal mental illness on the part of health practitioners (Darwin et al., 2014; Jarrett, 2016; McCauley, et al., 2011; Ross-Davie et al., 2006; Stewart & Henshaw, 2002). Although, the most recent changes in NICE guidelines in March 2019 may help towards filling this gap in knowledge.

NICE have also been criticised for their updated guidelines (NICE, 2007) for midwives and health practitioners to include the Whooley questions (Whooley et al., 1997), and the Arrol questions (Arrol et al, 2003). Further research by Darwin et al. (2016), Furber et al. (2009) and Martin & Redshaw (2009) criticised the validity of both, finding them less accurate than the EPDS. Darwin (2016) further criticised the use of questions with no established research validating the Whooley questions within clinical practice. Hewitt et al. (2009) concluded that there was insufficient evidence for its continued clinical use.

#### 12.4.3 Implications for midwifery and health visiting

The booking-in appointment, performed almost always by a midwife when a woman is in the early stages of pregnancy, offers an ideal opportunity of targeted diagnosis, with the resultant possibility of treatment prior to birth. Therefore, enhancing midwifery training highlighting the symptoms of illness (both explicit and implicit) at this early stage in pregnancy may help to capture more women at an earlier stage. Also highlighting the importance of mental illness and its consequences to mother and infant may help to highlight the importance of diagnosis. The change in NICE guidelines in March 2019 still only requires a midwife to 'consider' asking a woman about her mental health. It might be helpful if this was changed to become a mandatory set of questions.

#### **12.5 Where next?**

This study has highlighted many areas of further research needed. However, primarily, four main areas would benefit from further evaluation:

There is a need for an enhancement of knowledge of the aetiology of this condition. At present there is little agreement on what causes it, the symptoms and also the outcomes.

The possible link to prior mental health conditions also needs to be substantiated. A further exploration will enhance knowledge of whether a causal link exists.

The prevalence of this illness needs to be further researched incorporating all possible mental illnesses, not only depression and anxiety.

In particular, there is a need for further evaluation of TA therapy as it is not NICE approved and would therefore not be deemed suitable for use in the NHS.

# APPENDICES

## Appendix 1

### Glossary of Transactional Analysis Terms

Script (belief)	A belief, made in childhood, about self or others. This is a message we tell ourselves, in order to 'explain away' feelings that have not been appropriately responded to in childhood. Example: "Everything will be ok, as long as I ... (am strong, am perfect, try hard, please others, hurry up).
Manifestations of Script	Racket behaviours.
Racket behaviours	Behaviours learnt in childhood to get our needs met. The manipulation used in this type of behaviour is out of awareness. This type of behaviour is inappropriate in adulthood and a very unsatisfactory way of having needs met. Example: behaviours such as being really helpful, being bossy, moaning and whingeing, or being helpless.
Ego states	"a consistent pattern of feelings and experience directly related to a corresponding consistent pattern of behaviour" (Berne, 1964).
Adult ego state	The part of us that deals with the "here and now" reality of life. Any response that is appropriate to this reality is termed Adult, including feelings and emotions.
Child ego state	This ego state holds the thinking, feeling and behaviour of childhood. There is not a single child ego state but a set of them representing different developmental stages, Example C <sub>0</sub> , C <sub>1</sub> , C <sub>2</sub> . Often seen as the residues of child experiences, held in a personal form. Some psychoanalysts refer to this as the 'inner child'. The Child ego state is often split into two and is referred to as the Adapted Child, this is the child that adapts themselves to their caregiver, often due to fear, they are often quite anxious children, ready to please. The other Child ego state often referred to is the Rebellious Child (sometimes called the Free Child), this child often does not want to do as they are told and can be seen by the caregiver as 'naughty', whereas the child is pushing against the control of the caregiver and wants to be able to exert their own self. Both child ego states have positive and negative attributes, however.
Parent ego state	This ego state contains thinking, feeling and behaviour of

parent figures we have experienced from our past. We 'introject' these parent figures into ourselves. Again the Parent ego state can be often split into two – the Critical Parent, which is the parent that is often castigating the child, telling them off, controlling them, and is often seen as harsh and angry. There is also the Nurturing Parent ego state which is the parent who is kind and caring and who thinks about the child and wants to help them. However, again both of these ego states have positive and negative attributes.

Drivers	Kahler and Capers (1974) identified five drivers, Try Hard, Hurry Up, Be Perfect, Be Strong, Please Others. These drivers are brief observable behaviours in adulthood and indicate underlying defensive processes. They are responses to 'counterscript' and are developed in childhood as a coping strategy with an underlying conditional message that "I will be ok if .... (I please others, I try hard, I am perfect, I am strong, I hurry up). These messages come from the Parent ego state of parental figures.
Try Hard	When a person is in the Try Hard driver they are in script, trying to gain approval from the introjected parental figure. This behaviour is about effort, not about achievement, and often a person with a Try Hard driver will often struggle to achieve.
Be Perfect	Again a script behaviour to gain approval from the introjected parent, by being precise, getting everything right, never making mistakes.
Be Strong	When in this driver the person distances themselves from their emotion or feelings, and may even disown them completely.
Please Others	When in this driver the person has a sense that the way to okness is literally only through pleasing other people. When in this driver the person negates their own self always in favour of the other.
Hurry Up	This driver is about the person only gaining a sense of okness if they try to achieve everything as fast as they possibly can. This can lead people to seem as if they are constantly late or rushing within their behaviour, and often brings a sense of anxiety.
Gallows laughter	This type of laughter occurs when a person laughs about something that is unpleasant or unfunny. There is a real sense of incongruity between what is being said and the person's behaviour. This is a form of discounting and is an



invitation to the listener to reinforce the script message of the person laughing. Example: a person makes a terrible mistake, harms someone, then laughs and says “whoops, that’s just me/me bad”.

- Discounting This is an internal process whereby a person minimises themselves, others, the reality of a situation. Discounting is not an observable behaviour as such. However, it will normally manifest itself in often small behavioural ways, a classic is using the term “just” to minimise what is often a difficult situation. Example: “I just panicked”, “I just flipped”, I just felt suicidal”.
- Symbiosis This is when two people behave in relationship as if they are only one person. This usually means that one person negates their child ego state and remains only in Adult or Parent, and that the other, remains in their child ego state. Healthy symbiosis is when a parent looks after a child. Unhealthy symbiosis is when an adult daughter or son find themselves looking after their parent who remains in their child ego state and discounts their ability to do anything. Example: If an alcoholic is in a relationship it will often be symbiotic, particularly if that alcoholic has got to the stage of being unwell. They will rely on their partner to meet their needs (including meeting their needs to get alcohol), and will discount their own ability to stop drinking.
- Structural analysis This is the analysis of intrapsychic structures. There are two types of structural analysis, first order: which shows the three types of ego state: Parent, Adult, and Child; second order: this includes the historic, ego states within the Parent and Child.
- Functional analysis This is the analysis of behavioural aspects of the ego state, as opposed to the intrapsychic structures. These are ‘functions’ of each ego state. This is more about the way different parts of the ego state function in interpersonal relationships.
- Exclusion This is when one ego state (Parent, Adult or Child) becomes dominant, and continues to remain dominant in threatening situations. The ego state is called excluding because its dominance excludes the use of the other two ego states.
- Contamination When the Adult ego state (the here and now) is confused by the Parent or Child ego state (both historical). The contamination may be single (contaminated by one ego state) or double (contaminated by both ego states). The

first task in TA psychotherapy is to decontaminate the Adult ego state.

Games

These are repetitive patterns of behaviour, that occur out of awareness and involve the manipulation of others. They are viewed as negative, yet they do have social and psychological advantages.

Recognition Hunger

Berne, (1961) believed that the search for recognition is a major motivator for humans and begins in infancy with a need for recognition through physical contact. He believed that normal psychological development was impossible without this hunger being satisfied at some level.

## Appendix 2

### Qualitative research studies on women's experiences of perinatal mental illness

Research studies in blue at the end of the table are meta-syntheses/systematic reviews, as opposed to single studies. Studies in red are puerperal psychosis.

Research	Date	Country	Topic	Perinatal, Antenatal, Postnatal	Depression, Stress, Anxiety	Other Factors
Abrams & Curran	2009	USA	Experiences	Postnatal	Depression	Low Income
Abrams et al	2016	Vietnam	Experiences	Perinatal	Mental Disorders	
Adeponle et al	2017	Nigeria	Experiences	Perinatal	Depression	
Ahmed et al	2017	Canada	Cultural Aspects	Perinatal	Depression	Syrian Refugees
Bennett et al	2007	Canada	Experiences	Antenatal	Depression	
Bilszta et al	2010	Australia	Help-seeking Barriers	Postnatal	Depression	
Boots Family Trust et al	2013	UK	Help-seeking Barriers	Perinatal	Mental Disorders	
Buultjens & Liamputtong	2007	Australia	Help-seeking Barriers	Postnatal	Depression	
Byatt et al	2013	UK	Barriers & Facilitators	Perinatal	Depression	
Chan & Levy	2003	Hong Kong	Experiences	Postnatal	Depression	
Chan et al	2009	Australia	Experiences	Postnatal	Depression	
Coates et al	2014	UK	Experiences	Postnatal	Distress	
Davies et al	2016	South Africa	Experiences	Perinatal	Depression	Low Income
Edhborg et al	2014	Bangladesh	Cultural Aspects	Postnatal	Depression	
Edwards & Timmons	2005	UK	Experiences	Postnatal	Mental Disorders	

Engqvist & Nilsson	2013	Sweden		Postnatal	Psychosis	
Engqvist et al	2011	Sweden		Postnatal	Psychosis	
Foulkes	2014	Canada	Barriers & Facilitators	Postnatal	Mental Disorders	
Furber et al	2009	UK	Experiences	Antenatal	Distress	
Gao et al	2010	China	Experiences	Postnatal	Depression	
Glover et al	2014	UK		Postnatal	Psychosis	
Haga et al	2012	Norway	Experiences	Postnatal	Depression	
Hanlon et al	2009	Ethiopia	Cultural Aspects	Postnatal	Mental Disorders	
Heron et al	2012	UK		Postnatal	Psychosis	
Highet et al	2014	Australia	Experiences	Perinatal	Depression & Anxiety	
Holopainen	2002	Australia	Help-seeking Experiences	Postnatal	Depression	
Jarrett	2016	UK	Help-seeking Barriers	Antenatal	Depression	
Mautthner	1999	Canada	Experiences	Postnatal	Depression	
Moore et al	2016	UK	Experiences	Perinatal	Depression	
Myors et al	2014	Australia	Help-seeking Barriers	Perinatal	Mental Disorders	
Nahas et al	1999	Australia	Cultural Aspects	Postnatal	Depression	Middle-Eastern Immigrants
Nakku et al	2016	Uganda	Barriers & Facilitators	Perinatal	Mental Disorders	
Nicolson	1999	UK	Experiences	Postnatal	Depression	
O'Mahen et al	2015	UK	Help-seeking Barriers	Postnatal	Depression	
O'Mahony et al	2012	Canada	Barriers &	Postnatal	Depression	

			Facilitators			
Patel et al	2013	UK	Experiences	Postnatal	Depression	
Raymond et al	2014	USA	Experiences	Perinatal	Depression	
Robertson & Lyons	2003	UK		Postnatal	Psychosis	
Slade et al	2010	UK	Help-seeking Barriers	Postnatal	Depression	
Stone & Kokanovic	2016	Australia	Experiences	Postnatal	Depression	
Tol et al	2018	Uganda	Cultural Aspects	Perinatal	Mental Disorders	
Tseng et al	2008	Taiwan	Help-seeking Experiences	Perinatal	Mental Disorders	
Ugarriza	2002	USA	Experiences	Postnatal	Depression	
Beck	2002		Experiences	Postnatal	Depression	Meta-synthesis
Button et al	2017		Barriers & Facilitators	Perinatal	Mental Disorders	Meta-synthesis
Dennis & Chung Lee	2006		Barriers & Facilitators	Postnatal	Depression	Systematic Review
Knudsen-Martin & Silverstein	2009		Experiences	Postnatal	Depression	Meta-analysis
Mollard	2014		Experiences	Postnatal	Depression	Meta-synthesis
O'Mahoney & Donnelly	2010		Barriers & Facilitators	Postnatal	Depression	Meta-synthesis
Staneva et al	2015		Experiences	Antenatal	Distress	Meta-synthesis
Tobin et al	2018		Experiences	Postnatal	Depression	Meta-synthesis
Wittkowski et al	2017		Experiences	Postnatal	Depression	Meta-synthesis

### Appendix 3

#### Research studies included in the literature review on psychological treatment options

Research studies in blue at the end of the table are meta-analyses as opposed to single studies.

Research	Professional counsellors/ Psychotherapists Or other	Type of psychotherapy	Type of Research	Perinatal, Antenatal, Postnatal	Depression	Stress	Anxiety	Group/ Individual	Outcome
Austin et al (2008) (Australia)	Clinical psychologist	CBT	Quantitative	Postnatal	Yes		Yes	Group	No difference between CBT and control group
Barlow et al (2008)	Psychotherapist	PIP	Quantitative	Postnatal	Yes			Individual	No clear outcome
Beeber et al (2013)	Clinical psychologist	IPT	Quantitative	Postnatal	Yes		Yes	Individual	Significant reduction in depression and anxiety
Bevan, Wittowski & Wells (2013) Pilot study (UK)	Third year trainee Clinical psychologist	Metacognitive	Quantitative	Postnatal	Yes		Yes	Individual	Significant reduction in depression and anxiety
Bittner et al (2014) (Germany)	Clinical psychologists	CBT	Quantitative	Antenatal	Yes		Yes	Group	Not efficacious
Bowen et al (2014)	Clinical psychologists	IPT or Mindfulness	Quantitative	Antenatal	Yes		Yes	Group	Significant reduction in depression and worry
Burns et al (2013) (pilot study) (UK)	CBT therapists	CBT	Quantitative	Antenatal	Yes			Individual	Full scale trial needed
Clark et al (2008) (US)	Psychologists, psychiatry residents, and psychology interns	Eclectic mix	Quantitative	Postnatal	Yes			Group	MITG efficacious for depressive symptoms
Cooper et al (2003) (UK)	Experts and non-experts in each therapy	Non-directive counseling, CBT or Psychodynamic	Quantitative	Postnatal	Yes			Individual	Psycho-dynamic more effective than others
De Camps Meschino, Philipp, Israel, Vigod (2016) (Canada)	Maternal mental health specialist and child mental health specialist	Mother-infant dyadic therapy	Quantitative	Postnatal	Yes		Yes	Group	Good preliminary efficacy results
Dornelas et al (2010) (US)	Clinical psychologists	Affect focused (Eclectic)	Quantitative	Antenatal	Yes			Individual	Efficacious
Fonagy, Slead & Baradon (2016) (UK)	Parent-Infant psychotherapist	Parent-Infant psychotherapy	Quantitative	Postnatal	Not specified (but met possible psychiatric	Not specified (but met possible psychiatric case criteria)	Not specified (but met possible psychiatric case criteria)	Individual	Favourable outcomes for maternal mental health and

					case criteria)				parenting stress
Green et al (2015) (Canada)	Clinical psychologist	CBT	Quantitative	Perinatal			Yes	Group	Significant reduction in anxiety (and depression)
Grote et al (2009) (US)	IPT therapists	IPT	Quantitative	Perinatal	Yes			Individual	Significant reduction in depression
Hou et al (2014) (China)	Psychological Counsellors and Psychotherapists	CBT with Systemic Family Therapy	Quantitative	Postnatal	Yes			Individual	Improved symptoms in mild to moderate depression
Klier, Muzik, Rosenblum & Lenz (2001) (Austria)	Qualified IPT therapists	IPT	Quantitative	Postnatal	Yes			Group	Short and long term effects on the reduction of depression
Kurzweil (2008) (US)	Professional psychodynamic psychotherapists	'Relational Developmental' Psychodynamic psychotherapy	Quantitative	Postnatal	Yes			Group	Significant improvement
Kurzweil (2012) (US)	Professional psychodynamic psychotherapists	'Relational Developmental' Psychodynamic psychotherapy	Quantitative	Postnatal	Yes			Individual, Group & Combined	Significant improvement
Milgrom et al (2005) (Aus)	Psychologists	CBT, counselling	Quantitative	Postnatal	Yes			Both	Psychological intervention better than treatment as usual
Milgrom et al (2015) (Aus)	Psychologists trained in CBT	CBT	Quantitative	Antenatal	Yes		Yes	Individual	Strong reductions in anxiety, reductions in depression maintained at 9 months post birth
Moayedoddin et al (2013) (Swiss)	Professional psychodynamic psychotherapists	Psychotherapy Centred on Parenthood	Quantitative	Perinatal	Yes		Yes	Individual	Significant positive impact
Mulcahy et al (2010) (Aus)	Trained IPT therapists	IPT	Quantitative	Postnatal	Yes			Group	IPT more efficacious than treatment as usual
Muzik et al (2015) (US)	Masters level psychologists	Eclectic Mix	Quantitative	Postnatal	Yes			Group	Good outcomes with a decrease in depression
Nanzer et al (2012) (Swiss)	Professional psychodynamic	Psychoanalytic – Geneva mother-infant	Quantitative	Perinatal	Yes			Individual	Promising intervention for

	psychotherapists or psychiatrists	therapy							perinatal depression
O'Hara et al (2000) (US)	Experienced professional psychotherapists	IPT	Quantitative	Postnatal	Yes			Individual	Efficacious
O'Mahen et al (2013) (US)	Masters or Doctoral level psychologists	Modified CBT	Quantitative	Perinatal	Yes			Individual	A feasible, acceptable treatment
Pinheiro et al (2014) (Brazil)	Clinical psychology interns with specialist training	CBT & Relational Constructivist therapy	Quantitative	Postnatal	Yes			Individual	Both efficacious at maintaining reduction in depression at 12 months after completion
Reay et al (2012) (Aus)	Trained IPT clinicians	IPT	Quantitative	Postnatal	Yes			Group	2 year outcomes good
Spinelli (1997) (US)	Trained IPT clinicians	IPT	Quantitative	Antenatal	Yes			Individual	Good reduction in depression
Weidner et al (2010) (Germany)	Clinical psychologist	Psychosomatic intervention	Quantitative	Antenatal	Yes		Yes	Individual	Significant effect on anxiety but not on depression
Bledsoe & Grote (2006)	Meta-analysis	CBT, medication, IPT, group therapy with TA components	Quantitative	Antenatal, Postnatal	Yes			Individual & Group	Differing outcomes, more research needed
Claridge (2014)	Meta-analysis	Systemically oriented, relational IPT	Quantitative	Perinatal	Yes			Couple	Sgificant positive effects
Sockol et al., (2011)	Meta-analysis	IPT, CBT	Quantitative	Perinatal	Yes			Individual and Group	IPT better than CBT , individual better than group



## Appendix 4

### **Pro Forma For Interviews with Participants.**

Initials (interviewee):

Location:

Age:

Race:

Marital Status:

Children:

Family:

Perinatal Health:  
(history)

Previous mental health conditions:

Therapy:  
(length)

Route to therapy

Item brought:  
(significance)

Therapy:  
(experience)

Interviewer/interviewee relationship:

Other comments/themes/summaries:

## Appendix 5 Ethical Approval Letter of Consent

University of  
**Salford**  
MANCHESTER

Research, Innovation and Academic  
Engagement Ethical Approval Panel

Research Centres Support Team  
G0.3 Joule House  
University of Salford  
M5 4WT

T +44(0)161 295 2280

[www.salford.ac.uk/](http://www.salford.ac.uk/)

24 May 2016

Dear Emma,

**RE: ETHICS APPLICATION HSCR 15-147 – Women’s experiences of Transactional Analysis psychotherapy for the treatment of perinatal psychological distress.**

Based on the information you provided, I am pleased to inform you that application HSCR15-147 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting [Health-ResearchEthics@salford.ac.uk](mailto:Health-ResearchEthics@salford.ac.uk)

Yours sincerely,



Sue McAndrew  
Chair of the Research Ethics Panel

## Appendix 6

### Lucy's Transcript

1 (L glances at the two tape recorders I've placed on the table and points at one) *Is*  
2 *one a back up in case one doesn't work? Yes?*  
3 *Yes. Yes it is.*  
4 *That would be awful if you came all this way. It's worth having two.*  
5 *So, Lucy, this is about you helping me to understand what your experience of TA*  
6 *therapy was like for you.*  
7 *Yes*  
8 *So it would be really helpful for you to tell me just, erm, in whatever way you can,*  
9 *what brought you into the therapy*  
10 *Yes*  
11 *and you said it was because you were unwell*  
12 *erm, and I had my baby Oliver, in the May*  
13 *yes*  
14 *Erm, what actually happened was I started to experience anxiety during the*  
15 *pregnancy. So, the first time I thought, um, something's not quite right, was around*  
16 *the December time, kind of half way through the pregnancy*  
17 *yes*  
18 *(deep intake of breath), erm, and I, (pause), when I sort of look back, my thinking*  
19 *was already going a bit, sort of, peculiar. So, I sort of, kept that almost a bit*  
20 *separate and almost wanted to deal with the anxiety (pause) and, (pause), I*  
21 *mentioned it to my midwife and she, erm, referred me into, it was called 'the single*  
22 *point of access', that's what I was referred into and then sent out to see someone for*  
23 *basically CBT counselling. Which is what I wrote the article about.*  
24 *yes*  
25 *So I ended up, quite quickly, seeing a CBT therapist. And they allocated me up to 20*  
26 *sessions, and they, they saw me as high risk. I did the GAD test scoring and I was*  
27 *moderate to severe on that and because I was pregnant I was high risk, anyway, so*  
28 *I, I got quite a bit of intervention in terms of what you would probably get, you*  
29 *know, if you weren't pregnant (deep in-take of breath) erm, and I liked the*  
30 *therapist, she actually did some TA bits and bobs, but it was mainly CBT, erm, the*  
31 *therapy I got felt, quite like it was kind of missing what was really going on for me*  
32 *yes*  
33 *I kind of understood the theory of the CBT but I didn't, it wasn't really hitting what*  
34 *was going on, and I didn't really understand it, my symptoms were, erm, health*  
35 *anxiety, really, (drops voice) well I think its awful, you know, all the time thinking*  
36 *about my health.*  
37 *So yours, not the baby's? Yours?*  
38 *Mine, mine yes, that wasn't something totally new to me, I had experienced that*  
39 *about 5 years before when I'd been really stressed at work, erm, and I had had a,*  
40 *not much therapy. But about 3 or 4 sessions, and I'd taken Citalopram, only a low*  
41 *dosage, but it was enough to, sort of, get me through that period, and I thought all*  
42 *that's done and dusted, you know. Anyway, it reared its head when I was pregnant*  
43 *and it was about my health, erm, and, it was just a real process, like an internal*  
44 *process of "maybe this is wrong with me, let's try and figure it out, and let's try and*  
45 *solve it", so fuelling this idea that something was wrong with my health. Erm. So*  
46 *the CBT was focussed around that to challenge my thoughts really, erm, and it just*

47 wasn't really working, and I wasn't in a place where I could really **think** cognitively.  
48 My head had just gone skew whiff, really by that point, **erm**, so, I carried on with  
49 that therapy through having Oliver. So I had Oliver in the May and **erm**, sort of,  
50 he'd not hit 3 months, I'd had, had him and there was some trauma in the birth and  
51 so, it was actually a really quick and easy birth, easier than my daughter,  
52 **uhhuh**  
53 Who I'd had, she was about 2 ½ when I had Oliver, and **erm**, but my placenta got  
54 stuck, so, it was like an amazing birth experience, I had him and all that, and my  
55 placenta was stuck and they couldn't get it out and **erm**, there was a lot of  
56 manipulation of the placenta to remove it manually, they put me back on the drip  
57 so I would get contractions again so there was a lot of pushing and **erm** it was  
58 really unpleasant and in the back of my head **I'm thinking** "oh god, what's going to  
59 happen, what's going to happen" and I bled quite a lot too. **Erm**, and ended up  
60 having to go down to theatre as a piece got stuck, **erm** so, I did what my script  
61 behaviour is of "oh this 'll just be alright" and all the time **I kept on thinking**, during  
62 the pregnancy, **I'm thinking** all this stuff and "I'll be alright once the baby's here"  
63 and, **erm**. Yeah, 3 weeks into being at home with Oliver, and (**drops voice**) we did  
64 have a lot of building works going on in the house, (**voice changes back**) so we had  
65 some sort of other stuff going on which **I think** maybe escalated, **erm**, where I was  
66 at the time. I went to my mum's house and I just was having panic attacks really  
67 and I just, sort of, hit a wall and just said you know "I can't do this, I can't do this, I  
68 can't do it, I can't", I've just gone, "I can't look after Oliver, I can't". I had my  
69 daughter with me as well, **erm** and it was me just saying "look I can't cope", you  
70 know, and it was just fairly dramatic, can't cope you know. I didn't leave my mum's  
71 house for two weeks then, and (**pauses**)  
72 **And was it about you not being able to cope with yourself or with the children, or**  
73 **was it everything?**  
74 (**pause**) it felt probably like everything, because **I think** I knew that **my thinking**,  
75 and this sort of health anxiety and checking, and I sort of knew enough to know,  
76 you know, I probably am ok but I couldn't stop **the thinking** and I'd, I'd got to a  
77 point where I just can't function because I, **I'm thinking** all these **thoughts** and I just  
78 don't know what to do and it felt, and it just felt like **erm**, like it would, how could I  
79 exist like this, "I can't exist like this because I can't", it was depression as well by  
80 this point, so there was the hopelessness  
81 **yeah**  
82 as well as the anxiety, so it felt very hopeless and it felt, I was very frightened of  
83 having panic attacks with the kids, so **I thought**, if I have a panic attack and I can't  
84 breath and you know, I'm holding Oliver or, my daughter's there, she's going to  
85 worry what's going on (**voice elevates**) and so of course the worry of having it  
86 fuelled having them, so that was a big thing for me, **so that made me think** I  
87 couldn't really look after them effectively, that I sort of needed other people around  
88 in case, you know, I was going to panic, **erm** (**pause**). I never at any point **thought** I  
89 would do anything to the kids, it wasn't that sort of depression, you know, it wasn't  
90 that sort of (**pause**) I really bonded actually with Oliver, probably more than I did  
91 with Olivia and I do wonder if I did have, you know, a bit of, of similar stuff going on  
92 after I had my first child.  
93 **yeah**  
94 **erm**, and that sort of really wasn't perhaps sort of dealt with as well as maybe it  
95 could have been. Cos I went back into work quite quickly and there was probably a

96 lot more distracting stuff going on, we moved into this house after having my first,  
97 after having Olivia and so, yep, so you know I felt the bond there with Oliver and so  
98 as I never feared I would do something **erm**, **I didn't think** I'd ever really do  
99 anything to myself, but **I did think**, "I don't know how long can I go on feeling like  
100 this, and if this is how I'm going to feel forever, what is the point in living" (**voice**  
101 **get's shaky**), so that was there too. But I was never going to actually do anything  
102 to myself, **erm**, so. So during this period we had contacted my CBT therapist and,  
103 you know, she was really trying to keep hold of me, and, you know, trying to help,  
104 and I'd started medication with my GP, **er** which was Citalopram again and also  
105 Beta Blockers (**sharp intake of breath**) and the experience of taking the medication  
106 wasn't very nice either, cos that, it, I mean I went up to 40mg, so I went quite high  
107 really, and, **er** (**pause**)  
108 were you breast feeding at the time?  
109 No. **I erm**, that had been a factor, **I think** that contributed, **erm**, I really wanted to  
110 feed my daughter and, I found it really difficult and **erm**, got a lot of **erm**, well she  
111 had a tongue-tie, to start with and then I got really really damaged nipples, **erm**  
112 and, I don't know if she was really getting enough or not, it's all a bit hazy but it felt  
113 like the hardest thing in the world at the time,  
114 yes  
115 and I fed her for about 3 weeks and stopped, but I really didn't want to. I did, so  
116 there was a lot of failure around that really, and I was worried about doing it  
117 again, **err**, so I did feed Oliver for about 3 days and then moved onto bottles, cos **I**  
118 **just think** in my head, this is going to be something else that makes me feel crap. So  
119 if I take control of this, this wouldn't, then **erm**. And looking back, I don't know if I  
120 had fed effectively, what sort of difference it would have made, in terms of how I  
121 was feeling, **erm**. I am glad that we did move onto bottles, because I did need so  
122 much help around that period, that if I'd carried on breastfeeding, it might have  
123 been difficult, especially when, sort of like, **erm**. I used to get panic attacks, I used  
124 to just run into (**small gallows laugh**) my mum's bedroom and just be like,  
125 (**breathes**), just like, I just need to get away, just need to get away, and then, **erm**,  
126 and it was always when my mum and my stepdad were around, this was this sort of  
127 two week period where I got, (**pause**)  
128 yes  
129 And so I knew the kids would be alright and **I just thought** I've got to get away and  
130 of course, it didn't really help just getting away from people either, because it was  
131 me that I was sort of trying to escape, **the thoughts** and stuff, **erm**, so yeah the  
132 symptoms were sort of this panic, and get away and anxiousness and what's  
133 happening to me, which would then quickly descend into hopeless depression, a real  
134 mix, so yes, if I had been feeding while experiencing all of that, **I think** it would have  
135 been, **erm**, really difficult. But yeah, feeding, **I think**, is a big thing  
136 yes  
137 for women with depression, I have spoken to a lot of people with similar sort of  
138 things, so, I kept in touch with the CBT therapist, I also kept in touch with [name  
139 removed], and **erm**, you know, we talked about when I might go to try TA therapy,  
140 **erm**. Well she [the therapist] actually asked me to come in and see her, **erm**, so I  
141 did, at at that point, I didn't go agoraphobic but I didn't want to leave the house  
142 because again afraid of how I was, out and about, **erm**, so I did go up to see her,  
143 took Oliver, and she didn't, spoke to my kid [Child ego state] basically and she said,  
144 "you know, this can be ok, you can start to feel ok again. But it will take time, and

145 *let's think about stopping your CBT and starting TA therapy, do you feel ok to do*  
146 *that?" Erm and at that point I think I'd have just done anything (gallows laugh) to*  
147 *try and feel better and erm and yep I think she was my first port of call to see if I*  
148 *liked her and we got on and we did, and I had my first session, it was in July I think,*  
149 *so only a couple of months after Oliver was born, so quite soon*  
150 *quite early on*  
151 *yep and I started off with hour sessions each week and this took priority over*  
152 *everything obviously, erm and I started to see her and that's when really I did start*  
153 *to, sort of, I didn't, I wouldn't say I felt well quickly, but I started to feel a sense of*  
154 *grounding and a glimmer of hope, really, that this isn't going to be the same for*  
155 *ever, erm and I start, so yes it was quite quick, and I'm still seeing her now and so*  
156 *(pause)*  
157 *Does it still come into your therapy now?*  
158 *Erm well I'm in group therapy now, erm and it's not so specific but we do still talk*  
159 *about that period of time*  
160 *yes*  
161 *in a lot of sort of reflection about how that impacted, I guess, on my life, how it was,*  
162 *my relationships, because I think, you know, there are still problems, my*  
163 *relationships are still affected now from that period of time. Erm. We talk about it*  
164 *in terms of, you know, that's how I felt then, and I don't want to go back there so*  
165 *what do I do differently, erm, yeah, it's referred to quite a lot in terms of my journey*  
166 *now, erm*  
167 *And how old is Oliver now?*  
168 *Two and a half*  
169 *Ok*  
170 *So he was two in May you know and I said to my husband just the other day, I just*  
171 *said, actually, in terms of like recovering from that period, it's not long. And I*  
172 *sometimes feel like it is ages ago and I'm in such a different place and in terms of*  
173 *how hideous and hard it was, it's not that long really, two and a half years*  
174 *No*  
175 *And I don't think I give myself space for that, to think that, a lot of the time, a lot of*  
176 *my process is rushing, and getting better and being ok, a bit of a 'hurry up' [Hurry*  
177 *Up Driver] and it's almost like, I've still got to really, integrate that into part, who I*  
178 *was and what happened in that time*  
179 *So how long do you think the TA therapy was actually focussed towards that*  
180 *period of your time?*  
181 *(big intake of breath) yeah (big pause) (big intake of breath), about well,*  
182 *definitely, intensively for at least 6 months. And then I see a lot of the work I've*  
183 *done since, because I sort of see that period of time as not just postnatal depression,*  
184 *I sort of see it as, part of, like a, I think it was (deep breath) who, if I hadn't have*  
185 *had Oliver, I'm not sure it would have come out in the same way. And I think it was*  
186 *part, part, the experience I had then was just part of me and still needs working on,*  
187 *if, you know, if that makes sense*  
188 *yeah, absolutely*  
189 *yeah*  
190 *it absolutely makes sense and I guess that's one of the other thoughts I have, that*  
191 *I'm curious about. Have you had, other than when you said that you had this*  
192 *sense of rising anxiety*  
193 *yeah*



194 Four or five years ago at work  
195 yeah  
196 have you ever had anything, in the past, in your history?  
197 Yes *I think* so and that's probably, a lot of really, the therapy that I do do now with,  
198 with [name removed] and yes, *erm* (pause) *I think, I think*, you know, put very  
199 loosely, my my experience of growing up, *erm*, was quite chaotic, *erm* so, so my  
200 early years were spent, my parents divorced, well separated when I was 8, and my  
201 early years were very, *erm*, there was a lot of arguing and a lot of anger, in my  
202 house and *erm*, and then they split up and then my dad really went off the rails,  
203 drinking and (sigh), you know, he's not been a very solid father-figure and *erm* I  
204 lived with my mum and we're we're very sort of enmeshed, quite symbiotic and  
205 (pause) she's very, she's very *erm*, she's quite narcissistic and quite, very sort of, she  
206 knows what's right and I, I've responded very much in a very "ok then I'll just be the  
207 quiet person that pleases others" and *erm*, she, I had a memory which I did take to  
208 therapy that *erm*, what, one time my parents were arguing in the house and my  
209 auntie came, and they were having a fight or whatever and I was, I just turned the  
210 television up and sat there just with the volume up and we all would say that I  
211 would turn the volume up to just say well "you know, I'm just going to ignore that"  
212 or "it'll be fine, it'll be fine" and *erm*, *I think* that is probably a replay that I do when  
213 I find things hard *erm* so whilst on one hand I sort of project to the rest of the world  
214 that I am very much in control and I'm very *erm*, ok, and and you know fine, it's, it's  
215 really not the case inside and *I think* that's really what it was, and *I think*, (sigh)  
216 there was a few things that came together and ended in me having Oliver, but it  
217 just went "Pow" you know "this is, this is, I can't really do this anymore" and so I  
218 guess a lot of my therapy has been around accepting and I guess the permissions  
219 for actually, this stuff did happen when you were growing up and *erm*, you know,  
220 even just saying that was a really big thing for me, and *erm*, you know, a lot of of  
221 what we do in my therapy is behaviour now and my relationships and how I behave  
222 in those, and *erm*, yes, even though it was, it was strange really, in terms of, I don't  
223 know what other people do when they are feeling how I was, but I couldn't even  
224 express to anybody near me what was happening  
225 yeah  
226 and it was a terrible shock really to my husband and my mum, even though we  
227 knew I was getting these CBT sessions, it was still like, oh my god I didn't know you  
228 were that ill, really, and it was that bad, because it was just the real cover all the  
229 time, really  
230 yeah, so your cover?  
231 my cover, yeah, *erm* and *I do think* that my, people in my life played into that too, *I*  
232 *think* it was easier for them if I was alright, you know, you will be all, alright, yeah  
233 Do you feel that that you found it difficult for you to actually ask for help?  
234 (deep breath) it was during the pregnancy, *erm* so so, so what happened, *erm* just  
235 before I got pregnant with Oliver I used to work, work in the family company, it  
236 was my mum's company, so when I say like in my, we were enmeshed  
237 yes  
238 *erm*, and it was a construction training company and I was *erm* a director with my  
239 mum when, our business, right at the back of the recession, was a training company  
240 that got funding through Europe and from colleges and stuff like that to train  
241 unemployed people, and it went (pause) bust, err probably a year almost exactly to  
242 the date of me having Oliver, so that went and I knew I wanted another child which

243 was a lot of the reason why I didn't go straight into another job, I started training,  
244 **erm** so that happened, and it was horren, it was so stressful that it was a really  
245 awful experience and then, in terms of the actual stress of it happening, but in the  
246 family too. And then **erm** on top of that we'd moved into this house so all the lovely  
247 kitchen and everything (**laughs**) it didn't look like that, it looked like a building site  
248 whilst I was pregnant **erm**, I can't remember why I'm saying this, there was like  
249 other stuff going on where I couldn't ask for, yes  
250 so asking for help?  
251 Yes yes so **erm**, so it felt like like everybody really that I would have normally asked  
252 for help for, was all very distracted with this company going bust and (**deep intake**  
253 **of breath**) all the work in the house and it sort of felt like, well if I do you know,  
254 need help, that's just like an extra, pressure on, you know, if I admit that I'm not  
255 feeling good here, where does it end because I'm not sure I've got the resources and  
256 the people that are around me to really help me to. And **I think** there was a bit of  
257 oh "what's your problem" because (**voice changes**) you've got this lovely house and  
258 you've got, your alright your not working, you're, and you know, you've got all this,  
259 you've got a gorgeous 2 year old and", so  
260 who was that?  
261 that's my, that's my process, **erm** and **I don't think** everybody really (**pause**) **said** it  
262 to me, I don't think they did, but, **I think** I'd had a sense of people around me might  
263 not get it  
264 And do you think that stopped you from saying?  
265 Ummm, (**hesitant**) **I think** so. I, I, I was worried, **I think** I was worried, I probably  
266 put how, I would say that people I would ask for help would be my mum and would  
267 be my husband and I was worried about the impact it would have on them, if I  
268 wasn't ok.  
269 yes  
270 yeah, and "how's your husband coped", **erm**, well **I think** definitely, when, when,  
271 when it first started to uncover, actually how ill I was, **erm** there was a bit of  
272 resistance at first, and **I think** he just thought, ok, her mum's helping her, because  
273 I'd sort of ended up at my mum's house. A lot of the reason I'd sort of not come  
274 back here as well because the work was still going on in the house **erm** and **erm** **I**  
275 **think** he, part of him was like "oh good, she's there and she's getting looked after  
276 there" and he was carrying on working and stuff and then it started to dawn on  
277 him, **I think**, that this wasn't gonna just be ok, it was gonna be a long process and  
278 you know, I wasn't going to take a tablet and I was going to, you know, get better,  
279 so once her realised that, and he never, he never said **erm**, you know, "come on pull  
280 yourself, come on pull yourself together"  
281 yes  
282 sort of thing, (**intake of breath**) **erm**, but **I do think** it was, a bit like, umm, **I don't**  
283 **think** he really got it at first, until he saw how bad it was and how sort of like, how I  
284 couldn't control it, you know, (**pause**)  
285 yes  
286 so once that dawned on him, he was pretty good really, (**pause**) he gave me the  
287 space I needed, **I think** to, (**pause**) or once I could start to sort of say this is what I  
288 feel like I need, which was really just basic, on a weekend we need to just potter and  
289 perhaps go to the park, and that really was about it  
290 umm



291 And may you cook and you, you know, it was real basic stuff, it was just, but  
292 previously it would have just been me just taking charge of everything and so I  
293 *think* that was quite a change for him.  
294 yeah, and for you too?  
295 and me, yeah, yeah and I'd say how he was, he sort of became sort of wrapped up  
296 with this sort of TA journey as well because I talked to him about it a lot and he is  
297 he is quite sort of in into it in some senses and he is very open to me, like  
298 discovering what was going on, and he's open to me changing  
299 yeah  
300 and (pause) we often talk about how much I've changed, and he's he's alright with  
301 that, but we've managed to keep the relationship ok  
302 yes  
303 During the change, I don't know how alright it would have been (wry laughter) you  
304 know, the relationship had gone the other way with all the change we've been  
305 through, erm, there's been ups and downs really there has been ups and downs too,  
306 erm, really and I *think* a lot of that has been about me being noticed really.  
307 Yes  
308 If I *think* about it, a lot of that is a bit like, "hang on a minute I'm here as well you  
309 know". And whilst he doesn't, he doesn't erm, you know, abandon me, in terms of  
310 he's here, but sometimes I *think*, you know, how sometimes we're not really here  
311 when we're here, so you're sort of busy with whatever's going on for you or  
312 whatever, sometimes it's a bit like, you know, I need a bit of you, I need a bit of  
313 decent communication and (pause)  
314 What was it suddenly spoke to you? If that's what it did? Did the therapy speak  
315 to you?  
316 yeah it gave me, it gave me (pause), it gave me a framework from where I could  
317 start to understand what was happening and I *think* that was really important to  
318 me that I could understand what was happening?  
319 Yes  
320 Because the, the madness of thinking, you know, that a lot of *my thoughts* were "I'm  
321 gonna have, I've got a brain tumour and nobody knows and I'm just gonna collapse  
322 at home and the kids aren't gonna", you know, "I'm gonna be dead, and the kids are  
323 gonna be there (breath in) erm and I've got to", I used to do stuff like get all of his  
324 bottles ready and think "oh good they're all ready, so if I get ill, they're all ready",  
325 even just in that sort of few hours and put stuff *errr*, just sort of, so erm,  
326 you seem quite confused as to why you might do that  
327 yes  
328 And I'm wondering whether anything like that had ever happened to you in the  
329 past, where somebody had left very suddenly or become ill very suddenly or  
330 something like that had happened?  
331 Well erm the only person that has been close to me that has died, was my granddad  
332 and he did die of a brain tumour, when, oh it was about 9 years ago and it was  
333 quite quick erm so I *do think* that did have an impact and it was that sort of  
334 *thought* of well how did he not know and what could something be done about it  
335 and it was ultimately like a control thing for me, I *thought* well if I could control, if I  
336 am going to get ill I need to control it and get help and so it became, like, I *think* a  
337 way of just trying, it was definitely a distraction, the health anxiety was a  
338 distraction I *think* from what was actually really happening. So it's like I, if I *think*  
339 about that and I really worry about that and I become obsessed about that and if I

340 can sort that out, in *my sort of skewed thinking*, it was then a distraction away  
341 from something's really not right for me inside here, more about, like it's another  
342 way of ignoring myself really  
343 yes so it was definitely internally to you? But you knew it wasn't about the baby  
344 you were carrying?  
345 yep, oh yes, yeah I've never really worried about the kids being ill *erm* I did have  
346 *erm* a lot of problems with my hips when I was pregnant with Oliver, that that  
347 didn't, I wasn't worried about that, in terms of, my health, I, I knew that would be  
348 fine, but, *I don't think* it helped in terms of I couldn't move very easily so I ended up  
349 being stuck really a lot in the house and I couldn't go out and walk and things like  
350 that, so *I think* that had an impact. *Erm*, the TA therapy, the first thing that really I  
351 remember was "this is your kid [child ego state] asking for something here and it's  
352 like you've put", (*voice changes*) she's put her hands up and is saying hang on I  
353 can't do this anymore and I need help (*pause*).  
354 yes  
355 so I could start to understand that there was like this frantic anxiety, wasn't about  
356 being ill, it was and having health problems, *erm*, it was about something that I  
357 was ignoring really (*pause*). There was something else going on which she [Child  
358 ego state] just, really wasn't happy about *erm*, so that was the first thing I  
359 remember making sense. And *er* it was [name removed] that had said if you start  
360 to listen to that, your symptoms will start to alleviate.  
361 And they did?  
362 Well I did have a, a, a small relief after that conversation because *I remember*  
363 *thinking* ok maybe there is something I can do about this and it starts I guess, a bit  
364 of Adult [ego state] came into play where *I could think*, "right this is manageable"  
365 yes  
366 This isn't a mass [*word cut off*] (*sigh*), it felt like, the anxiety and everything, and  
367 the depression felt like something that had sort of attacked me. It, it sort of felt like  
368 it was external to me  
369 Hmm  
370 and for some reason and it felt like (*pause*), it felt like it (*pause*), was something  
371 that had, had almost attached itself to me and I couldn't control and *I think* that  
372 was this, like this really scary part. It was just like (*breathes*) whereas  
373 understanding it was an internal process  
374 yes  
375 there was, I was soothed by that, because *I could think*, well this is me, it's me that's,  
376 even though I suppose I could sound quite critical that I'm doing this to myself, it  
377 didn't feel critical because *I could think*, hey this is just me and some *thoughts* that  
378 I'm having, and, we can respond to them and try and alleviate whatever there is  
379 going on and understand it. Whereas I guess the CBT literally just responds to the  
380 symptoms and doesn't really understand why they're there, so it never really made  
381 sense to me, it was a bit like well you know maybe I can convince myself one day  
382 that if *I think* something else then it, you know, if I challenge *my thoughts*, that  
383 might work. And actually sometimes *I think* if you are functioning ok, CBT is  
384 sometimes useful, if sometimes, I don't know, if you see something on the TV where  
385 *you think*, you know there is something about cancer on the news, I could use a CBT  
386 technique and *think*, you know, hope I don't get that. Well then you can say, well  
387 you probably won't. At that time I couldn't do that, I just couldn't do that, to me it  
388 was like well I might do, *erm* (*pause*)

389 So you couldn't have that internal dialogue?  
390 No, the chances of this happening are, you know, it probably isn't going to happen  
391 it, your going to be ok, I couldn't have that at all, it was like *if I thought* it, I just  
392 couldn't soothe myself at all, and I would carry on, more and more with it. It was  
393 quite OCD-ish really, *quite compulsive thinking* and just I really found it so hard to  
394 break the pattern of *thought*, really, so this sort of idea that I could begin to  
395 understand it by understanding those sorts of messages that I was giving myself,  
396 *erm*, you know why am I giving myself those messages, which is still what we're  
397 working on really, (*pause*).

398 Yes  
399 And *I could still have thoughts* now. I do if I am feeling particularly anxious about  
400 something, I sort of go to could be something to do with health anxiety (*long*  
401 *pause*) sort of anxious and light headed, yeah and I catch myself and ask what's  
402 going on

403 Yes. So what I'm curious about is, it feels as though there was this (*pause*, to  
404 think) like a black shadow following you around?

405 Yep, yep, yes, yep, so, *erm*, yep, so once I'd got into the therapy, the (*long pause*) we  
406 talked about (*pause*) we went really quite quickly into me and who I was, and my  
407 past, and history and stuff. That's where [name removed] started from, and we did  
408 talk about the health anxiety, and and my symptoms, but not a huge amount, she  
409 did it really, *I think*, probably how she would work with most people, really, that  
410 had come with some sort of symptoms, *erm*, really. I guess what she was doing was  
411 working with my kid [Child ego state] and giving me the permissions to you know,  
412 there was a lot of, (*pause*) I remember in the early sessions there was a lot of, a lot  
413 of, yes, "you have had a lot of really stressful things happening all at once and" *erm*  
414 "you've had a very busy time" and sort of starting to pick out things *I think* that I  
415 probably was beating myself up about, and saying "you have, this has been a lot for  
416 anybody to deal with."

417 Yes  
418 You know, so she started to nurture and give permissions really really early on and  
419 *I think* that, that did soothe my kid [child ego state] and start, and then I started to  
420 take those as well, and say, yeah "you don't have to, *erm*, criticise yourself for not  
421 coping with this stuff. You don't have to, *erm*" (*pause*), I mean thankfully, you  
422 know, I didn't really have any critical *thoughts* about my parenting or to the kids,  
423 although I did have the sort of fear of not looking after them properly that, *I think*  
424 as I started to alleviate my anxiety then that really just started to drain away too.

425 Yes  
426 I'd say there was probably quite a bit of depression there after the anxiety. I  
427 started to say, there was still quite a lot of depression

428 What I think I heard you say is almost like it for you, you experienced it starting  
429 off with stress?

430 Yes  
431 Then it, then a sense of anxiety?  
432 Yes  
433 and then the depression came towards  
434 [talks over me] yeah  
435 the end of the anxiety and was almost like a sense, you mentioned a sense of  
436 hopelessness?

437 Yes, yes, like this is going to be forever, and err, yes, and *I think* that was, *I think*  
438 that was my kid [Child ego state], just, again I can't keep this level of anxiety up, I  
439 can't keep this fear up, and *erm* just sort of, you know just sort of really that low  
440 mood and helplessness just sort of kicked in, as a sort of almost opposite to the  
441 heightened, you know, busyness, chaotic-ness, *awful thoughts*, so I guess, I guess the  
442 sort of *anxious thoughts* sort of did settle, *I think* really, once the depression did  
443 sort of kick in, actually, if I'm really, you know, sort of honest, and there was quite a  
444 long period of, you know, who am I, you know, and I feel low low mood and, and I  
445 *definitely remember thinking* I actually really don't know who I am anymore, *erm*,  
446 so there was a big identity thing there, and that has been, *erm* part of my therapy,  
447 and it still is part of my therapy, what's my identity now, *erm* I did see, my gp  
448 wasn't really that great really, unfortunately, and I did see a good gp just by  
449 accident. I'd had horrendous headaches well afterwards and a lot of great bleeding  
450 and stuff too around my periods and he said it was it was there was another  
451 problem with that later on which I'll touch on, *erm* I did see a gp and he sat me  
452 down and he said (*laughs*) it was quite a medical way of thinking, well I don't know  
453 it, it spoke, it did speak to me, he said "you know that it's like (*wry laugh*)" and it's  
454 quite funny really, he said "there are some of us who are like Meer cats who are like  
455 that all of the time and looking for the next problem, and *erm*, you know, in a hyper  
456 arousal a lot of the time and that's great when you're in the work place, like  
457 looking out for problems, problem-solving and stuff", he said "you, there isn't a need  
458 for you to be doing that now", and he said "your body has got absolutely exhausted  
459 with, *erm*, your nervous system basically is worn out". So it just sort of made real  
460 sense, I'd gone in about my headaches and he said no this is actually what's  
461 happening and I can see you're not breathing properly and *erm*, it was just so nice,  
462 it was just such a relief to have somebody else say this is absolutely normal.

463 Yes

464 And, err, "you know there's a reason why you feel, cos actually that's one of the  
465 problems with health anxiety, cos you actually feel really ill when you've got  
466 anxiety and depression", (*slight change of voice*) well you are sort of, actually, and  
467 all the tingly hands that you get, and so yeah, and it sort of just really made sense,  
468 he was great, and I was just sort of, like (*intake of breath*) what a relief you know,  
469 and my husband was there too, and *I think* that really helped. (*pause*)

470 Helped him to understand?

471 Yeah, yeah, yes, *I think* it was sort of, once the depression really sort of kicked in it  
472 was sort of like, it felt preferable actually to the anxiety. It felt more manageable,  
473 because even if I was low I knew I could still function quite well with the kids and *I*  
474 *think* also the kids did, you know it's horrendous looking after the kids when you're  
475 in that place, cos it's bad enough trying to look after yourself *I think* they did give  
476 me the purpose and the sort of like routine was a massive thing really and getting  
477 better so I'd, I'd walk up to the, so I'd, so it was all sort of over that summer from  
478 the May.

479 *hmm*

480 But that was the most awful part and then my daughter started at the pre school in  
481 the September, so we'd sort of potter up there 3 days a week, so that was part of my  
482 routine, and I started this sort of music with mummies sort of thing with Oliver, and  
483 the connection and contact with people. Just, you know, just saying hello to people  
484 and starting to recognise them in the street and I started to get a really good group  
485 of friends, actually, that were other mums and you know started to really help, so



486 the routine was a massive thing too and *I think* that knowing that I had sort of this  
487 routine each week that I could manage and just sort of potter with not too much  
488 pressure and I also remember thinking each day, even if I don't really do anything  
489 today it's ok, even if I just sit in the garden today, it's ok, you know, I don't have to  
490 do, I don't know what I thought I had to do, but I don't have to do it, if I don't want  
491 to you know, *erm* which again I guess that's one of the more nurturing messages  
492 that *erm* yeah, (long pause)  
493 So you told me that you had a poem that you used, for your object?  
494 (Lucy picks the poem up from the coffee table between us, where it has been  
495 throughout the interview) Yes, now this was in the last year, postnatal so about  
496 Oliver was probably a year and 4 months, something like that (she hands me the  
497 poem) and I did a creative weekend, you know a creative weekend and I thought  
498 "that's just me", you know, you just read something and think "that's me". I don't  
499 know, *I think* it's a fairly (long pause)  
500 (I look down at the poem and begin to feel distracted when I see the title is  
501 "Masks") So it was just you?  
502 Yes  
503 and it's called "masks"  
504 Yeah, so it, it felt like, *erm*, it just made real sense, *erm*, of actually (voice changes)  
505 "this is what I look like, but this is what's happening inside" and it felt like it was a  
506 really nice way of saying (drops voice to nearly a whisper) "hang on a minute, I'm  
507 here"  
508 Yes  
509 (slightly louder) "And I needed your help", (voice drops again) really, which *I think*  
510 is what I did.  
511 Yes  
512 That's what my kid [Child ego state] was doing after.  
513 How did you find it?  
514 It was the guy that was doing the workshop brought it to us. Yeah, and the actual,  
515 the actual activity, we did an activity afterwards which was making a mask.  
516 Yes  
517 So I made a tiger mask (laughs, then pauses)  
518 Yes  
519 Yeah (Lucy does not say anything, she seems to be waiting for something? A  
520 reaction from me?)  
521 And what did the tiger mask, what were your thoughts behind that, or was it just  
522 unconscious?  
523 It was quite unconscious, but I feel I (pause), *I think* it was at a point where I was  
524 actually starting to feel more, *erm*, I wouldn't say powerful, but a bit more, "hang  
525 on, this is who I am and I've got strength and I've got", you know, "a roar and  
526 everything", you know, "it's here". So it was quite unconscious *I think*. But, on  
527 reflection, we didn't go into it masses in the creative workshop. But, *I think* it was,  
528 sort of about, *erm*, me finding my place a bit, really and taking it.  
529 Yeah. I'm really struck by it being a tiger.  
530 (laughs) Because I wouldn't have felt like a tiger?  
531 Well, I guess it's just such a beautiful way, (pause), my first thought was "ah, well,  
532 what about the tiger mothers that  
533 (Lucy talks over me) Oh yes.

534 that they talk about in China, Hong Kong or wherever it is and that maybe what  
535 you are getting in contact with is that part of you that might be, you know the  
536 fearless, the strongest, that's gonna keep your babies safe.. yes, but just  
537 fascinating

538 *Yeah, I think, and yeah, definitely I do remember thinking, all of the time when I,*  
539 *when I started to, sort of, start the journey of recovery, all that actually really*  
540 *matters is this, within my four walls really (she gestures around the room) and*  
541 *that was, so, (Lucy's voice changes to a slightly stronger voice) "right, this has to*  
542 *be the focus now so", (her voice drops back again), yeah, so maybe in some ways,*  
543 *you know, its like a protective, "this isn't", you know, "this is what's going to make*  
544 *me happy, if I've got this right."*

545 *Yeah, and I'm thinking that a mask is protection isn't it?*

546 *(Lucy seems to have drifted a little, thinking about something) Hmmm, yeah yeah,*  
547 *which is kind of what the poem is about.*

548 *Yes*

549 *protecting yourself.*

550 *Yes, so is there any particular part of it that really spoke to you about, about*  
551 *what happened to you?*

552 *Erm, (pause), (Lucy is quite hesitant), well just, just really, all of it. But in, in*  
553 *particular this (voice strengthens a little) "so I panic at the thought of my*  
554 *weakness and fear of being exposed" erm, yeah "I put on the sophisticated façade"*  
555 *(voice drops again) and its really, you know I, I am really open with people about*  
556 *how ill I was and because I just hid myself really from the world, (voice is low and I*  
557 *begin to struggle to hear her) even like my closest friends didn't really know what*  
558 *was going on, erm. I still don't think people really believe how hideous, well you*  
559 *can't really explain to people. (pause)*

560 *No*

561 *Well, how awful it was, I think, unless somebody is in it, or works with people, or*  
562 *have experienced it themselves, its quite hard to explain, and I still think people*  
563 *think (voice changes to a quite mocking tone) "well look at you", you know, "well*  
564 *you're alright", (voice changes to sounding sad) you know, so that is there. And*  
565 *I'm always conscious of that now. So, actually I don't just pretend. Because I'm*  
566 *presenting alright, I am, it's a constant check, you know. (voice drops again and*  
567 *sounds even sadder) "I'm afraid your glance won't be followed by acceptance and*  
568 *love", and that's a massive thing actually. I started the group therapy, I think*  
569 *maybe about 8 or 9 months after see, starting to see [name removed], and I got a*  
570 *massive lot of acceptance from the group. And that has been a big big thing for me*  
571 *that actually you can expose you know the bits of yourself that you are*  
572 *uncomfortable with and still experience acceptance and support and really good*  
573 *stuff back has really helped me to you know, push through with that sort of side, I*  
574 *guess that I'm still working on really but (pause)*

575 *Hmmm*

576 *Erm (long pause)*

577 *I'm also struck by what you said about your father*

578 *Yeah*

579 *And I'm wondering whether there's something about your father, (pause) about*  
580 *this*

581 *Yes*

582 *you know "your glance will not be followed by acceptance and love"*

583 Yes, yes.  
584 Because it feels as though he disappeared?  
585 Yeah, yeah, he's still around, erm, (pause) He is around, but he's not around in the  
586 sort of way I'd want him to be, so I do still see him and stuff, but erm  
587 So emotionally he's not around?  
588 Yeah, that sort of fantasy, (pause) that he's the dad that's really gonna be there for  
589 you and be a big support. He, he's not, and whilst I've got the closeness with my  
590 mum, I'm not sure if there is always acceptance really, just in the stuff, like, you  
591 know, am I able to say I'm not very happy today, you know.  
592 Yes  
593 That sort of, you know, if I say I'm not happy it's sort of, (pause) she get's very  
594 anxious if she thinks there's something wrong with me, she does get anxious  
595 (pause)  
596 Yes  
597 Erm, (pause) she's got her own, (voice changes significantly) as we all have  
598 (laughs), she's got her own, erm, stuff going on, which I'm really working through,  
599 as well in therapy that, how I manage that and how I separate myself (pause)  
600 How you separate yourself from?  
601 Yeah, erm (long pause). Yeah I just thought it was, I just thought it, yeah and like  
602 when people show that they care, that it starts to grow wings  
603 Yes  
604 Erm (long pause)  
605 Were you surprised to find something [the poem] that spoke to you so, erm  
606 strongly?  
607 Yes, I was really, yeah, yes, and I'm not somebody that would read poetry. Well I  
608 like music, I do, erm, you know, I can sort of like tap into songs and yeah it makes a  
609 lot of sense. But, erm, I was surprised to, to find that, that somebody had put it so  
610 well.  
611 Yes. Would you mind if I take a photograph of it?  
612 yeah no that's fine yeah, yep when I went back to work, so my work was delayed. I  
613 was going to start sort of quite soon after Oliver was born, really I think that's part,  
614 looking back that was part of, 'well I'll be fine', I did go back into re-training in the  
615 September  
616 Yes  
617 And I was glad that I did.  
618 Yes  
619 Because it (pause)  
620 Wow, that's quite quick  
621 Yeah, I started with the first session and I just basically sort of said, you know this is  
622 where I've been over the holidays, I'm still really, you know, in this, but I'm here and  
623 I want to be here. Basically and I'm glad that I did because it gave me enough of  
624 something else to me to have going on that didn't feel too pressured  
625 Another part of structure?  
626 Yes  
627 That you were talking about before, that maybe this was a structure for yourself?  
628 Yes  
629 Rather than for your family?

630 *Yeah, yeah, it felt really important to carry work on although I didn't start working*  
631 *with my new clients, you know, for almost a year after that, erm, (pause). I can't*  
632 *remember where I was going with my clients. It's gone (pause)*  
633 *Hopefully it will come back.*  
634 *It might (laughs) come back, I'm thinking that's another thing with motherhood is*  
635 *that I can't keep my train of thought (pause)*  
636 *Don't worry*  
637 *Erm (long pause) Yeah and erm, (Lucy seems a little embarrassed) I don't know*  
638 *where its gone, it'll come back.*  
639 *Don't worry*  
640 *There's some more (Lucy seems quite frustrated that she has forgotten what she*  
641 *was going to say)(long pause)*  
642 *I was going to ask you, were there any parts that you struggled with, or that you*  
643 *found weren't helpful, in the therapy, or that you thought at the time weren't*  
644 *helpful, but maybe you've reflected on since?*  
645 *Well I do remember, sort of some of the sessions thinking "well what have we*  
646 *done?" you know "what have we done" and I do know now that was just giving me*  
647 *permission to tell my story really, really, I think that's what it was*  
648 *Would that have been a difficult thing to tell your story?*  
649 *Hmmm (again Lucy seems to have drifted), yeah, yes really difficult, I mean I*  
650 *didn't even really tell my husband really my story erm, you know, we'd been*  
651 *married, well we'd been together about 8 years when Oliver was born, so you know*  
652 *it yeah it was (pause)*  
653 *So he didn't know?*  
654 *Not really. You know, he knew bits, but he didn't know sort of how, quite how*  
655 *chaotic it was at times and erm, or I wouldn't ever say you know I'm not really*  
656 *happy with the way I am with my mum or you know, I just think I convinced myself*  
657 *everything was ok.*  
658 *Yes*  
659 *You know, it wasn't even a conscious cover up, it was, it was ok, so I'm..... I guess at*  
660 *times the therapy was a bit like well I wonder what the, what the point of that was,*  
661 *erm, but [the therapist] works very slowly and, erm, she said that from the start,*  
662 *and I think that was part of it, you know, building the bricks and making me feel*  
663 *safe and, and stuff erm. She can she can be quite strict as well (laughs), I laugh*  
664 *because I was just thinking back on that she will challenge, when I bring out my*  
665 *games she just really challenges, she will challenge it. And that's a bit like, "ooh"*  
666 *(her voice changes when she says ooh), like that, and she'll challenge that too, so*  
667 *she'll keep pulling, and then, but she does it in a really ok way, erm.*  
668 *I guess she was challenging from the start if you've got a 'hurry up' [Driver] and*  
669 *by going slow that must have, how was that?*  
670 *I knew, (pause). She said that at the start and I remember thinking well this will be*  
671 *good for me cos it'll be a different experience, well it was a bit sort of like, I'd almost*  
672 *put my trust into other people at that point too, so I thought well you know*  
673 *(laughs) I haven't done a great job of keeping myself, you know taking care of*  
674 *myself, erm so I need to trust this process really, erm, so I wasn't, I guess it probably*  
675 *was the times when I thought well I'm not really sure what happened in that*  
676 *session, there were times when I wanted to feel more, and I think I did start, there*  
677 *was something about moving into the group that did sort of escalate more my*  
678 *development I think*



679 Yes, so the group work was a good shift?  
680 It was, then it's a good group cos its people, everybody else in the group are lovely,  
681 so I get a very real lot from it, so I guess she's [group therapist] massively  
682 challenging, which I need, because everybody in my life buys into you know, my  
683 script. Yeah, they really do so I need it, erm, and I appreciate it. [Therapist] said  
684 "you know I find it quite hard with you, like whichever way I go in", you know, "to  
685 try and", you know, she takes really a relational approach, and er, puts a lot on the  
686 transference and stuff, so erm, you know, rather than (pause). I was thinking that  
687 she's gonna tell me what to do in my next therapy session, but it wasn't like that so,  
688 I did sort of, I think I really resisted, you know, exposing myself, in the, in the  
689 therapy and that sort of was happening around the same time that work around,  
690 you know, I was becoming a bit more uncovered in my therapy, so it all sort of hit  
691 around the same time, so there was a real sort of like maybe I'm just gonna have to  
692 do this (laughs).

693 Yes

694 Sort of go with the flow

695 So a few painful parts of the therapy then?

696 Yes, yeah, erm, yeah really, erm, (big sigh) you know on the one hand it sort of like,  
697 it's lovely to get all the permissions, like "you don't have to keep turning the sound  
698 up", you know, and the understanding that you get from it as well, but then (long  
699 pause) Er, what's been hard, but good as well, is the accepting the bits of yourself  
700 that's actually doing this you know, or even accepting the bits that you just don't  
701 like of yourself, I think is is been really hard because, but what I've learnt actually is  
702 they are not that bad, and you know people have tolerated, are able to tolerate, you  
703 know, tolerate it, erm (long pause), it has been hard talking, I tell you what's been  
704 hard, really hard is my relationship with my mum, because I've kept it ok and then  
705 I've had times when "do I really want to talk to you anymore?" Erm, so that has,  
706 that's probably been the hardest bit

707 Yes

708 Because its sort of like that, and because I am still, I talk to her every other day and,  
709 you know, she looks after the kids one day a week and stuff, so, so she's very much  
710 there so, there is stuff she would have done historically, or it would have played out  
711 in our relationship historically and I just tolerated. I don't anymore, so even though  
712 I feel stronger in some ways, I also feel sadder and I guess the grief of, part of this  
713 relationship isn't what I thought it was, has been really hard. We're kind of at a  
714 stage where it is sort of like, I think we are re-figuring out our relationship  
715 together.

716 Both of you together?

717 Yeah, yeah, which needed to happen. But sometimes it does still feel like, sometimes  
718 I wish I could go back to you know how, you know where you sort of ignore it all, its  
719 put so much more in my conscious, but for the better.

720 So, has it been transformational in a way?

721 Yes, I think it has, I think it has. I think it was, the one thing I really took from that  
722 period is I can't have this happen again in my life, I can't just, I didn't want that  
723 period of time just to be like, "oh well you were ill and now you're better", because  
724 that may have happened. I may have made some recovery on medication, or  
725 whatever, (pause) I thought, well actually I don't want to do this anymore, I don't  
726 want to have these feelings and thoughts, so I really knew that, that I wanted

727 change and to transform from that period and I just didn't really know how, and  
728 sometimes I still don't know how (wry laugh) but erm I think I have changed  
729 And is it ok not to know how?  
730 Yeah, yeah, it's ok to sort of go with that process and erm (long pause) erm and still  
731 I sometimes, I think its just going back to what I used to be like, which maybe  
732 before kids and marriage and everything kicked in, sometimes I'm like well I  
733 probably would have done that when I was like 20 you know, umm, which is ok too,  
734 cos I think of maybe my, sort of like would it be critical parent saying, well you  
735 should be like this, this is what you should be doing, this is, you know, you've got,  
736 you shouldn't feel like that. Well actually its ok, its ok  
737 Do you think you would have got better without it?  
738 No. I think that maybe the med, I think I'm off all medication now, I came off very  
739 gradually. I came off 2 years, when Oliver was 2. Erm and I think that that did, it  
740 did just shut off quite a lot of feelings, and actually once I came off the medication a  
741 lot more happened in my therapy too, and (pause) so I think I would of sort of, you  
742 know, everything would of, I might, my symptoms would have gone I think, from the  
743 medication. But it, I don't think I'd have really started to figure it out without the  
744 therapy, definitely not. (pause)  
745 Erm, so is there anything else that you, that you might want to say, that you  
746 might have not said, so far?  
747 Hmmm (long pause) I don't know. I did have a health visitor that was coming in  
748 every week for quite a long time, but I wouldn't say she did, I think she had had  
749 some sort of counselling training. And she was very nice, and she was contact, and  
750 she was, but I don't think she made a massive difference in terms of the proper  
751 recovery, I think she was sort of there as a friendly sort of support. But they are  
752 pretty good the health visitors and stuff round here for anxiety and depression, that  
753 was my experience.  
754 Would you have wanted more?  
755 Erm (long pause) (sigh) it feels sort of wrong to say this, I do know that they did,  
756 you know I got all of the CBT sessions and stuff, so I think that they thought there  
757 was a health visitor every week, so sort of as an outsider that didn't really know  
758 very much, you would think that that was great, I think, and there was  
759 [organisation name removed] which is a postnatal depression charity, so I had the  
760 option to go there too. So I think if I'd been your average person that didn't really  
761 know much about therapy I think I would have thought that was really good.  
762 Hmm  
763 But (pause) I think you would have wanted more of what I'd done really, and I only  
764 had the TA therapy really because of the fact of [name removed], I don't think I  
765 would have found it. So in some ways I was very lucky to have that process of  
766 having the erm, that type of psychotherapy really, you know, that actually finds out  
767 why you are like you are feeling this way. You know, I think really, had I not had  
768 that everything, like the medication the CBT would have been like the sticking  
769 plasters and I think definitely my relationships could of got worse, so I think the TA  
770 therapy has helped me figure out how to get what I need more out of my  
771 relationship with my husband  
772 Yes  
773 You know, that could have imploded, quite easily, I think, had I not started to figure  
774 out what I wanted. Erm, you know I think it, I think I'd have got probably enough  
775 support to get me through and get me back functioning, but I don't think it would

776 *have, you know, gone to this sort of level of figuring it out and this sort of*  
777 *reassurance I've had through it, and erm, just the ability to change*  
778 *So, I don't want to make an assumption, so how has TA helped you?*  
779 *It's been massively powerful, yeah, yeah. I, I say to people I don't know what, I don't*  
780 *know if I'd have had this experience and I do, I mean it, it's such a change for me as*  
781 *well. It's everything really, you know, a whole new group of people and as well as*  
782 *the therapy, erm. But yeah, massively powerful, it's given me a new way to look at*  
783 *the world really and myself, which I just really needed, you know.*  
784 *Yes, yes*  
785 *So, if I took anything away from that period of having Oliver, it was absolutely*  
786 *hideous, but it encouraged me to, you know, in a very roundabout way, to go and*  
787 *get what I needed really.*  
788 *Thank you*

#### Colour coding details of Lucy's transcript

<b>Text with this highlight</b>	Lucy's voice changes, sighs, intakes of breath or laughter
<b>Text with this highlight</b>	Lucy's pauses, including all her pauses using "erm"
<i>"I think"</i>	Lucy's "I think" statements have a red font

**Appendix 7**  
Lucy's 'other' voices

Lost Identity 'Mask	Psychotherapy 'Making sense of'	'My journey'	Integration
<i>'I went to my mum's house and I just was having panic attacks really ... I didn't leave my mum's house for two weeks.'</i> (66)	<i>'My process is rushing.'</i> (176)	<i>A sense of grounding and a glimmer of hope.'</i> (153)	<i>I'm in such a different place, and in terms of how hideous and hard it was, it's not that long really, two and a half years'</i> (172)
<i>'I'd got to a point where I just can't function because I, I'm thinking all these thoughts, and I just don't know what to do,'</i> (76)	<i>The experience I had then was just part of me.'</i> (186)	<i>I've still got to really integrate that'</i> (177)	<i>'I'm here as well you know'</i> (308)
<i>'I can't exist like this.'</i> (79)	<i>'my granddad died of a brain tumour when I was 8.'</i> (331)	<i>They (the kids) did give me the purpose and the sort of like routine.'</i> (475)	<i>I can soothe myself by thinking: 'this is me ...I'm doing it to myself'</i> (376)
<i>'I was very frightened of having panic attacks with the kids' (82) 'I couldn't really look after them effectively' (87)</i>	<i>'How did [granddad] not know?' (334)</i>	<i>Maybe there is something I can do about this.'</i> (363)	<i>'Accepting the bits of yourself ... that you just don't like' (700)</i>
<i>My symptoms were, erm health anxiety, really'</i> (34)	<i>health anxiety was a distraction, I think, from what was actually really happening... from something's really not right for me inside here ... it's another way of ignoring myself.'</i> (337 - 342)	<i>my cover, and I do think that my, people in my life played into that too, it was easier for them if I was alright'</i> (231)	<i>I don't want to [do it]'</i> (490)
<i>I think it's awful, you know, all the time thinking about my</i>	<i>'[health anxiety] wasn't something totally new to me, I</i>	<i>people I would ask for help would be my mum and would be</i>	<i>I've got strength and I've got a roar.'</i> (525)

<i>health. (35)</i>	<i>had experienced that about 5 years before.’(38)</i>	<i>my husband and I was worried about the impact it would have on them if I wasn’t ok.’ (266)</i>	
<i>A lot of my thoughts were ... I’ve got a brain tumour, and nobody knows, and I’m just gonna collapse at home, ... I’m going to be dead, and the kids are going to be there.’ (320) ‘If this is how I’m going to feel forever, what is the point in living. (100)</i>	<i>This isn’t going to be the same for ever.’ (154)</i>	<i>I don’t want to go back there, so what do I do differently?’ (164)</i>	<i>I am really open with people about how ill I was’ (555)</i>
<i>‘[Breastfeeding] felt like the hardest thing in the world’ (112) ‘so there was a lot of failure around that.’ (115)</i>	<i>[Lucy’s choice about breastfeeding] ‘this is something else that makes me feel like crap. So if I take control of this...’ (118)</i>	<i>‘Accepting ... this stuff did happen when [I] was growing up’ (218)</i>	<i>I don’t just pretend.’ (565)</i>
<i>‘I used to get panic attacks, I used to run into my mum’s bedroom, ... I just need to get away.’ (123)</i>	<i>‘I was trying to escape, the thoughts and stuff’ (131)</i>	<i>I need to trust this process’ (674)</i>	
<i>my experience of growing up, erm, was quite chaotic,’ (199)</i>	<i>This stuff did happen when you were growing up .... even just saying that was a really big thing for me’ (219)</i>	<i>When talking about gaining connection and contact with people: ‘The routine was a massive thing’ (487)</i>	
<i>‘There was a lot of arguing and a lot of anger in my house’ (201)</i>	<i>Silence: ‘I couldn’t even express to anybody near me what was happening’ (223) it’s another way of ignoring myself really’</i>	<i>Hey this is just me and some thoughts that I’m having and we can respond to them and try and alleviate whatever there is going</i>	

	(341)	on.' (377)	
<i>then they split up, and then my dad really went off the rails.'</i> (202)	<i>'Understanding it was an internal process, there was, I was soothed by that.'</i> (372)	<i>I made a tiger mask'</i> (517) <i>'it was quite unconscious'</i> (523)	
<i>I'll just be the quiet person, that pleases others.'</i> (206)	<i>There was a big identity thing, that has been part of my therapy and still is part of my therapy, what is my identity now?'</i> (446)	Understanding her GP: <i>'your nervous system basically is worn out'</i> (459)	
<i>'I just turned the telly up and sat there'</i> (209)	Metaphor: <i>'Some of us are like Meer cats ... who are looking for the next problem ... in hyper-arousal a lot of the time.'</i> (454)	<i>that's one of the problems with health anxiety you actually feel really ill.'</i> (464)	
<i>'I'm just going to ignore it, or it'll be fine.'</i> (211)	<i>'I don't know what I thought I had to do.'</i> (490)	<i>'I don't have to.'</i> (490)	
<i>'[I] project to the rest of the world that I am very much in control and very erm ok.'</i> (213)	<i>'I just hid myself really.'</i> (556)	<i>Even like my closest friends didn't really know what was going on.'</i> (557)	
<i>I couldn't even express to anybody near me what was happening.'</i> (223)	<i>I'm afraid your glance won't be followed by acceptance and love, that's a massive thing.'</i> (567)	<i>'I got a massive lot of acceptance from the group (therapy).'</i> (569)	
<i>The anxiety and everything and the depression felt like something that had sort of attacked me. It, it sort of felt like it was external to me.'</i> (366)	<i>That sort of fantasy, that he's the dad that's really gonna be there for you and be a big support.'</i> (588)		
<i>'I actually really don't know who I am anymore.'</i> (445)			

**Appendix 8**  
Shoshana's 'other' voices

The angry voice	The frightened voice	The sad voice	Nurturing Parent	The realist
We were really having the same fight over, and over, and over again	I had some of the worst panic I'd ever experienced	Shoshana used sighing a lot in her interview, which gave a real sense of her sadness.	I started to look at things more from an anxiety perspective	So she was always fine, she was born, and she was very small and she was very sleepy
That cut things off abruptly (laughs)	Feeling the wall closing in and having a lot of physical...feeling almost paralysed...and this was in the crazy stress of having a newborn child who never slept, she was a month early.	I was probably feeling suicidal at some point, erm, I probably was (laughs) (pause) it happens.	I had a complicated pregnancy, I had gestational diabetes so I had known it would be a medical birth.	I do have a physiological response early on, which I didn't always notice before
I've always experienced very strong mood swings.	I had a complicated birth, I had gestational diabetes ... but I also had pre-eclampsia	It was an intense (pause) unusual even, and unusual demands (said matter of factly) putting me into, errr (pause) a terrible, if not unexpected state of mind.	I probably wouldn't characterise it as depression now	Now that I notice that bit earlier I realise that it maybe isn't so terribly different.
It was very sudden	Just my body being pushed to such extremes	I would never really accomplish	That was surprising in that I was less anxious about	I found it massively helpful to be in a session with John and

		it	motherhood, and mothering	to discuss our interactions as the basis for deeper personalised relations
It was very extreme, and it was maddening	I had to bring it up, I had to confront it	I'm just gonna have this for ever, you know, it's the way I am	It wasn't the inward spiral that I would often, mentally, get myself into	I did much more extensive, much more productive work than I had ever done before
Every feeding method known to man	I did absolutely feel overwhelmed and completely pushed to every extreme, to every emotional extreme, every physical extreme		The more I've kind of focused on more mindful techniques the more I've really looked at it, looked at my triggers and noticed my responses earlier	The key realisation – breaking down my narrative around the experience of my anxiety and then relating that back to places where I'd experienced that previously
There were nights when she literally woke up every 15 minutes	I would have this eternal hill to climb		Now I notice that a bit earlier, I realise that it maybe isn't so terribly different.	I think it's helped our communication with each other so much that we're able to kind of mitigate the other .....help calm the situation effectively for the other person
I immediately gave them the wrong names in my head			The key was really there in my relationships with the people I was closest to.	That's the fundamental, help the other person get what they need so we can all calm down for the sake of everybody
"Really"! Most people I know have been in therapy for like 10 years!			I was conscious of wanting to protect her from [my anger]	To take pro-active steps that actually allow for the anger but keep it in a, in a contained [way]



**Appendix 9**  
Jane's 'other' voices

“Terrified” Fear – Adapted Child	“Mortified” Shame – Adapted Child	Critical Parent Angry	Nurturing Parent	Adult - Therapy
<i>I remember it all which I hate</i>	<i>I basically went psychotic, not that I heard voices or anything like that</i>	<i>Once I was labelled as sort of being mentally unwell people weren't focusing on my physical health</i>	<i>I've tried to understand about the feelings of guilt [...] towards my little boy</i>	I had this injection and after this injection I seemed to get this reaction
<i>I became real paranoid, like I was being watched and different things</i>	<i>I was completely psychotic basically (sobs)</i>	<i>It had nothing to do with [perinatal mental health team] what I was doing and I was quite annoyed</i>	<i>I wasn't interested [in my son], I know that's awful to say but I wasn't</i>	<i>That sounds very much like what I'm going to talk about</i>
<i>I had to get involved with perinatal (voice faltering) because I'd just gone really</i>	<i>I could barely look after [son] because I just had no interest at all</i>	<i>My husband and his family, they don't have a clue about mental health</i>	<i>I needed that care without having to ask</i>	<i>I've actually gone back [to therapy]</i>
<i>I was, it was like a different person</i>	<i>I feel quite embarrassed about it</i>	<i>[to self] Stop it!</i>	<i>Why did I come back to work so quickly?</i>	<i>It was about a month after I had my little boy</i>
<i>I was convinced I was dying, and that was it really</i>	<i>I thought I was dying so I was off to A and E, as you do</i>	<i>I thought "I won't cry, I'll just be able to reel it all off"</i>	<i>I just didn't want to do it anymore</i>	<i>I got to the point where I went psychotic</i>
<i>There is that fear that it could happen again</i>	<i>I felt like [therapist] was frightened of me, cos I was that paranoid</i>	<i>My mum wasn't particularly present when I was ill</i>	<i>Why do I have to put up with this, why do I want to do this?</i>	<i>It has really changed my perspective on things</i>
<i>I shied away from talking about it [...] I mean like doing the therapy</i>	<i>I threw away my antibiotics [...] I pretended I'd took em</i>	<i>As soon as I was ill my mum and dad disappeared</i>	<i>I don't want to do this anymore</i>	<i>It wasn't really effective at all because really I just needed to get well</i>

<i>beforehand, I explored a lot around attachment with my mum</i>	<i>and I went upstairs and dropped them down the sink</i>	<i>People around me didn't give me that care that I needed</i>		<i>I didn't have any insight</i>
<i>I felt very alone</i>	<i>I felt really embarrassed (starts to cry)</i>	<i>My mum had been put to sleep with me and I always found it very selfish that she'd done that, not wanting to be present at my birth</i>	<i>I remember actually coming to terms with dying</i>	<i>I felt like I was there but not particularly there</i>
<i>It was the worst fear that I had</i>	<i>I felt really embarrassed for you know my family seeing me like that and I was just mortified</i>	<i>I'm again being critical of my mum</i>	<i>I had to be looked after, I needed special care</i>	<i>I told a couple of people at work, one being my manager</i>
<i>I thought my mum might come and help me, I thought my husband's mum might come and help me, and I didn't really get anything</i>	<i>I do still feel embarrassed and I haven't, I suppose I haven't talked about it as much as maybe I could have done</i>	<i>I never felt [mum] could offer that care and attention</i>	<i>People with psychosis seem to get treated so different</i>	<i>I enjoy TA therapy</i>
<i>I had a planned cesarean which I was so frightened of</i>	<i>In my mind its people thinking "Oh you're gonna become psychotic again"</i>	<i>If I actually thought about it I could make a massive complaint, it was terrible</i>		<i>I was very absent</i>
<i>They rushed me in and put me to sleep which again was my worst fear</i>	<i>I felt so guilty that I'd had to be involved [with perinatal]</i>	<i>I'm sort of blaming all my mental health problems on medical things</i>		<i>I've mainly focused on thinking about my relationship with my little boy [in therapy]</i>
<i>I just tried to avoid feeling about anything, it was</i>	<i>I had to be involved [at work] with the crisis team</i>	<i>I was really anxious and that was nothing to do</i>		<i>I've focused on "well that happened" and I can</i>

<i>really traumatic</i>	<i>that I accessed – bobbed into our office and things like that, yeah hated every second</i>	<i>with anything</i>		<i>either stay with that and feel completely guilty or I can move</i>
<i>It felt like a lost time</i>	<i>I wasn't present at my little boy's [birth] so he ended up in NICU and that was a big guilt trip for me</i>	<i>In terms of my process I don't ask</i>		<i>Doing the therapy I've come through it</i>
<i>I felt really toxic, really really unwell, because it had spread as well, well it felt like it had spread</i>	<i>I hadn't done it properly and then I repeated what my mum had done</i>	<i>I've not challenged medical staff maybe as much as I should have</i>		<i>After that injection I seemed to become really unwell, anxious, shaking and heart palpitations</i>
<i>I just felt so overwhelmed</i>	<i>"not crazy anymore"</i>	<i>I really reproach myself all the time about the birth</i>		<i>TA has helped me to think differently about [my experience]</i>
<i>I don't feel like I'm allowed to ask for help</i>	<i>I was anxious on acid</i>	<i>I've closed the formal complaint and I give up</i>		<i>Doing therapy has changed me as a mum</i>
<i>I can be really anxious about having something wrong with me</i>	<i>I remember somebody saying[chronic fatigue] is an avoidance thing</i>	<i>"Don't even go there" changes pitch of voice "Don't even go there"</i>		<i>[Therapy] has changed the way I see things</i>
<i>I'm frightened of actually asking for help</i>	<i>I'm taking up your time</i>	<i>Your midwives, they discharge you and all they're bothered about is your child, but that I personally feel, that's the medical profession full stop!</i>		<i>I've found that I can open up</i>
<i>I was convinced I was</i>	<i>When I had the</i>	<i>Even that [the</i>		<i>I was given permission</i>

<i>going to die. I don't really want to go through that and talk to her about it, well that's my avoidance</i>	<i>miscarriage I tucked it down as far as I could</i>	<i>miscarriage] they managed to bodge up</i>		<i>that it's ok to feel</i>
<i>We went to live with my in-laws and they were really good with me</i>	<i>I was paying lip service to [my therapist]</i>	<i>He [radiographer] missed that I hadn't fully miscarried</i>		<i>It's made me be kind to myself as well</i>
<i>They looked after me and looked after my little boy</i>	<i>I remember having this sense that I was lying to her and knowing I was lying to her and hating that</i>	<i>They just discharged me</i>		<i>I've made a massive decision to leave my job</i>
	<i>We've [Jane and therapist] have never spoken about it. That's my embarrassment</i>	<i>It's across the board, it's not just when you have a baby its everything</i>		<i>His mum, she just let me sleep, because I was so unwell, and she looked after my little boy</i>
	<i>I was mortified I could be like that with [therapist]</i>	<i>Everything, every possibility where they could support you professionally and there is nothing</i>		<i>I would say to anyone to have therapy, even the way I deal with people in my day-to-day life I think differently</i>
	<i>I think it was the fact that I could like, because I felt quite deceitful</i>	<i>We've had a pretty shit time</i>		<i>It's that care that I don't get from [my mum]</i>
	<i>I think its my pure embarrassment, because I didn't want to let you down, but I was like, I don't know if I can do it, I</i>	<i>I shouldn't feel anything cos I've gone through that process, I've had my injection and I'm no longer pregnant, then you</i>		<i>I am going to be anonymous, it's fine</i>

	<i>don't know if I can actually admit I was psychotic</i>	<i>can't have any time off.</i>		
	<i>Even my husband, when they said I was psychotic to him, he was frightened of me, so frightened that I would come and hurt him. That was hard, that's why its been so hard, because it's everybody else's view.</i>	<i>As soon as I wasn't having any medical treatment I thought that's it, I've got to go back to work, I'm not allowed to spend anymore time off, "how dare you have three weeks off!"</i>		
		<i>As daft as it sounds</i>	<i>No it doesn't sound daft because I was psychotic!</i>	
		<i>You are just medicated and that's it.</i>		
		<i>The woman from perinatal was nice enough but it wasn't, it wasn't very good at all.</i>		
		<i>Working in mental health you see how prejudiced people are</i>		

**Appendix 10**  
Julija's 'other' voices

Disconnection - Fear and Anxiety	The depressed child Grief	Guilt and Shame	"I don't want to live like this" Change	Recognition and Integration
<i>I had a small baby and I had no time for him and everything just exploded.</i>	<i>I had a small baby and I had no time for him and everything just exploded.</i>	<i>I was like holding him tight and screaming and doing things I'm so not proud of, but then again guilt feelings because of that and it was just a circle, like never ending, so I was not good.</i>	<i>It was like a reality check for me, and an alarm, and I said no I don't want to live like this, this is not good</i>	<i>It [the u-tube video] suddenly made all the sense, also my depression, it was like a depressed child</i>
<i>I was totally, yeah, down, trembling, anxious, very anxious. I couldn't go to work at all</i>	<i>I was totally, yeah, down, trembling, anxious, very anxious. I couldn't go to work at all</i>	<i>The guilt feelings, because, because you should be now very happy and very enthusiastic and another baby is coming and the family, and blah blah blah</i>	<i>I took TA therapy, when he was 7 months old, I got very, erm, in contact with this pain of mine, that I had from when I was 11 months old, and even before 9 months old</i>	<i>I started basically to become more nurture, nurturing to myself,</i>
<i>This fear started to grow because er, because of the antidepressants, so I was really like I spent my whole pregnancy, the second time around, with guilt, and then fear, what</i>	<i>I got in contact with this sorrow because I was hospitalised, for, for a few weeks, when I was 9 months old and then also when I was 11 months old, but at that time mum</i>	<i>When I look back to that time it's a lot of fear, a lot of fear and a lot of guilt</i>	<i>its so crazy because I don't have the images but like my body responds to it, so its like somatic memory</i>	<i>To accept my erm to accept my failures, or to accept myself in the way to be more erm gentle to myself, to be more gentle to the role of mum</i>

<i>would be the damage</i>	<i>could not stay with me, in the hospital so I was like alone for 3 weeks and then took home, and then again, yeah</i>			
<i>I was nervous, I was nagging, I was rough some times</i>	<i>I got in touch so, and in those it was so strong, because I could imagine Tomáš, being the same age and now leaving him at the hospital and only seeing him for 2 hours a day, and all the other, all the time out of these two hours I didn't know, what, I mean, I wouldn't know what has been happening to him, how they were treating him, in the night for example, what kind, and I could just imagine myself, that sorrow, that pain was so strong</i>	<i>it was guilt because of that, because of everything I was feeling, the whole pregnancy</i>	<i>So, the first step was like yes, connecting to it (depression)</i>	<i>This time I can be good enough, I don't have to be perfect all the time" this is certainly something that was, was, the therapy was doing for me</i>
<i>So it was like fear, yes, what would that mean, for us, for the family, for me, will that be taken away from me</i>	<i>the sorrow just, I opened up I started to cry, I could feel that, I could really feel that, erm sadness (sighs), and that sorrow, that erm waiting, waiting,</i>	<i>These guilt feelings because of course if I'm depressed and I'm grieving I cannot be there for my kids, and I would like to be there, so I'm not</i>	<i>To have somebody, to have a weekly appointment, to go in there when I was grieving, and even talking about different other</i>	<i>I have surely become more, erm, more, more accepting of myself, as a woman, as a mum, as a person</i>

	<i>waiting, waiting to, erm for somebody to show up, to feel loved, for her mummy to come, to take her to, erm, to hug her</i>	<i>spending enough time with them, I'm not cuddling them enough, I'm not playing with them enough, I'm not empathic enough, I'm nagging, I'm angry, erm, all those things, were like then circling, around</i>	<i>things, about for instance, other aspects yes, I think it was very helpful, for me, to know that I have this support, somebody I trust</i>	
<i>I was afraid of getting critics or somebody saying something to me, that is not positive</i>	<i>I think I was actually grieving for some time, because I remember I was always checking you know, and asking myself, is it depression? Is it sorrow, is it depression, am I depressed?</i>	<i>Every time I made a mistake or did something I wasn't so proud of it was like "I'm a bad mum"</i>	<i>Talking with my therapist, sharing that with someone, who doesn't judge you, or even lets you know, in some way that you are good enough, that you are not, err the baddest mum in the world and things like that is really like, (large deep sigh), hard, how do you say, hard and precious</i>	<i>I think it started to heal from that moment on, when somebody else said "oh, yes, you are in such a distress", and I was like "ah ok, I am, so it is legitimate to have pain around it</i>
<i>I was left alone with my mum, but mum was working pretty much, during week days, so I was home alone a lot</i>	<i>Depression is something that is certainly part of me, like goes up and down and up and down, it goes up and its better and then its worse</i>	<i>I came in such contact with my erm my story of not being deserving to be called a mum</i>	<i>A very important thing for me was to distinguish between what I am thinking and what I will do</i>	
<i>"oh my god what now,</i>	<i>It makes sense because I, I</i>		<i>when I expressed anger</i>	



<i>what do I say now? I don't know?" I mean in my head, "what is the right answers, how come you don't know, you should know"</i>	<i>think I had to grieve that part, for her. So I felt down, I felt like very sad, everything was, I was very, erm, not opening up to other people</i>		<i>towards her I could in a week or two express anger towards my boss</i>	
<i>I was so anxious how will I do, what will I (pause) What if I don't do them good enough, what will happen, but you know not afraid of somebody else but of life in general</i>	<i>I think now, when I know so much about depression, I think I've had it, that's why I said that my depression started for sure in that hospital. I'm like (laughs wryly) I couldn't be more sure</i>		<i>in the therapy sessions I came in anxious but I never came out, went out with this feeling, it always, I'm not sure but she always managed to get somewhere with me</i>	
<i>did I harm him with all of those feelings of anger and sadness during the pregnancy</i>	<i>It makes sense because I, I think I had to grieve that part, for her. So I felt down, I felt like very sad, everything was, I was very, erm, not opening up to other people</i>		<i>she was giving me like permissions, yes its ok not to do anything if you need rest. So these things were such a blessing, I so needed to hear that</i>	
	<i>It makes sense because I, I think I had to grieve that part, for her. So I felt down, I felt like very sad, everything was, I was very, erm, not opening up to other people</i>		<i>somebody was recognising my, my distress, my worries or, even if alone, my feelings at that time, because I have never spoken about that with anyone</i>	

	<i>It makes sense because I, I think I had to grieve that part, for her. So I felt down, I felt like very sad, everything was, I was very, erm, not opening up to other people</i>			
--	--	--	--	--

**Appendix 11**  
Sarah' other voices

<b>Child fear and shame</b>	<b>Child Confusion</b>	<b>Child Sadness</b>	<b>Getting Help</b>	<b>TA Therapy</b>
What is the matter with me that I feel like this?	I'd had another baby and I didn't have the same reaction.	It affected our relationship completely, oh yeah (sounds in pain)	I tried to get some help for myself	She [therapist] was much better.
There is something wrong with me, it is not normal to feel like this	It was huge love and great relieve when George was born	It was like a stigmata as well as a stigma	I can't do this anymore, I'm going to have to tell Dominic	TA had a wealth of information and models about the person so that was hugely helpful
I've got a screw loose	I knew this was terrible for Sally, and I thought I can't do this to the children	I felt massively ashamed	We saw this useless psychologist	It helped me get a real sense of or framework to build up a picture
If I tell Dominic he will leave me	Maybe because she's a girl? Does it happen more with girls than boys?	Mine was huge antipathy, which has obviously got to do with hatred of myself.	I went to see a psychoanalyst	It gave me more information about the way I ticked and actually Sally, definitely me
I can't tell anyone, I can't tell Dominic	It could be hormonal, if I'd been given hormones it might not have happened	It's that transition to motherhood, it brings up all sorts of issues about yourself.	She was enormously helpful, she taught me strategies to manage	Sally and I would never have begun to operate without psychotherapy
This is horrendous	I don't know where it came from, it was cruel.	Dominic accepted it but he did not understand it.		I often think what the heck would have happened if I hadn't done all this psychotherapy
Oh my god what is the	It was kind of like	I'm sure he was terrified.		I was absolutely

matter with me	somebody had shot me	It was an extraordinary madness.		determined to sort this problem out [long pause] I had to
I will be horrendously shamed if I talk about this	I had this huge feeling of relief [when George was born] I had had an enormous fear actually.	We [her and Sally] operate, not in a way I'd like to but we operate		I believe so much in therapy because I've seen it in action, I've lived with it, I've seen it evolve, I've seen it develop, I've seen not just me but Dominic and our relationship and I've seen the impact on my son George.
I will lose my family, they will take George away	Like a child, it [mental illness] had gone, yes I really believe it had gone, it was a wicked awful witch and it had gone	It has had an enormous impact on her		The feeling that this isn't me dissipated over time
I felt worried, I can imagine I must have been terrified [pregnant with George]	It makes no sense why was I almost like attacked by this phenomenon.	[it was a dual process] That's what so desperately sad, you can imagine how she behaved, so it all got reactivated		I just think [TA] gave me a hugely greater understanding, of not only the process, Sally, or my assessment of her, it made me feel more stable in something that I just didn't understand, from which there were no answers.
Oh yes [huge shame]	It does have a kind of	It was a pretty grim		

	feeling that it was something out of me, but obviously it wasn't. But it has that kind of (pause) its so foreign.	experience		
I attached stigma to myself, I thought this is frightful.	Had it got anything to do with the fact that my great aunt was a schizophrenic?	You are wounded by stigmata aren't you and she was, that's my huge sadness.		
	It overtakes you. I felt absolutely overwhelmed by it			
	I have a sense that it came form the outside, although I knew it didn't and I am really kind of confused by that. Cos I thought this really isn't me, this feeling isn't me.			

## Reference List

- Abramowitz, M. (1996). *Regulating the lives of women: Social welfare policy from Colonial times to the present*. Rev. ed. Boston: South End.
- Abrams, L.S., Curran, L (2009). "And you're telling me not to stress?" A grounded theory study of postpartum depression symptoms among low-income mothers. *Psychology of Women Quarterly*, 33(3), 351-362
- Aderibigbe, Y.A., Gureje, O., Omigbodun, O. (1993). Postnatal emotional disorders in Nigerian women. A study of antecedents and associations. *British Journal of Psychiatry*, 163, 645–650.
- Adewuya, A.O., Fatoye, F.O., Ola, B.A., Ijaodola, O.R., Ibigbami, S.M. (2005). Sociodemographic and obstetric risk factors for postpartum depressive symptoms in Nigerian women. *Journal of Psychiatric Practice*, 11(5), 353–358.
- Agnafors, S., Sydsjö, G., deKeyser, L., Svedin, C.G. (2013). Symptoms of Depression Postpartum and 12 years Later – Associations to Child Mental Health at 12 years of Age. *Maternal Child Health Journal*, 17, 405-414
- Alanen, Y.O., Rääköläinen, V., Laakso, J., Rasimus, R., Kalgonen, A. (1986). *Towards Needs-specific Treatment of Schizophrenia Psychoses*. Heidelberg: Springer-Verlag
- Alanen, Y.O., Ugelstad, E., Armelius, B.E., Lehtinen, K., et al., (1994). Early treatment for Schizophrenic Patients: Scandinavian Psychotherapeutic Approaches. *Oslo: Scandinavian University Press*
- Alder, J., Fink, N., Bitzer, J., Hösli, I., Holzgreave, W. (2007). Depression and anxiety during pregnancy: A risk factor for obstetric, fetal and neonatal outcome? A critical review of the literature. *Journal of Maternal-Fetal & Neonatal Medicine*, 20, 189-209
- Allem, J.R. (2000). Biology and transactional analysis II: a status report on neurodevelopment. *Transactional Analysis Journal*, 10(4), 260-269
- American Psychiatric Association Practice guideline for the treatment of patients with major depressive disorder. (2010). *American Journal of Psychiatry* 167,1–152. Supplementary edition
- American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington, VA: American Psychiatric Association
- Anderson, L., Sundström-Poromaa, I., Bixo, M., Wulff, M., Bondestam, K., Aström, M. (2003). Point prevalence of psychiatric disorders during the second trimester of pregnancy: a populations-based study. *American Journal of Obstetrics & Gynecology*, 189, 148-154

Arnot, M., Reay, D. (2007). A sociology of pedagogic voice: Power, inequality and pupil consultation. *Discourse Studies in the Cultural Politics of Education* 28 (3): 311–25.

Arnup, K. (1994). *Education for motherhood: Advice for mothers in twentieth-century Canada*. Toronto: University of Toronto Press

Arrington, D.B. (2001). *Home is Where the Art Is: An Art Therapy Approach to Family Therapy*. Springfield, Illinois: Charles C Thomas

Arroll, B., Khin, N., Ngaire, K. (2003) Screening for depression in primary care with two verbally asked questions: cross sectional study. *British Medical Journal*, 327, 1144

Austin, M.P., Frilingos, M., Lumley, J., Hadzi-Pavlovic, D., Roncolato, W., Acland, S., Saint, K., Segal, N., Parker, G. (2003). Brief antenatal cognitive behaviour therapy group intervention for the prevention of postnatal depression and anxiety: A randomised controlled trial. *Journal of Affective Disorders*, 105, 35-44

Austin, M.P., Kildea, S., Sullivan, E. (2007) Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. *The Medical Journal of Australia*, 186, 364-367

Australian Government Department of Health and Ageing (2008). National Perinatal Depression Plan.

Ayers, S. (2013). Fear of childbirth, postnatal post-traumatic stress disorder and midwifery care. *Midwifery*, 30(2), 145-148

Baardseth, T.P., Goldber, S.B., Pace, B.Y., Wislocki, A.P., Frost, N.D., Siddiqui, J.R., Lindemann, A.M., Kivlighan III, D.M., Laska, K.M., Del Re, A.C., Minami, T., Wampold, B.E. (2013). Cognitive-behavioural therapy versus other therapies: Redux. *Clinical Psychology Review*, 33, 395-405

Baba Neal, S. (2017). A Therapist's Review of Process: Rupture and repair cycles in relational transactional analysis psychotherapy for a client with a dismissive attachment style: 'Martha'. *International Journal of Transactional Analysis Research & Practice*, 8(2), 24-34

Backenstrass, M., Joest, K., Frank, A., Hingmann, S., Mundt, C., Kronmüller, K.T. (2006). Preferences for treatment in primary care: a comparison of nondepressive, subsyndromal and major depressive patients. *General Hospital Psychiatry*, 28(2), 178-180

Badinter, E. (1981). *The myth of motherhood: an historical view of the maternal instinct*. London: Souvenir Press

Bakhtin, M.M. (1981). *The dialogic imagination: Four essays* (C. Emerson, & M Holquist, trans). Austin: University of Texas

- Bakker, M.K., Kölling, P., van den Berg, P.B., et al. (2008). Increase in use of selective serotonin reuptake inhibitors in pregnancy during the last decade, a population-based cohort study from the Netherlands. *British Journal of Clinical Pharmacology*
- Balint, M. (1968). *The Basic Fault*. London: Tavistock
- Banks, M. (2001). *Visual Methods in Social Research*. London, Sage
- Barlow, J., Bennett, C., Midgley, N., Larkin, S.K., Wei, Y. (2015). Parent-infant psychotherapy for improving parental and infant mental health. *The Cochrane Database of Systematic Reviews*, January 2015, Vol 1
- Barr, J. (1987). Therapeutic Relationship Model: Perspectives on the Core of the Healing Process. *Transactional Analysis Journal*, 17(4), 134-140
- Barth, J., Munder, T., Gerger, H., Nüesch, E., Trelle, S., Znoj, H., Jüni, P., Cuijpers, P. (2013). Comparative efficacy of seven psychotherapeutic interventions for patients with depression: a network meta-analysis. *Public Library of Science*, 10(5), e1001454
- Barthes, R. (1977). *Image, Music, Text*. New York: Hill & Wang
- Bates, L., Stickley, T. (2013). Confronting Goffman: How can mental health nurses effectively challenge stigma? A critical review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 20, 269-575
- Battle, C.L., Salisbury, A.L., Schofield, C.A., Ortiz-Hernandez, S. (2013). Perinatal Antidepressant Use: Understanding Women's Preferences and Concerns. *Journal of Psychiatric Practice*, 19(6), 443-453.
- Bauer, A., Parsonage, M., Knapp, M., Iemmi, V., Adelaja, B. (2014). *Costs of perinatal mental health problems*. London School of Economics and Political Science, London, UK.
- Bauer, A., Pawlby, S., Plant, D.T., King, D., Pariante, C.M., Knapp, M. (2015). Perinatal depression and child development: exploring the economic consequences from a South London cohort. *Psychological Medicine*, 45, 51-61.
- Beauchamp, T.L., Childress, J.F. (1979). *Principles of Biomedical Ethics*. Oxford: Oxford University Press
- Beck, A.T., War, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4, 561-571
- Beck, C., (1995). The effects of postpartum depression on maternal-infant interaction: a meta-analysis. *NursingResearch*, 44, 298-304.



- Beck, C. (1996) BDI-11. United States of America Patent No. 0154018392
- Beck, C.T. (2001). Predictors of postpartum depression: an update. *Nursing Research*, 50(5), 275-285.
- Beck, C.T. (2002). Postpartum depression: a metasynthesis. *Qualitative Health Research*, 12, 469-488
- Beck, C. T. (2006). Postpartum depression: It isn't just the blues. *The American Journal of Nursing*, 106(5), 40-50.
- Becker, H.S. (1986). Photography and sociology. In *Doing things together: Selected papers* (p 223-271). Evanston, IL: Northwestern University Press
- Beeber, L.S., Schwartz, T.A., Holditch-Davis, D.W., Canuso, R.W., Lewis, V.W., Hall, H.W. (2013). Parenting Enhancement, Interpersonal Psychotherapy to reduce Depression in Low-Income Mothers of Infants and Toddlers: Ad Randomized Trial. *Nursing Research*, 62(2), 82-90
- Belenky, M.F., Clinchy, B.M., Goldberger, N.R., Tarule, J.M. (1986). *Women's ways of knowing: The development of self, voice, and mind*. New York: Basic Books
- Benelli, E., Bergamaschi, M., Capoferri, C., Morena, S., Calvo, V., Mannarini, S., Palmieri, A., Zanchetta, M., Spinelli, M., Widdowson, M. (2017). TA Treatment of depression: a hermeneutic single-case efficacy design study – 'Deborah'. *International Journal of Transactional Analysis Research*, 8(1), 39-58
- Benelli, E., Boschetti, D., Piccirillo, C., Quagliotti, L., Calvo, V., Palmieri, A., Sambin, M., Widdowson, M. (2016). TA Treatment of Depression: A Hermeneutic Single-Case Efficacy Design Study - 'Luisa'. *International Journal of Transactional Analysis Research*, 7(1), 35-50
- Benelli, E., Filanti, S., Musso, R., Calvo, V., Mannarini, S., Palmieri, A., Widdowson, M. (2017). 'TA treatment of depression: A Hermeneutic Single-Case Efficacy Design Study – Caterina'. *International Journal of Transactional Analysis Research*, 8(1), 21-38
- Benelli, E., Moretti, E., Cavallero, G.C., Greco, G., Calvo, V., Mannarini, S., Palmieri, A., Widdowson, M. (2017). TA Treatment of depression: a hermeneutic single-case efficacy design study – 'Anna'. *International Journal of Transactional Analysis Research*, 8(1), 3-20
- Benelli, E., Revello, B., Piccirillo, C., Mazzetti, M., Calvo, V., Palmieri, A., Sambin, M., Widdowson, M. (2016). TA treatment of depression: A hermeneutic single-case efficacy design study – Sara. *International Journal of Transactional Analysis Research*, 7(1), 3-18

- Benelli, E., Scottà, F., Barreca, S., Palmieri, A., Calvo, V., de Rénoche, G., Colussi, S., Sambin, M., Widdowson, M. (2016). TA treatment of depression: a hermeneutic single-case efficacy design study. *International Journal of Transactional Analysis Research*, 7(1), 19-34
- Benjamin, J. (2002). Principles of relational psychoanalysis. First biannual meeting of the International Association for Relational Psychoanalysis and Psychotherapy, New York
- Bennett, H.A., Einarson, A., Taddio, A., Koren, G., Einarson, T.R.. (2004). Prevalence of depression during pregnancy: Systematic re- view. *Obstetrics & Gynecology*, 103, 698–709.
- Bennett, H., Boon, H., Romans, S., Grootendorst, P. (2007). Becoming the best mom that I can: women’s experiences of managing depression during pregnancy – a qualitative study. *BMC Women’s Health*, 7, 13
- Bérard, A., Zhao, J., Sheehy, O. (2015). Sertraline use during pregnancy and the risk of major malformations. *American Journal of Obstetrics & Gynecology*, 795.e1-e12.
- Berne, E. (1961). *Transactional Analysis in Psychotherapy*. First published 1961, New York: Grove Press
- Berne, E. (1964). *Games People Play*. New York: Grove Press
- Berne, E. (1994[1966]). *Principles of Group Treatment*. Menlo Park, CA: Shea Books (Republished 1994)
- Berne, E. (1968). *A Layman’s Guide to Psychiatry and Psychoanalysis*. New York: Penguin
- Berne, E. (1970). *Sex in Human Loving*. London: Penguin
- Berne, E. (1971). Away from a Theory of the Impact of Interpersonal Interaction on Non-Verbal Participation. *Transactional Analysis Journal*, 1(1), 6-13
- Berne, E. (1972). *What Do You Say After You Say Hello?* London: Corgi.
- Bertaux, D. (1981). *Biography and Society*. Beverly Hills, CA: Sage
- Bevan, D., Wittkowski, A., Wells, A. (2013). A Multiple-Baseline Study of the Effects Associated with Metacognitive Therapy in Postpartum Depression. *Journal of Midwifery & Women’s Health*, 58, 69-75
- Biegler, P. (2011). *The Ethical Treatment of Depression: Autonomy through psychotherapy*. Cambridge, MA: The MIT Press

- Bilszta, J., Ericksen, J., Buist, A., Milgrom, J. (2010). Women's experiences of postnatal depression – beliefs and attitudes as barriers to care. *Australian Journal of Advanced Nursing*, 27(3), 44-54
- Bion, W. (1962a) *Learning from experience*. London: Karnac
- Bion, W.R. (1967). *Second thoughts*. London: Heinemann (Maresfield reprints)
- Bittner, A., Peukert, J., Zimmerman, C., Junge-Hoffmeister, J., Parker, L., Stöbel-Richter, Y. (2014). Early Intervention in Pregnant Women with Elevated Anxiety and Depressive Symptoms: Efficacy of a Cognitive-Behavioral Group Program. *Journal of Perinatal & Neonatal Nursing*, 28(3), 185-195
- Blake, P. (2011). *Child and Adolescent Psychotherapy*. London: Karnac
- Bledsoe, S.E., Grote, N.K. (2006). Treating Depression during pregnancy and the postpartum: a preliminary meta-analysis. *Research on Social Work Practice*, 16 (2), 109-120
- Bloom, L.R. (1998). *Under the Sign of Hope: Feminist Methodology and Narrative Interpretation*. Albany: State University of New York Press
- Bollas, C. (1987). *The Shadow of the Object: Psychoanalysis of the Unthought Known*. New York: Columbia University Press
- Bonari, L., Pinto, N., Ahn, E., Einarson, A., Steiner, M., Koren, G. (2004). Perinatal risks of untreated depression during pregnancy. *Canadian Journal of Psychiatry*, 49, 726-735
- Bond, T. (2004). *Ethical Guidelines for Researching Counselling and Psychotherapy*. Rugby: British Association of Counselling and Psychotherapy
- Boots Family Trust Alliance, Netmums, Institute of health Visiting, Tommy's, The Royal College of Midwives. (2013). *Perinatal Mental Health Experiences of Women and Health Professionals*. London: Boots Family Trust
- Bowen, A., Baetz, M., Schwartz, L., Balbuena, L., Muhajarine, N. (2014). Antenatal Group Therapy improves Worry and Depression Symptoms, *The Israel Journal of Psychiatry and Related Sciences*, 51(3), 226-231
- Bowen, A., Stewart, N., Baetz, M., Muhajarine, N. (2009). Antenatal depression in socially high-risk women in Canada. *Journal of Epidemiology and Community Health*, 63, 414-416
- Bower, P., Gilbody, S. (2010). The Current View of Evidence and Evidence-Based Practice in M Barkham, G. Hardy, J. Mellor Clark (editors) *Developing and Delivering Practice- Based Evidence: A guide for the Psychological Therapies*. London, UK: Wiley & Sons

- Bowlby, J. (1961). *Attachment and Loss*. London: Hogarth
- Bowlby, J. (1977). 'The making and breaking of affectional bonds', *British Journal of Psychiatry*, 130, 201-210 and 421-431,
- Bowlby, J. (1979). *The Making and Breaking of Affectional Bonds*. Abingdon, UK: Routledge Classics
- Bowser, D., Hill, K. (2010) *Exploring Evidence for Disrespect and Abuse in Facility-based Childbirth: Report of a Landscape Analysis*. Harvard School of Public Health and University
- Boyce, P., Barriball, E. (2010). Puerperal psychosis. *Archives of Women's Mental Health*, 13(1), 45-47
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 2, 77-101.
- British Medical Journal (2014) p349 doi: <https://doi-org.salford.idm.oclc.org/10.1136/bmj.g7535>
- Britton, J.R. (2008). Maternal anxiety: Cause and antecedents during the early postpartum period. *Depression and Anxiety*, 25(9) 793-800
- Brown, B. (2007). *I Thought It Was Just Me (But It Isn't) – Making the Journey from "What Will People Think?" to "I Am Enough"*. New York: Avery
- Brown, G.W., Harris, T. (1978). *Social origin of depression: a study of psychiatric disorder in women*. London: Tavistock Publications
- Brown, S., Lumley, J., Small, R., Astbury, J. (1994). *Missing voices: the experience of motherhood*. Melbourne: Oxford University Press
- Brown, L.M., Gilligan, C. (1992). *Meeting at the crossroads: Women's psychology and girls' development*. Cambridge, MA: Harvard University Press
- Bruner, J. (1986). *Actual Minds, Possible Worlds*. Cambridge, MA: Harvard University Press
- Bruner, J. (1990). *Acts of Meaning*. Cambridge, MA: Harvard University Press
- Bruner, J. (1991). The narrative construction of reality. *Critical Inquiry*, 18, 1-21
- Bruner, J. (2002). *Making Stories: Law, Literature, Life*. New York: Farrar, Straus and Giroux
- Budd, R., Hughes, I. (2009). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review*, 26, 17-31

- Buist, A., Bilszta, J., Barnett, B., Milgrom, J., Ericksen, J., Condon, J., Hayes, B., Brooks, J. (2005). Recognition and management of perinatal depression in general practice--a survey of GPs and postnatal women. *Australian Family Physician*, 34(9), 787-790
- Buist, A., Bilszta, J., Milgrom, J., Barnett, B., Haynes, B., Austin, M. (2006) Health professional's knowledge and awareness of perinatal depression: results of a national survey. *Women and Birth*, 19, 11-16
- Burns, A., O'Mahen, H., Baxter, H., Bennert, K., Wiles, N., Ramchandani, P., Turner, K., Sharp, D., Thorn, J., Noble, S., Evans, J. (2013). A pilot randomised controlled trial of cognitive behavioural therapy for antenatal depression. *BMC Psychiatry*, 13, 33
- Burton, M., Chapman, M.J. (2004). Problems of Evidence Based Practice in Community Based Services. *Journal of Learning Disabilities*, 8, 56-70
- Butler, J. (1993/2011). *Bodies That Matter*. Abingdon, Oxon: Routledge
- Butler, J. (2001). *Giving an Account of Oneself*. Fordham University Press: New York
- Butler, J. (1997). *The Psychic Life of Power*. Stanford, CA: Stanford University Press
- Buttner, M.M., O'Hara, M.W., Watson, D. (2012). The structure of women's mood in the early postpartum. *Assessment*, 19, 247-256.
- Button, S., Lee, S., Shakespeare, J., Ayers, S. (2017). Seeking help for perinatal psychological distress: A meta-synthesis of women's experiences. *The British Journal of General Practice*, 67(663), e692-e699
- Buultjens, M., Liamputtong, P. (2007). When giving life starts to take the life out of you: women's experiences of depression after childbirth. *Midwifery*, 23(1), 77-91
- Byatt, N., Biebel, K., Friedman, L., Debordes-Jackson, G., Ziedonis, D., Pbert, L. (2013). Patients' views on depression care in obstetric settings: how do they compare to the views of perinatal health care professionals? *General Hospital Psychiatry*, 35(6), 598-604
- Byrne, P. (2001). Psychiatric Stigma. *The British Journal of Psychiatry*, 178, 281-284
- Byrom, S., & Downe, S. (Eds) (2015). *The Roar Behind The Silence: Why Kindness, Compassion and Respect Matter in Maternity Care*. London: Pinter & Martin

- Carey, N. (2012). *The Epigenetics Revolution: How Modern Biology is Rewriting Our Understanding of Genetics, Disease and Inheritance*. London: Icon Books
- Carr, D. (1986). *Time, narrative and history*. Bloomington, IN: Indiana University Press.
- Caspi, A., Sugden, K., Moffitt, T.E., Taylor, A., Craig, I.W., Harrington, H., McClay, J., Mill, J., Martin, J., Braithwaite, A., Poulton, R. (2003). Influence of life stress on depression: Moderation by a polymorphism in the 5-HT gene. *Science*. 301, 386-389
- Chabrol, H., Teissedre, F., Armitage, J., Danel, M., Walburg, V. (2004). Acceptability of psychotherapy and antidepressants for postnatal depression among newly delivered mothers. *Journal of Reproductive and Infant Psychology*, 22, 5-12
- Chafe, W. (1994). *Discourse, consciousness, and time: The flow and displacement of conscious experience in speaking and writing*. Chicago: University of Chicago Press.
- Chamberlayne, P., Rustin, M. Wengraf, T. (eds)(2002). *Biography and Social Exclusion in Europe: Experiences and Life Journey*. Bristol: The Policy Press
- Chan, S., Levy, V. (2004). Research in brief postnatal depression : a qualitative study of the experiences of a group of Hong Kong Chinese women. *Journal of Clinical Nursing*, 13(1), 120-123
- Chan, S.W., Williamson, V., McCutcheon, H. (2009). A Comparative study of the experiences of a group of Hong Kong Chinese women and Australian women diagnosed with postnatal depression. *Perspectives in Psychiatric Care*, 45(2), 108-118
- Charura, D., Paul, S. (2014). *The therapeutic relationship handbook: theory and practice*. Maidenhead, England: McGraw Hill Education/Open University Press
- Cheng, R.C., Lai, S.S., Sin, H.F. (1994). A study exploring the risk of postnatal depression and the help-seeking behaviours of postnatal women in Hong-Kong. *Hong-Kong Nursing Journal*, 68, 12-17
- Choi, H., Yamashita, T., Wada, Y., Narumoto, J., Nanri, H., Fujimori, A., Yamamoto, H., Nishizawa, S., Masaki, D., Fukui, K. (2010). Factors associated with postpartum depression and abusive behavior in mothers with infants. *Psychiatry and Clinical Neuroscience*, 64(2),120-12
- Choi, K.W., Sikkema, K.J., Vythilingum, B., Geerts, L., Faure, S.C., Watt, M.H., Roos, A., Stein, D.J. (2017). Maternal childhood trauma, postpartum depression, and

infant outcomes: Avoidant affective processing as a potential mechanism. *Journal of Affective Disorders*, 211, 107-115

Choi, P., Henshaw, C., Baker, S., & Tree, J. (2005). Supermum, superwife, supereverything: performing femininity in the transition to motherhood. *Journal of Reproductive and Infant Psychology*, 23 (2), 167-180.

Chu, B.C., Kendall, P.C. (2009). Therapist responsiveness to child engagement: Flexibility within manual-based CBT for anxious youth. *Journal of Clinical Psychology*, 65(7), 736-754.

Cicchetti, D., Toth, S.L., Rogosch, F.A. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment & Human Development* 1(1), 34-66.

Cicchetti D, Rogosch FA, Toth SL (2006) Fostering secure attachment in infants in maltreating families through preventive interventions. *Developmental Psychopathology*, 18(3), 623-649

Clandinin, J., Connelly, P. (2000). *Narrative Inquiry: Experience and Story in Qualitative Research*. San Francisco, CA: Jossey-Bass

Claridge, A. (2014). Efficacy of systemically oriented psychotherapies in the treatment of perinatal depression: a meta-analysis. *Archive of Women's Mental Health*, 17(1), 3-15

Clark, B. (1991). Empathic Transactions in the Deconfusion of the Child Ego State. *Transactional Analysis Journal*, 21(2), 92-98

Clark, R., Tluczek, A., Brown, R. (2008). A mother-infant therapy group model for postpartum depression. *Infant Mental Health Journal*, 29(5), 514-536

Clarkson, P. (1992). *Transactional Analysis Psychotherapy: An Integrated Approach*. London: Routledge

Clarkson, P. (1995). *The therapeutic relationship in psychoanalysis, counselling psychology and psychotherapy*. London: Whurr

Clarkson, P. (1996). Researching the "therapeutic relationship" in psychoanalysis, counselling psychology and psychotherapy – a qualitative inquiry. *Counselling Psychology Quarterly*, 9(2), 143-162

Cloitre, M., Stolbach, B.C., Herman, J.L., van der Kolk, B., Pynoos, R., Wang, J., Petkova, E. (2009). A developmental approach to complex PTSD: childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Trauma Stress* 22(5), 399-408.

Coates, R., Ayers, S., de Visser, R. (2009). Women's experiences of postnatal distress: a qualitative study. *BMC Pregnancy & Childbirth*, 14:359

Cohen, J., Altshuler, L.L., Harlow, B.L., Nonacs, R., Newport, J., Viguera, A.C., Suri, R., Burt, V.K., Hendrick, V., Reminick, A.M., Loughhead, A., Vitonis, A.F., Stowe, Z.N. (2006). Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. *JAMA*, 295:499– 507.

Collins, P.H. (1991a). *Black feminist thought: Knowledge, consciousness and the politics of empowerment*. New York and London: Routledge

Connerton, P. (1976). (ed) *Critical Sociology*. London: Penguin Books Ltd

Cooper, M., McLeod, J. (2015). Client Helpfulness Interview Studies: A guide to exploring client perceptions of change in counseling and psychotherapy. (Working Paper). Retrieved from [https://www.researchgate.net/profile/Mick\\_Cooper](https://www.researchgate.net/profile/Mick_Cooper)

Cooper, P.J., Murray, L., Wilson, A., Romaniuk, H. (2003). Controlled trial of the short-and long-term effect of psychological treatment of postpartum depression, 1. Impact on maternal mood. *British Journal of Psychiatry*, 182(5), 412-419

Cooper, P.J., Tomlinson, M., Swartz, L., Woolgar, M., Murray, L., Molteno, C. (1999). Post-partum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry*. 175, 554–558.

Copper, R.L., Goldenberg, R.L., Das, A., et al (1996). The preterm prediction study: maternal stress is associated with spontaneous preterm birth at less than thirty-five weeks' gestation. *American Journal of Obstetrics and Gynecology*, 175, 1286-1292

CORE Information Management Systems Ltd. Outcome Measure 34. From <http://www.coreims.co.uk>

CORE Information Management Systems Ltd. (2007). CORE Net. From <http://www.coreims.co.uk>

Cornell, W.F. (2001). There ain't no cure without sex: the provision of a "vital" base. In W.F. Cornell and H. Hargaden (eds), *From Transactions to Relations: The Emergence of a Relational Tradition in Transactional Analysis* (p213-224). Chadlington, UK: Haddon Press , 2005

Cornell, W.F., Bonds-White, F. (2001). Therapeutic relatedness in transactional analysis: The truth of love or the love of truth. *Transactional Analysis Journal*, 31, 71-93

Cornell, W.F., Hargaden, H. (eds) (2005). *From Transactions to Relations: the Emergence of a Relational Tradition in Transactional Analysis*. Chadlington, UK: Haddon Press

Costley, C., Elliott, G., & Gibbs, P. (2010). *Doing Work-Based Research: Approaches to Enquiry for Insider-Researchers*. London: Sage



Cotterill, P. (1992). Interviewing women: Issues of friendship, vulnerability, and power. *Women's Studies International Forum*, 15(5), 593-606

Cox, J.L., Holden, J.M. & Sagovsky, R. (1987) Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786.

Craib, I.(2004). Narratives as Bad Faith. In M. Andrews, S.D. Sclater, C. Squire, and A. Treacher (eds) (*Uses of Narrative*). New Brunswick, NJ: Transaction

Craig, R., Mindell, J., Hirani, V. (eds) (2009). *Health Survey for England 2008*. London: The Information Centre

Cramer, B. (1998). Mother-infant psychotherapies: a widening scope in technique. *Infant Mental Health Journal*, 19(2), 151-167

Cresswell, J.W. (2003). Research design: Qualitative, quantitative, and mixed methods approaches (2nd ed.). Thousand Oaks, Calif.: Sage.

Crisp, A. (1998). Changing Minds: every family in the land. The coming College campaign to reduce the stigmatisation of those with mental disorders. *Bulletin of the Royal College of Psychiatrists* 22, 328-329

CSIP (2008) Improving Access to Psychological Therapies (IAPT Commissioning Toolkit.

Cuijpers, P., Brännmärk, J.G., van Straten, A.(2008). Psychological treatment of postpartum depression: a meta-analysis. *Journal of Clinical Psychology*, 64, 103-118

Cuijpers, P., Geraedts, A.S., van Oppen, P., Andersson, G., Markowitz, J.C., van Straten, A. (2011). Interpersonal Psychotherapy for Depression: A Meta-Analysis. *The American Journal of Psychiatry*, 168(6), 581-592

Cuijpers, P., Smit, F., Bohlmeijer, E., Hollon, S., Andersson, G. (2010). Efficacy of cognitive-behavioural-therapy and other psychological treatments for adult depression: a meta-analytic study of publication bias. *British Journal of Psychiatry: The Journal of Mental Science*, 196(3), 173-178

Cuijpers, P., Weitz, E., Karyotaki, E., Garber, J., Andersson, G. (2015). The effects of psychological treatment of maternal depression on children and parental functioning: a meta-analysis. *European Child & Adolescent Psychiatry*, 24(2), 237-245

Culler, J. (2002). *The Pursuit of Signs*. Ithaca, NY: Cornell University Press

- Da Costa,, D., Larouche, J., Dritsa, M., Brender, W. (2000). Psychosocial correlates of prepartum and postpartum depressed mood. *Journal of Affective Disorders* 59, 31-40
- Dahlen, H. (2010). Undone by fear? Deluded by trust? *Midwifery*, 26(2), 156-162
- Dahlen, H., Gutteridge, K. (2015). Stop the fear and embrace birth. In S. Byrom, & S. Downe, (Eds) (2015). *The Roar Behind The Silence: Why Kindness, Compassion and Respect Matter in Maternity Care*. (p98-104). London: Pinter & Martin
- Darwin, Z., McGowan, L., Edozien, L.C. (2016) Identifiacion of women at risk of depression in pregnancy: using women’s accounts to understand the poor specificity of the Whooley and Arroll case finding question in clinical practice. *Archives of Women’s Mental Health*, 19(1), 41-49
- Darwin, Z., McGowan, L., Edozien, L.C., (2014) Antenatal mental health referrals: Review of local clinical practice and pregnant women’s experiences in England, *Midwifery*, 31(3), e17-e22
- David, D.H., Styron, T., Davidson, L. (2011) Supported parenting to meet the needs and concerns of mothers with severe mental illness. *American Journal of Psychiatric Rehabilitation*, 14(2), 137-153
- Davies, B., Allen, D. (2007). Integrating ‘mental illness’ and ‘motherhood’: The positive use of surveillance by health professionals. A qualitative study. *International Journal of Nursing Studies*, 44(3), 365–76
- Dean, M. (2016). *Using Art Media in Psychotherapy: Bringing the Power of Creativity to Practice*. New York, NY: Taylor & Francis Group
- Deave, T., Heron, J., Evans, J., Emond, A. (2008). The impact of maternal depression in pregnancy on early child development. *British Journal of Obstetrics & Gynecology*, 115, 1043-1051
- Delamont, S., Atkinson, P. (1995). *Fighting Familiarity: Essays on Education and Ethnography*. Cresskill, NJ: Hampton Press
- Deleuze, H. (1966). *Le Bergsonisme*. Paris: PUF
- Deleuze, G. (1968). *Différence et Répétition*. Paris: PUF
- Deleuze, G. (2000). *Proust and Signs* (R. Howard trans). London: Athlone
- Deleuze, G., Guattari, F. (1976). *Rhizôme: Introduction*. Paris: Minuit
- Dennis, C.-L., Chung-Lee, L. (2006). Postpartum Depression Help-Seeking Barriers and Maternal Treatment Preferences: A Qualitative Systematic Review. *Birth*, 33, 323-331

- Dennis, C.-L., Hodnett, E. (2007). Psychosocial and psychological interventions for treating postpartum depression. *The Cochrane database of systematic reviews*, (4), pp.CD006116
- Dennis, C.-L., Ross, L.E., Grigoriadis, S. (2007). Psychosocial and psychological interventions for treating antenatal depression. *The Cochrane database of systematic reviews*, 18 July 2007(3), CD006309
- Denzin, N.K., Lincoln, Y.S. (Eds.). (2000). *Handbook of qualitative research* (2nd edition). Thousand Oaks, CA: Sage.
- Department of Health and Social Care (1999). *National Service Framework for Mental Health: Modern Standards & Service Models*. [Retrieved from: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/198051/National\\_Service\\_Framework\\_for\\_Mental\\_Health.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198051/National_Service_Framework_for_Mental_Health.pdf)]
- Department of Health and Social Care. (2008). *High Quality Care for All: NHS Next Stage Review Final Report*. [Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/228836/7432.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf) 13th February 2018]
- Department of Health and Social Care (2012). *Maternal Mental Health Pathway*. <https://www.gov.uk/government/publications/maternal-mental-health-pathway>
- Derrida, J. (1977). *Of Grammatology*. Baltimore, MD: Johns Hopkins University Press
- Derrida, J. (2000). *Of hospitality: Anne Dufourmantelle invites Jacques Derrida to respond*. (R. Bowlby, Trans). Stanford, CA: Stanford University Press. (Original work published 1997)
- Derrida, J. (1994). *Specters of Marx: The state of the debt, the work of mourning, & the new international* (P. Kamuf, Trans) New York: Routledge. (Original work published 1993)
- deCamps Meschino, D., Philipp, D., Israel, A., Vigod, S. (2016). Maternal-infant mental health: postpartum group intervention. *Archive of Women's Mental Health*, 19, 243-251
- DeYoung, P. (2003). *Relational Psychotherapy – a Primer*. New York: Brunner-Routledge
- DeYoung, P. (2015). *Understanding and Treating Chronic Shame – A Relational/Neurobiological Approach*. New York and Hove: Routledge
- Diaz-Caneja, A., Johnson, S. (2004). The views and experiences of severely mentally ill mothers: a qualitative study. *Social Psychiatry and Psychiatric Epidemiology*, 39(6), 472-482

- Di Mascio, V., Kent, A., Fiander, M. and Lawrence, J. (2008). Recovery from postnatal depression: A consumer's perspective. *Archives of Women's Mental Health*, 11(4), 253-257.
- Dipple, H., Smith, S., Andrews, H., Evans, B. (2002). The experience of motherhood in women with severe and enduring mental illness. *Social Psychiatry and Psychiatric Epidemiology*, 37(7), 336-340
- Dmitri, S., Tuchina, O., Novikov, S., Fedotov, I. (2016). Combinations of Injunctions and Personality Types Determining Forms of Self-Destructive Behaviour in Alcohol-Dependent Clients: Findings of a Russian Observational Study. *International Journal of Transactional Analysis Research*, 7(2), 10-20
- Dornelas, E.A., Ferrand, J., Stepnowski, R., Barbagallo, J., McCullough, L. (2010). A Pilot Study of Affect-Focused Psychotherapy for Antepartum Depression. *Journal of Psychotherapy Integration*, 20(4), 364-382
- Doucet, S., Letourneau, N., & Blackmore, E. R. (2012). Support needs of mothers who experience postpartum psychosis and their partners. *Journal of Obstetric, Gynecologic and Neonatal Nursing*, 41, 236-245.
- Dressler, W.W., Balieiro, M.C., Ribeiro, R.P., dos Santos, E.E. (2007a). Cultural consonance and psychological distress: examining the associations in multiple cultural domains. *Culture, Medicine & Psychiatry*. 31, 195-224
- Dressler, W.W., Balieiro, M.C., Ribeiro, R.P., dos Santos, J.E. (2007b). A prospective study of cultural consonance and depressive symptoms in urban Brazil. *Social Science & Medicine*. 65, 2058-2069
- Dunkel Schetter, C. (2009). Stress Processes in Pregnancy and Preterm Birth. *Current Directions in Psychological Science*, 18 (4), 205-209
- Dunkel Schetter, C., Tanner, L. (2012). Anxiety, Depression and Stress in pregnancy: implications for mothers, children, research, and practice. *Current Opinion in Psychiatry*, 25 (2), 141-148
- Dusay, J. (1972). Egograms and the Constancy Hypothesis. *Transactional Analysis Journal*, 2(3), 37
- Dwight-Johnson, M., Sherbourne, C.D., Liao, D., Wells, K.B. (2000). Treatment preferences among depressed primary care patients. *Journal of General Internal Medicine*, 15(8), 527-534
- Eberhard-Gran, M., Garthus-Niegel, S., Garthus-Niegel, K., Eskild A. (2010). Postnatal care: A cross-cultural and historic perspective. *Archives of Women's Mental Health*. 13, 459-466.
- Edge, D., Baker, D., Rogers, A. (2004). Perinatal depression among black Caribbean women. *Health and Social Care in the Community*, 12, 430-438

Edhborg, M., Nasreen, H.E., Kabir, Z.N. (2015). "I can't stop worrying about everything"—Experiences of rural Bangladeshi women during the first postpartum months. *International Journal of Qualitative Studies on Health and Well-Being*, 10(1), [http://www.tandfonline.com/doi/full/10.3402/qhw.v10.26226, accessed 18<sup>th</sup> February 2018]

Edwards, E., Timmons, S. (2005). A qualitative study of stigma among women suffering postnatal illness. *Journal of Mental Health*, 14(5), 471-481

Edwards, R., Weller, S. (2012). Shifting analytic ontology: using I-poems in qualitative longitudinal research. *Qualitative Research*, 12(2), 202-217

Ehrenreich, B., English, D. (1973). *Witches, Midwives and Nurses*. Glass Mountain Pamphlets, New York, The Feminist Press

Elkin, I. (1994). The NIMH Treatment of Depression Collaborative Research Programme: Where we began and where we are. In A.E. Bergin and S.L. Garfield (eds), *Handbook of Psychotherapy and Behavior Change*, 4<sup>th</sup> edn. Chichester: Wiley

Elkin, I., Parloff, M.B., Hadley, S.W., Autry, J.H. (1985). NIMH Treatment of Depression Collaborative Research Program: Background and research plan. *Archives of General Psychiatry*, 42(3), 305-316

Elkin, I., Shea, M.T., Watkins, J.T., Imber, S.D., Sotsky, S.D., Collins, J.F., Glass, D.R., Pilkonis, P.A., Leber, W.R., Docherty, J.P., Fiester, S.J., Parloff, M.B. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Archives of General Psychiatry*, 46, 971-982

Elliott, R. (2001). Hermeneutic single case efficacy design (HSCED): An overview. In K.J. Schneider, J.F.T. Bugental & J.F. Fraser (eds), *Handbook of Humanistic Psychology* (p315-324). Thousand Oaks, CA: Sage

Elliott, R. (2002). Hermeneutic Single-Case Efficacy Design. *Psychotherapy Research Journal of the Society for Psychotherapy Research*. 12, 1-21

Elliott, R., Partyka, R., Alperin, R., Dobrenski, R., Wagner, J., Messer, S., Watson, J.C., Castonguay, L.J. (2009). An adjudicated hermeneutic single-case efficacy design study of experiential therapy for panic/phobia. *Psychotherapy Research*, 19, 543-557

Emmett, E. (1972). *Learning to Philosophize*. Pelican: London.

English, F. (2007). I'm Now a Cognitive Transactional Analyst, Are You? *The Script*, 37(5), 1, 6-7

- Engqvist, I., Ferszt, G., Ahlin, A., & Nilsson, K. (2011). Women's experience of postpartum psychotic episodes – Analyses of narratives from the internet. *Archives of Psychiatric Nursing*, 25, 376–387.
- Epperson, C.N., Jatlow, P.I., Czarkowski, K., Anderson, G.M. (2003). Maternal fluoxetine treatment in the postpartum period: effects on platelet serotonin and plasma drug levels in breastfeeding mother-infant pairs. *Pediatrics*, 112, e425-e429
- Ernst, F. (1971). The OK Corral: The Grid for Get-On-With. *Transactional Analysis Journal*, 1(4), 231-240
- Erskine, R.G. (1991). Transference and Transactions: Critique from an Intrapsychic and Integrative Perspective, *Transactional Analysis Journal*, 21(2), 63-76
- Erskine, R.G. (2001). Psychological function, relational needs, and transference resolution: Psychotherapy of an obsession. *Transactional Analysis Journal*, 31, 220-226
- Erskine, R., Moursund J.P., Trautmann, R.L. (1999). *Beyond Empathy: A Therapy of Contact-in-Relationship*. New York: Brunner-Routledge
- Erskine, R.G., Trautmann, R.L. (1996). Methods of an Integrative Psychotherapy. *Transactional Analysis Journal*, 26(4), 316-328
- Erskine, R., Zalcman, M. (1979). The Racket System: A Model for Racket Analysis. *Transactional Analysis Journal*, 9(1), 51-59
- Erwin, E. (1997). *Philosophy & Psychotherapy*. London: Sage
- ESRC, 2015:10 found at <http://www.esrc.ac.uk/files/funding/guidance-for-applicants/esrc-framework-for-research-ethics-2015/> (downloaded 31.12.2017)
- Etherington, K. (2004). *Becoming a Reflexive Researcher: Using Our Selves in Research*. London: JKP
- Ettinger, B.L. (2006). *The Matrixial Borderspace*. Minneapolis, MA: University of Minnesota Press
- Ettinger, B.L. (2010). (M)Other re-spect: Maternal subjectivity, the *Ready-made mother-monster* and the Ethics of Respecting, *Studies in the Maternal*, 2(1)
- Fairbairn, W.R.D. (1940). *Psychoanalytic Studies of the Personality*. London: and New York: Tavistock/Routledge
- Fairclough, N. (1995). *Critical Discourse Analysis*. London: Longman

Faisal-Curry, A., Menzes, P. (2007). Prevalence of anxiety and depression during pregnancy in a private setting sample. *Archive of Women's Mental Health*, 10, 25-32

Faisal-Curry, A., Menzes, P., Araya, R., Zugaib, M. (2009). Common mental disorders during pregnancy: prevalence and associated factors among low-income women in Saor Paulo, Brazil: depression and anxiety during pregnancy. *Archive of Women's Mental Health*, 12, 335-343

Federn, P. (1952). *Ego Psychology and the Psychoses*. New York: Basic Books

Field, T. (2008). Breastfeeding and antidepressants. *Infant Behaviour and Development*, 31, 481-487

Field, T., 2010. Postpartum depression effects on early interactions, parenting, and safety practices: a review. *Infant Behaviour & Development*, 33, 1-6.

Field, T., Diego, M., Hernandez-Reif, M., Figueiredo, B., Deeds, O., Ascencio, A., Schanberg, S., Kuhn, C., (2010). Comorbid depression and anxiety effects on pregnancy and neonatal outcome. *Infant Behavior and Development*, 33, 23-29

Field, T., Diego, M., Dieter, J., Hernandez-Reif, M., Schanberg, S., Kuhn, C., Yando, R., (2004). Prenatal depression effects on the fetus and the newborn. *Infant Behavior and Development*, 27, 216-229

Fine, M. (1992/2002). *Disruptive voices: the possibilities for feminist research*. University of Michigan Press.

Fink, P., Rosendal, M., Toft, T. (2002). Assessment and treatment of Functional Disorders in General Practice: The extended reattribution and management model – an advanced educational program, *Psychosomatics*, 43, 93-131

Finn, C.C. (2002). *For the Mystically Inclined*. 1<sup>st</sup> Books Library

Finn, C.C. (2017). 'Journey of Please Hear'  
<https://poetrybycharlescfinn.com/pages/journey-of-please-hear> [accessed 10 November 2017]

Fisher, J., Cabral de Mello, M., Rahman, A., Tran, T., Holton, S., Holmes, W. (2011). Prevalence and determinants of common perinatal mental disorders in women in low- and lower- middle-income countries: a systematic review. *Bulletin of the World Health Organization*, Vol 90 (2), 77-156

Fisher, R.C. (2011). *Epigenetics – How Environment Shapes Our Genes*. New York: W.W. Norton

Fitelson, E., Kim, S., Scott Baker, A., Leight, K. (2011). Treatment of postpartum depression: clinical, psychological and pharmacological options. *International Journal of Women's Health*, 3, pp1-14

- Fontana, A., Frey, J. (2000). 'The interview: from Structural Questions to Negotiated Text' in Denzin, N. and Lincoln, Y. (eds), *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage
- Forna, A. (1999). *Mother of all myths: How society moulds and constrains mothers*. London: Harper Collins Publishers.
- Fonagy, P., Allison, E. (2017). Commentary: A refresh for evidence-based psychological therapies – reflections on Marchette and Weisz (2017). *The Journal of Child Psychology and Psychiatry*, 58, 985-987
- Fonagy, P., Slead, M., Baradon, T. (2016). Randomized Controlled Trial of Parent-Infant Psychotherapy for Parents with Mental Health Problems and Young Infants. *Infant Mental Health Journal*, 37(2), 97-114
- Fonow, M.M., Cook, J.A. (eds) (1991) Back to the future: A look at the second wave of feminist epistemology and methodology. In M.M. Fonow & J.A.Cook (eds) *Beyond methodology: Feminist scholarship as lived research*, p 1-15. Bloomington: Indiana University Press.
- Fontana, A., Frey, J.H. (2005). The Interview: from Neutral Stance to Political Involvement. In, N.K. Denzin and Y.S. Lincoln (eds) *The Sage Handbook of Qualitative Research*, 3<sup>rd</sup> ed, p 695-727. London: Sage
- Foucault, M. (1972). *The Archaeology of Knowledge*. London: Routledge
- Foucault, M. (1988). 'The Ethic of Care for the Self as a Practice of Freedom', in Bernasser, J. and Rasmussen, D. (eds), *The Final Foucault* (Cambridge, MA: MIT Press).
- Foulkes, M. (2011). Enablers and Barriers to Seeking Help for a Postpartum Mood Disorder. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, 40(4), 450-457
- Fowlie, H. (2005). Confusion and introjection. A model for understanding the defensive structure of the Parent and Child ego states. *Transactional Analysis Journal*, 35, 192-204.
- Fowlie, H., Sills, C. (2011). *Relational Transactional Analysis: Principles in Practice*. London: Karnac
- Fox, M., Martin, P., Green, G. (2007). *Doing Practitioner Research*. London: Sage
- Fraiberg, S.H. (1980). *Clinical Studies in Infant Mental Health: The First Year of Life*. Basic Books.
- Frank, A. (1995). *The Wounded Storyteller: Body, illness and ethics*. Chicago: University of Chicago Press.



- Freeman, M.P. (2009). Perinatal psychiatry: the challenges of making rational treatment decisions at the interface of psychiatry and obstetrics. *Journal of Clinical Psychiatry*, 70(9), 1311-1312.
- Freeman, M. (2010). *Hindsight: The Promise and Peril of Looking Backwards* Oxford: Oxford University Press
- Freud, S. (1920). *A General Introduction to Psychoanalysis* (trans: G. Stanley Hall). New York: Boni and Liveright
- Furber, C.M., Garrod, D., Maloney, E., Lovell, K., McGowan, L. (2009). A Qualitative study of mild to moderate psychological distress during pregnancy. *International Journal of Nursing Studies*, 46, 669-677
- Galbally, M., Lewis, A.J., Lum, J., Buist, A. (2009). Serotonin discontinuation syndrome following in utero exposure to antidepressant medication: a prospective study. *Australian and New Zealand Journal of Psychiatry*, 43, 846-854
- Gao, L-L., Wai-Chi Chan, S., Liming, Y., Xiaomao, L. (2010). Experiences of postpartum depression among first-time mothers in mainland China. *Journal of Advanced Nursing*, 66(2), 303-312
- Gatens, M. (1995). 'Between the sexes: Care of Justice', in Almond, B. (ed) *Introduction to Applied Ethics*. Oxford: Blackwell
- Gavin, N.I., Gaynes, B.N., Lohr, K.N., Meltzer-Brody, S., Gartlehner, G., Swinson, T. (2005). Perinatal Depression: A Systematic Review of Prevalence and Incidence. *Obstetrics & Gynecology*, 106(5), 1071-1083
- Gaynes, B.M., Gavin, N., Meltzer-Brody, S., et al (2005). Perinatal depression: prevalence, screening accuracy, and screening outcomes. *Evidence report/technology assessment (Summary)*, 119, 1-8
- Geer, B. (1964). 'First Days in the Field', in P.E. Hammond (ed) *Sociologists at Work*, p372-398. New York: Basic Books
- Geertz, C. (1973). *Interpretation of Cultures: Selected Essays*. New York: Basic Books, p5
- Gelaye, B., Rondon, M.B., Araya, R., Williams, M. (2016). Maternal depression 1: Epidemiology of maternal depression, risk factors, and child outcomes in low-income and middle-income countries. *Lancet Psychiatry*, 3(10), 973-982
- Genete, G. (1979). *Narrative Discourse: An Essay in Method*. Ithaca, NY: Cornell University Press

- Gentelet, B., Widdowson, M. (2016). Paradoxical Alliances in Transactional Analysis Psychotherapy for Anxiety: A Systematic Adjudicated Case Study. *Transactional Analysis Journal*, 46(3), 182-195
- Gentile, S. (2015). Prenatal antidepressant exposure and the risk of autism spectrum disorders in children. Are we looking at the fall of Gods?. *Journal of Affective Disorders*. 182, 132-137
- Gergen, K.J. (2015). *An Invitation to Social Construction*, 3<sup>rd</sup> edition. Thousand Oaks, CA: Sage Publications Inc
- Gerhardt, S. (2009). *Why Love Matters – How affection shapes a baby's brain*. Hove, UK: Routledge
- Ghaderi, A. (2006). Does individualisation matter? A randomised trial of standardised (focused) versus individualised (broad) cognitive behavior therapy for bulimia nervosa. *Behavior Research and Therapy*, 44(2), 273–288.
- Gill, M.M. (1979). The Analysis of Transference. *Journal of the American Psychoanalytic Association*, 27, 263-288
- Gilligan, C. (1982). *In a Different Voice: Psychological Theory and Women's Development* London: Harvard University Press
- Gilligan, C. (2015). The Listening Guide Method of Psychological Inquiry: Introduction. *Qualitative Psychology*, 2(1), 69-77
- Gilligan, C., Spencer, R., Weinberg, K., Bertsch, T. (2003). On the listening guide: A voice-centred, relational method. In P.M. Camic, J.E.Rhodes, and L. Yardley (eds), *Qualitative research in psychology: Expanding perspectives in methodology and design*. Washington, DC: American Psychological Association.
- Glaser, B.G., Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine de Gruyter
- Glover, V. (2014) Maternal depression, anxiety and stress during pregnancy and child outcome; what needs to be done. *Best Practice & Research Clinical Obstetrics and Gynaecology*, 28, 25-35
- Glover, L., Jomeen, J., Urquhart, T., Martin, C.R. (2014). Puerperal psychosis – a qualitative study of women's experiences. *Journal of Reproductive and Infant Psychology*, 32:3, 254-269
- Glover, V., & O'Connor, T.G. (2002). Effects of antenatal stress and anxiety. *British Journal of Psychiatry*, 180, 389-391
- Goffman, E. (1990). *Stigma. Notes on the Management of Spoiled Identity*. London: Penguin

- Goldbort, J. (2006). Transcultural analysis of postpartum depression. *American Journal of Maternal Child Nursing*, 31, 121-126
- Golovan, G. (2015). A pilot study to investigate and analyse script components of hospitalised individuals in Ukraine diagnosed with schizophrenia paranoid sub-type. *International Journal of Transactional Analysis Research*, 6(1), 54-69
- Goodman, J.H. (2009). Women's attitudes, preferences, and perceived barriers to treatment for perinatal depression. *Birth* 36(1):60-9
- Goodman, J.H., Tyer-Viola, L. (2010). Detection, treatment and referral of perinatal depression and anxiety by obstetrical providers. *Journal of Women's Health*, 19(3), 477-490
- Goulding, M.M., Goulding, R.L. (1979). *Canging Lives Through Redecision Therapy*. New York: Grove Press
- Grant, A. (2014). Troubling 'lived experience': a post-structural critique of mental health nursing qualitative assumptions. *Journal of Psychiatric and Mental Health Nursing*, 21(6), 544-549
- Grant, K.A., McMahon, C., Austin, M.P. (2008). Maternal anxiety during the transition to parenthood: a prospective study. *Journal of Affective Disorders* 108(1-2):101-111
- Green, S.M., Haber, E., Frey, B.N., McCabe, R.E. (2015). Cognitive-behavioral group treatment for perinatal anxiety: a pilot study. *Archives of Women's Mental Health*, 18(4), 631-638
- Grigoriadis, S., de Camps Meschino, D., Barrons, E., Bradley, L., Eady, A., Fishell, A., Mamisachvili, L., Cook, G.S., O'Keefe, M., Romans, S., Ross, L.E. (2011). Mood and anxiety disorders in a sample of Canadian perinatal women referred for psychiatric care. *Archive of Women's Mental Health*. 14(4), 325-333.
- Grote, N., Swartz, H.A., Geibel, S.L., Zuckoff, A., Houck, P.R., Frank, E. (2009). A Randomized Controlled Trial of Culturally Relevant, Brief Interpersonal Psychotherapy for perinatal Depression. *Psychiatric Services*, 60(3), 313-321
- Guba, E.G. (1990). Subjectivity and objectivity. In E.W. Esner and A. Peshkin's (eds) *Qualitative Inquiry in Education: The continuing debate*, p74-91. New York: Teachers College Press
- Guba, E.G., Lincoln, Y.S. (1994). Competing Paradigms in Qualitative Research. In N.K. Denzin and Y.S. Lincoln (eds), *Handbook of Qualitative Research* (p105-117). Thousand Oaks, CA: Sage Publications Inc
- Halbreich, U., Karkun, S. (2006). Cross-cultural and social diversity of prevalence of postpartum depression and depressive symptoms. *Journal of Affective Disorders*, 91, 97-111

- Hanley, J. and Long, B. 2006. A study of Welsh mothers' experiences of postnatal depression. *Midwifery*, 22(2):147-157.
- Hanlon, C., Whitley, R., Wondimagegn, D., Alem, A., Prince, M. (2009). Postnatal mental distress in relation to the sociocultural practices of childbirth: An exploratory qualitative study from Ethiopia. *Social Science & Medicine*, 69(8), 1211-1219
- Harding, S. (1987). *Feminism and Methodology: Social Science issues*, 1-14. Bloomington: Indiana University Press
- Harding, S. (1991). *Whose science? Whose knowledge?: Thinking from women's lives*. Ithaca: Cornell University Press
- Harford, D. (2013). Preliminary Evaluation of Outcomes of Transactional Analysis Psychotherapy for Armed Forces Veterans presenting with Post-Traumatic Stress Disorder. *International Journal of Transactional Analysis Research*, 4(2), 27-29
- Harford, D., Widdowson, M. (2014). Quantitative and Qualitative Outcomes of Transactional Analysis Psychotherapy with Male Armed Forces Veterans in the UK presenting with Post-Traumatic Stress Disorder. *International Journal of Transactional Analysis Research*, 5(2), 35-65
- Hargaden, H. (2001). There ain't no cure for love: The psychotherapy of an erotic transference. *Transactional Analysis Journal*, 31, 213-220
- Hargaden, H., Sills, C. (2001). Deconfusion of the Child ego state. *Transactional Analysis Journal*, 31, 55-70
- Hargaden, H., Sills, C. (2002). *Transactional Analysis: A Relational Perspective*. Hove: Brunner-Routledge
- Harper, D., Thompson, A.R. (eds). (2012). *Qualitative Research Methods in Mental Health and Psychotherapy – A Guide for Students and Practitioners*. Chichester, West Sussex: John Wiley & Sons Ltd
- Hartsock, N.C.M. (1983). "The Feminist Standpoint: Developing the Ground for a Specifically Feminist Historical Materialism" from *Discovering Reality* edited by Merrill B. Hintikka and Sandra Harding, pp 283-310, Kluwer Academic Publishers.
- Haynes, E. (2017). Listening to the Voices of Women Suffering Perinatal Psychological Distress, *Transactional Analysis Journal*, Vol 47, (2), 126-137
- Hays, S. (1996). *The cultural contradictions of motherhood*. New Haven, CT: Yale University Press

Health and Safety Executive (2013). Working alone: Health and safety guidelines on the risks of lone working. INDG73(rev 3), 05/13

Heimann, P., Isaacs, S., Klein, M. (1989). *Developments in Psychoanalysis*. London: Karnac Books

Held, V. (1993). *Feminist Morality: Transforming Culture, Society, and Politics*. Chicago, IL: University of Chicago Press

Held, V. (2006). "Feminist Moral Inquiry and the Feminist Future" in V.Held (ed) *Justice and Care*. Boulder, Co: Westview Press

Heller, L., LaPierre, A. (2012). *Healing Developmental Trauma – How Early Trauma Affects Self-Regulation, Self-Image, and the Capacity for Relationship*. Berkeley: North Atlantic Books

Herman, J. (1992). *Trauma and recovery: the aftermath of violence—from domestic abuse to political terror*. Basic Books, New York

Heron, J., Gilbert, N., Dolman, C., Shah, S., Beare, I., Dearden, S., Muckelroy, N., Jones, I., Ives, J. (2012). Information and support needs during recovery from postpartum psychosis. *Archives of Women's Mental Health*. 15(3), 155-165

Heron, J., Robertson Blackmore, E., McGuinness, M., Craddock, N., & Jones, I. (2007). No 'latent period' in the onset of bipolar affective puerperal psychosis. *Archives of Women's Mental Health*, 10, 79–81.

Heron, J., Gilbert, N., Dolman, C., Shah, S., Beare, I., Dearden, S., et al. (2012). Information and support needs during recovery from postpartum psychosis. *Archives of Women's Mental Health*, 15, 155–165.

Hewitt, C.E., Gilbody, S., Brealey, S., Paulden, M., Palmer, S., Mann, R., Green, J., Morrell, J., Barkham, M., Light, K., Richards, D. (2009). Methods to identify postnatal depression in primary care: An integrated evidence synthesis and value of information analysis. *Health Technology Assessment* 13(36), 1-145, 147-230

Highet, N., Stevenson, A.L., Purtell, C., Coe, S. (2014). Qualitative insights into women's personal experiences of perinatal depression and anxiety. *Women and Birth*, 27, 179-184

Hill Collins, P. (1990). *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment*. Boston: Unwin Hyman

Hirschfield, R.M. (2001). The comorbidity of major depression and anxiety disorders: recognition and management in primary care. *Primary Care Companion Journal of Clinical Psychiatry* 3, 244-254

HM G. (2011). *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*. London: Department of Health.  
[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_123991](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123991)

Hogg, S. (2013). *Prevention in Mind. All Babies Count: Spotlight on Perinatal Mental Health*. NSPCC, London

Hollway, W. (2015). *Knowing Mothers: Researching Maternal Identity Change*. Basingstoke: Palgrave Macmillan.

Hollway, W., and Jefferson, T. (2000). *Doing Qualitative Research Differently: Free Association, Narrative and the Interview Method*. 2<sup>nd</sup> ed. London: Sage.

Holopainen, D. (2002). The experience of seeking help for postnatal depression. *Advanced Journal of Nursing*, 19, 39-44

Horowitz, J.A., Cousins, A. (2006). Postpartum depression treatment rates for at-risk women. *Nursing Research*, 55(2), s23-s27

Horvath, A.O. (1986). Another Approach to Assess the Counselling Relationship: The Working Alliance. Paper Presented at the American Educational Research Association.

Hou, Y., Hu, P., Zhang, Y., Lu, Q., Wang, D., Yin, L., Chen, Y., Zou, X. (2014). Cognitive behavioural therapy in combination with systemic family therapy improves mild to moderate postpartum depression. *Revista Brasileira de Psiquiatria*, 36(1),  
[http://www.scielo.br/scielo.php?script=sci\\_arttext&pid=S1516-44462014000100009&lng=en&tlng=en](http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1516-44462014000100009&lng=en&tlng=en) [accessed 8<sup>th</sup> February 2018]

Howell, E.A., Mora, P.A., Horowitz, C.R., Leventhal, H (2005). Racial and ethnic differences in factors associated with early postpartum depressive symptoms. *Obstetrics & Gynecology*, 105, 1442-1450

Howes, R. (2014). How Long is Too Long in Psychotherapy. *Psychology Today*. Available at: <https://www.psychologytoday.com/blog/in-therapy/201403/how-long-is-too-long-in-psychotherapy> [accessed 6<sup>th</sup> February 2018]

Hunsley, J., Di Giulio, G. (2002). Dodo bird, phoenix, or urban legend? The question of psychotherapy equivalence. *Scientific Review of Mental Health Practice*, 1

Hydén, L.-C. (2013) In M. Andrews, C. Squire, and M. Tamboukou (eds) *Doing Narrative Research*. London: Sage Publishing Ltd

Improving Access to Perinatal Mental Health Services in England – A Review. (2015). Published by NHS Improving Quality

- Irigaray, L. (1993). *Sex and Genealogies*. New York: Colombia University Press
- Jack, D.C. (1991) *Silencing the self: Women and depression*. Cambridge, MA: Harvard University Press
- Jack, D.C. (1999). Silencing the self: Inner dialogues and outer realities. In T.E. Joiner and J.C. Coyne (eds), *The Interactional nature of depression: Advances in interpersonal approaches* (p 221-246). Washington, DC: American Psychological Association
- Jack, D.C. (2003). The anger of hope and the anger of despair: How anger relates to women's depression. In J. Stoppard and L. McMullen (eds), *Situating sadness: Women and depression in social context* (p 62-87). New York university Press Series on Qualitative Studies in Psychology, Michelle Fine and Jeanne Maracek (Series eds). New York: New York University Press
- Jack, D.C., Ali, A. (eds)(2010). *Silencing the Self Across Cultures: Depression and Gender in the Social World*. New York: Oxford University Press
- Jackson, M. (2001). *Weathering the storm*. London: Karnac
- Jackson, R.L. II, Drummond, D.K., Camara, S. (2007). What is Qualitative Research? *Qualitative Research Reports in Communication*, 8(1), 21-28
- Jacobs, M. (1988). *Psychodynamic Counselling in Action*. London: Sage
- Jäger, S., Maier, F. (2009). "Theoretical and Methodological Aspects of Foucauldian Critical Discourse Analysis and Dispositive Analysis", in R. Wodak and M. Meyer (eds) (2009). *Methods of Critical Discourse Analysis*. Second edition. London: Sage
- James, J. (1973). The Game Plan. *Transactional Analysis Journal*, 3(4), 14-17
- James, M. (1974). Self-Parenting: Theory and Process. *Transactional Analysis Journal*, 4(3), 32-9
- James, M. (1981). *Breaking Free: Self Re-Parenting for a New Life*. Reading, MA.: Addison-Wesley
- James, M. (2002). *It's Never Too Late to be Happy! Reparenting Yourself for Happiness*. Sanger, CA:Quill Driver Books
- James, M., Jongeward, D. (1971). *Born to Win: Transactional Analysis With Gestalt Experiments*. Reading, MA: Addison-Wesley
- Jarrett, P.M. (2016). Pregnant women's experiences of depression care. *The Journal of Mental Health Training, Education & Practice*, 11(1), 33-47

Johanson, R., Newburn, M. (2002). Has the medicalisation of childbirth gone too far. *British Medical Journal*, 324:892, Available at:  
doi: <https://doi.org/10.1136/bmj.324.7342.892> [accessed 10 October 2017]

Jones, I., Chandra, P.S., Dazzan, P., Howard, L.M. (2014). Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the postpartum period. *Lancet*, 15, 384(9956), 1789-1799

Jones I, Craddock N (2001) Familiality of the Puerperal Trigger in Bipolar Disorder: Results of a Family Study. *American Journal of Psychiatry* 158, 913–917

Josselson, R. (2011). ‘“Bet you think this song is about you”: whose narrative is it in narrative research?’ *Fielding Graduate University*, 1(1). Available at [Journals.hil.unb.ca/index.php/NW/article/download/18472/19971](http://Journals.hil.unb.ca/index.php/NW/article/download/18472/19971) [accessed 9 October 2017]

Josselson, R. (2013). *Interviewing for Qualitative Inquiry: A Relational Approach*. New York and London: Guildford Press

Josselson, R., Lieblich, A. (eds) (1993). *The Narrative Study of Lives*, vol. 1. Thousand Oaks, CA: Sage

Josselson, R., Lieblich, A.(eds) (1995). *Interpreting Experience: The Narrative Study of Lives*, vol. 3. Thousand Oaks, CA: Sage

Josselson, R., Lieblich, A. (eds) (1999). *Making Meaning of Narratives: The Narrative Study of Lives*, vol. 6. Thousand Oaks, CA: Sage

Josselson, R., Lieblich, A., McAdams, D. (eds) (2003). *Up Close and Personal: The Teaching and Learning of Narrative Research*. Washington, DC: American Psychological Association

Jung, C.G. (1971). *Psychological Types. Collected Works Volume 10*, chapter X. London: Routledge & Kegan Paul

Kaplan, B.J., Leung, B.M., Giesbrecht, G.F., Field, C.j., Bernier, F.P., Tough, S., Cui, X., Dewey, D., and the APrON Study Team (2013). Increasing the quality of life from womb to grave: the importance of pregnancy and birth cohorts. *Applied Physiology Nutrition and Metabolism*, 38, 85-89

Karpman, S. (1968). Fairy Tales and Script Drama Analysis. *Transaction Analysis Bulletin*, 7(2), 39-43

Karpman, S. (1971). Options, *Transactional Analysis Journal*, 1(1), 79-87

Katz, I., Hetherington, R. (2006). Co-operating and communicating: a European perspective on integrating services for children. *Child Abuse Review*, 15, 429-439



Kelly, G. (1991) *The psychology of personal constructs. Volume One, A theory of personality*. London; New York: Routledge in association with the Centre for Personal Construct Psychology

Kennedy, H.P., Beck, C.T., Driscoll, J.W. (2002). A Light in the fog: Caring for women with postpartum depression. *Journal of Midwifery & Women's Health*, Vol 47, (5), 318-330

Kessler, R.C. (1997). The effects of stressful life events on depression. *Annual Review of Psychology*, 48, 191-214.

Kim, D.R., O'Reardon, J.P., Epperson, C.N. (2010). Guidelines for the management of depression during pregnancy. *Current Psychiatry Reports*, 12, 279-281

Kim, J., Buist, A. (2005). Postnatal depression: A Korean perspective. *Australasian Psychiatry*, 13, 68-71

Kitchener, K.S. (1984). Intuition, critical evaluation and ethical principles: the foundation for ethical decisions in counselling psychology. *Counseling Psychologist*. 12, 43-55

Kitson G.C., Sussman B., Williams G.K., Zeehandelaar R.B., Shickmanter B.K. & Steinberger J.L. (1982). Sampling issues in family research. *Journal of Marriage and the Family*, 44, 965-981.

Klein, M. (1959). Our Adult World and its roots in infancy. In M. Klein, *Collected Works, Vol III, Envy and Gratitude and Other Works*. London: Karnac, 1993.

Klein, J. (2005 [1987]). *Our Need for Others and its Roots in Infancy*. Hove, UK: Routledge

Klerman, T.B., Weissman, M.M. (1993). *New applications of interpersonal psychotherapy*. Washington, DC: American Psychiatric Press

Klerman, G.L., Weissman, M.M., Rounsaville, B.J., Chevron, E.S. (1984). *Interpersonal psychotherapy for depression*. New York: Basic Books

Klier, C.M., Muzik, M., Rosenblum, K.L., Lenz, G. (2001). Interpersonal Psychotherapy Adapted for the Group Setting in the Treatment of Postpartum Depression. *The Journal of Psychotherapy Practice and Research*, 10(2), 124-131

Knight, M., Nair, M., Tuffnell, D., Shakespeare, J., Kenyon, S., Kurinczuk, J.J. (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013-15. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2017.

- Knox, R., Cooper, M. (2015). *The therapeutic relationship in counselling & psychotherapy*. Los Angeles : SAGE 2015
- Knudson-Martin, C., Silverstein, R. (2009). Suffering in silence: a qualitative meta-data-analysis of postpartum depression. *Journal of Marital and Family Therapy*, 35(2):145-158.
- Kralik, D., van Loon, A.M., Watson, R. (2008). Feminist research. In R. Watson, H. McKenna, S. Cowman, & J. Keady (eds.), *Nursing research: Designs and methods* (pp. 35–43). Philadelphia, PA: Elsevier Health Sciences.
- Kroenke, K., Spitzer, R.L., Williams, J.B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606-613
- Krumm, S., Becker, T. (2006). Subjective views of motherhood in women with mental illness – A sociological perspective. *Journal of Mental Health*, 15(4), 449-460
- Kuhn, T.S. (1962). *The Structure of Scientific Revolution*. Chicago: University of Chicago Press
- Kupfer, D., Haimowitz, M. (1971). Therapeutic Interventions Part 1. Rubberbands Now. *Transactional Analysis Journal*, 1(1), 10-16
- Kurzweil, S. (2008). Relational-Developmental Therapy Group for Postnatal Depression. *International Journal of Group psychotherapy*, 58(1), 17-34
- Kurzweil, S. (2012). Psychodynamic Therapy for Depression in Women with Infants and Young Children. *American Journal of Psychotherapy*, 66(2), 181-199
- Kuzel, A. (1992). Sampling in qualitative inquiry. In B.F. Crabtree and W.L. Miller (eds), *Doing Qualitative Research* (p 31-44). Thousand Oaks, CA: Sage
- Kwan, B., Dimidjian, S., Rizvi, S. (2010). Treatment preference, engagement and clinical improvement in pharmacotherapy versus psychotherapy for depression, *Behaviour Research and Therapy*, 48(8), 799-804
- Labov, W. (1997). Some further steps in Narrative Analysis. *Journal of Narrative and Life History*, 7(1-4), 395-415
- Labov, W., Waletzky, J. (1967). Narrative analysis: Oral versions of personal experience. In J. Helms (ed), *Essays in the Verbal and Visual Arts*. Seattle, WA: University of Washington Press
- Lacan, J. (1977). *Ecrits*. New York: W.W. Norton
- Ladd-Taylor, M. Umansky, L. (1998) *“Bad” mothers: The politics of blame in twentieth-century America*. New York: New York University Press

- Lambert, M.J., Ogles, B.M. (2004). The Efficacy and Effectiveness of Psychotherapy. In M.J. Lambert (Ed) *Bergin and Garfield's handbook of psychotherapy and behaviour change*. (5<sup>th</sup> edition), p 139-193. New York, NY: Wiley
- Lammers, W. (1992). Using the Therapist's Kinesthetic Responses as a Therapeutic Tool. *Transactional analysis Journal*, 22(4), 216-221
- Langellier, K., Peterson, E. (2004). *Storytelling in Everyday Life*. London: Routledge
- Lapworth, P., Sills, C., Fish, S. (2001). *Integration in counselling and psychotherapy: developing a personal approach*. London: Sage
- Lather, P. (1991). *Getting smart: Feminist research and pedagogy with/in the postmodern*. New York: Routledge.
- Layne, L. (1990). Motherhood lost: Cultural dimensions of miscarriage and stillbirth in America. *Women & Health*, 6, 69-98.
- Laughlin, L. (2011). Maternity leave and employment patterns: 1961-2008. U.S. Census Bureau, Washington, DC, p14
- Leichsenring, f., Rabung, S. (2011). Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis. *British Journal of Psychiatry*, 199(1), 15-22
- Leight, K.L., Fitelson, E.M., Weston, C.A., Wisner, K.L. (2010). Childbirth and Mental Disorders. *International Review of Psychiatry*, 22(5), 453-471
- Lester, B., Conradt, E., Marsit, C.J. (2013). Epigenetic Basis for the Development of Depression in Children. *Clinical Obstetrics and Gynecology*, 56(3), 556-565
- Levin-Landheer, P. (1982). The Cycle of Development. *Transactional Analysis Journal*. London: WileyBlackwell
- Lewis, G. (ed). (2007). Saving mothers' lives: reviewing maternal deaths to make motherhood safer – 2003-2005. *Seventh report on Confidential Enquiries into Maternal Deaths in the United Kingdom*. London, UK: The Confidential Enquiry into Maternal and Child Health, 2007.
- Lewis, I. (2002). In the Cemetery of Lost Lives. *Transactional Analysis Journal*, 32(4), 234-242
- Lieberman, A.F., Weston, D.R., Pawl, J.H. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development*, 62(1), 199-209

- Linde, K., Sigterman, K., Kriston, L., Rücker, G., Jamil, S., Meissner, K., Schneider, A. (2015). Effectiveness of Psychological treatments for depressive disorders in primary car: systematic review and meta-analysis. *Annals of Family Medicine*, 13(1), 56-68
- Lindgren, K. (2001). Relationships among maternal-fetal attachment, prenatal depression, and health practice in pregnancy. *Research in Nursing & Health*, 24, 203-217
- Link, J. (1983). 'Was ist und was brings Diskurstaktik', *kultureRRevolution* 2: 60-66 (translation by author)
- Lipowski, Z.J. (1987). Somatisation: The experience and communication of psychological distress as somatic symptoms, *Psychotherapy & Psychosomatics*, 47, 160-167
- Loots, G., Coppens, K., Sermijn, J. (2013). "Practising a rhizomatic perspective in narrative research". In Andrews, M., C. Squire & M. Tamboukou (eds) *Doing Narrative Research*. London: Sage
- Lorentzen, S., Ruud, T., Fieldstad, A., Høglend, P. (2013). Comparison of short- and long-term dynamic group psychotherapy: randomised clinical trial. *The British Journal of Psychiatry*, 204(4), 280-287
- Lorenzer, A. (1977) *Sprachspiel und Interaktionsformen* (Language Games and Interaction forms ). Frankfurt/M: SuhrKamp
- Lorenzer, A. (1986). 'Tiefenhermeneutische Kulturanalyse', In Alfred Lorenzer (ed) *Kultur-Analysen: Psychoanalytische Studien zur Kultur*. Frankfurt/M: Fischer p11-98
- Love, C., David, R.J., Rankin, K.M., Collins J.W. Jr. (2010). Exploring weathering: effects of lifelong economic environment and maternal age on low birth weight, small for gestational age, and preterm birth in African-American and white women. *American Journal of Epidemiology*, 172, 127-134
- Lugo-Candelas, C., Cha, J., Hong, S., et al. Associations Between Brain Structure and Connectivity in Infants and Exposure to Selective Serotonin Reuptake Inhibitors During Pregnancy. *JAMA Pediatrics* published online 9<sup>th</sup> April 2018 doi:10.1001/jamapediatrics.2017.5227
- Lugones, M., Spelman, E. (1983). Have we got a theory for you! Feminist theory, cultural imperialism and the demand for "the women's voice." *Women's Studies International Quarterly*, 4(1), 1-12
- Lupton, D. (1999) 'Content analysis' In V. Minichiello, G Sullivan, K M Greenwood and R Axford (eds) *Handbook for research methods in health sciences*. Frenchs Forest, Sydney: Pearson Education, p449-61

- Luttrell, W., Chalfen, R. (2010). Lifting up voices of participatory visual research. *Visual Studies*, 25:3, 197-200
- Lyerly, A.D., Little, M.O., Faden, R. (2008). "The second wave: Toward responsible inclusion of pregnant women in research". *International Journal of Feminist Approaches to Bioethics*, 1(2), 5-22
- Lyotard, J.-F. (1984). *The Postmodern Condition*. Manchester: Manchester University Press
- Maher, M. (1999). Relationship-based change: A feminist qualitative research case. In Kopola, M., and L.A. Suzuki (eds). *Using qualitative methods in psychology* Thousand Oaks: Sage p187-198
- Malacrida, C., Boulton, T. (2012). Women's perceptions of childbirth "choices": Competing Discourses of Motherhood, Sexuality and Selflessness. *Gender & Society*, 26(5), 748-772
- Man, K.K.C., Tong, H.H.Y., Wong, L.Y.L., Chan, E.W., Simonoff, E., Wong, I.C.K. (2015). Exposure to selective serotonin reuptake inhibitors during pregnancy and risk of autism spectrum disorder in children: A systematic review and meta-analysis of observational studies. *Neuroscience & Biobehavioral Reviews*, 49, 82-89
- Mannay, D. (2010). "Making the Familiar Strange: Can Visual Research Methods Render the Familiar Setting more Perceptible?" *Qualitative Research*, 10(1), 91-111
- Mannay, D. (2016). *Visual, Narrative and Creative Research Methods – Application, reflection and ethics*. New York, and Abingdon, Oxon: Routledge
- Mantle, F. (2002). The role of alternative medicine in treating postnatal depression. *Complementary Therapies in Nursing and Midwifery*, 8, 197-203
- Marcus, S.M., Flynn, H.A., Blow, F.C., Barry, K. (2003). Depressive symptoms among pregnant women screened in obstetrics settings. *Journal of Women's Health*, 12(4), 373-380
- Margolis, M. (2001) Putting mothers on the pedestal. In *Family patterns: Gender relations*, edited by B.J.Fox. Toronto, Canada: Oxford University Press.
- Maroda, K.J. (2004). *The Power of Countertransference*. Hillsdale, NJ: Analytic Press
- Martin, C.R., Redshaw, M. (2009). Carry on screening. *Journal of Reproductive and Infant Psychology* 27, 327-329
- Marziali, E., Alexander, L. (1991). *The Power of the Therapeutic Relationship*.

*American Journal of Orthopsychiatry*, Jul 1991, Vol.61(3), p.383

Masuda, A., Latzman, R.D. (2011). Examining associations among factor-analytically derived components of mental health stigma, distress, and psychological flexibility. *Personality and Individual Differences*, 51(4), 435-438

Matthey, S. (2004). Detection and treatment of postnatal depression (perinatal depression or anxiety). *Current Opinion in Psychiatry*, 17, 21-29

Mauthner, N. (1999). Feeling low and feeling really bad about feeling low: Women's experiences of motherhood and postpartum depression. *Canadian Psychology*, 40, 143-161

Mauthner, N.S. (2001). 'Postnatal depression: how can midwives help?' *Midwifery*, 13(1), 163-171

Mauthner, N. S. (2002). *The darkest days of my life: Stories of postpartum depression*. Cambridge, MA: Harvard University Press.

McAdams, D., Josselson, R., Lieblich, A. (eds) (2001). *Turns in the Road: Narrative Studies of Lives in Transition*. Washington, DC: American Psychological Association

McCauley, K., Elsom, S., Muir-Cochrane, E., Lyneham, J. (2011). Midwives and assessment of perinatal mental health. *Journal of Psychiatric Mental Health Nursing*, 18, 786-795

McEwen, B.S. (1998). Protective and damaging effects of stress mediators. *New England Journal of Medicine*, 338(3),171-9.

McEwen, B.S. (2008). Central effects of stress hormones in health and disease: understanding the protective and damaging effects of stress and stress mediators. *European Journal of Pharmacology*, 583(2-3), 174-185

McGrath, L., Peters, S., Wieck, A., Wittkowski, A. (2013). The process of recovery in women who experienced psychosis following childbirth. *BMC Psychiatry*, 13(1), 341

McIntosh, J. (1993). Postpartum depression: women's help-seeking behavior and perceptions of cause. *Journal of Advanced Nursing*, 18, 178-184

McLeod J. (2010). *Case study research in counselling and psychotherapy*. London: Sage.

McLeod, J. (2011). *Qualitative Research in Counselling and Psychotherapy*. London: Sage

McLeod, J. (2012). 'Systematic Case Study Research in Psychotherapy: Principles and Methods'. University of Abertay, Dundee, John Tayside Institute for Health

Studies. Available at: [www.crf.ac.uk/reports/IMcLeod.pdf](http://www.crf.ac.uk/reports/IMcLeod.pdf) [accessed 6 October 2017]

McLoughlin, J. (2013). Stigma associated with postnatal depression: A literature review. *British Journal of Midwifery*, 21, (11),

McMahon, M. (1995). *Engendering motherhood: Identity and self-transformation in women's lives*. New York: Guildford

Mead, M. (1995). 'Visual Anthropology in a Discipline of Worlds', in p. Hocking (ed.) *Principles of Visual Anthropology*, p 3-10. Berlin: Mouton de Gruyter.

Mehrotra, K. (2016) Pfizer wins dismissal in Zolofit birth defect warning cases. Bloomberg Businessweek, <https://www.bloomberg.com/news/article/2016-04-06/Pfizer-wins-dismissal-in-zolofit-birth-defect-warning-cases>.

Mellor, K. (1980). Impasses: A Developmental and Structural Understanding. *Transactional Analysis Journal*, 10(3), 213-222

Mellor, K., Schiff, E. (1975). Discounting. *Transactional Analysis Journal*, 5(3), 295-302

Meltzer-Brody, S. (2011). New insights into perinatal depression: pathogenesis and treatment during pregnancy and postpartum. *Dialogues in Clinical Neuroscience*, 13, 89-100

Mental Health Taskforce to NHS England (2016). *The Five Year Forward View for Mental Health*. [Retrieved from <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf> 13th February 2018]

Merleau-Ponty, M. (1964). *Signs*. (R.C. McCleary, Trans). Evanston, IL: Northwestern University Press. (Original work published 1960)

Merriam-Webster Dictionary (2017) online version [accessed at <https://www.merriam-webster.com/dictionary/epigenetics> on 31 October 2017]

Meunier, M.R., Bennett, I.M., Coco, A.S. (2013) Use of antidepressant medication in the US during pregnancy 2002-2010. *Psychiatric Services, psychiatry online*, 62(11), 1157-1160

Mies, M. (1991). Women's research or feminist research? The debate surrounding feminist science and methodology. In *Beyond methodology: Feminist scholarship as lived research*, M.M. Fonow & J.A. Cook (eds) p60-84. Bloomington: Indiana University Press

- Milgrom, J., Holt, C., Holt, C.J., Ross, J., Ericksen, J., Gemmill, A.W. (2015). Feasibility study and pilot randomised trial of an antenatal depression treatment with infant follow-up. *Archives of Women's Mental Health*, 18, 717-730
- Milgrom, J., Negri, L.M., Gemmill, A.W., McNeil, M., Martin, P.R. (2005). A randomized controlled trial of psychological interventions for postnatal depression. *British Journal of Clinical Psychology*, 44, 529-542
- Milgrom, J., Gemmill, A.W., Bilszta, J.A., Hayes, B., Barnett, B., Brooks, J., Ericksen, J., Ellwood, D., Buist, A. (2008). Antenatal risk factors for postnatal depression: a large prospective study. *Journal of Affective Disorders*, 108, 147-157
- Miller, R., Pallant, J., Negri, L. (2006). Anxiety and stress in the postpartum: is there more to postnatal distress than depression? *BMC Psychiatry*, 6 (12)
- Mischler, E.G. (1986). *Research Interviewing: Context and Narrative*. Cambridge, MA: Harvard University Press
- Misri, S., Kendrick, K., Oberlander, T.F., Norris, S., Tomfohr, L., Zhang, H., Frunau, R.E. (2010). Antenatal depression and anxiety affect postpartum parenting stress: a longitudinal, prospective study. *Canadian Journal of Psychiatry*, 55, 222-228.
- Mitchel, W.J.T. (1994). *Picture Theory: Essays on Verbal and Visual Representation*. Chicago: University of Chicago Press
- Moayedoddin, A., Moser, D., Nanzer, N. (2013). The impact of brief psychotherapy centred on parenthood on the anxio-depressive symptoms of mothers during the perinatal period. *Swiss Medical Weekly*, 143, w13769
- Moiso, C. (1985). Ego States and transference. *Transactional Analysis Journal*, 15,
- Morrell, C., Slade, P., Warner, R., Paley, G., Dixon, S., Walters, S., Brugha, T., Barkham, M., Parry, G.J., Nicholl, J. (2009). Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women: Pragmatic cluster randomised trial in primary care. *British Medical Journal*, 338(7689), 1-14.
- Morris, T., McInerney, K. (2010). Media Representations of Pregnancy and Childbirth: An analysis of Reality Television Programmes in the United States, *Birth*, 37(2), 134-140
- Morrow, S.L. (2007). 'Honor and Respect: Feminist Collaborative Research with Sexually Abused Women'. In C.T. Fischer (ed) (2006). *Qualitative Research Methods for Psychologists: Introduction through Empirical Studies*. Amsterdam; Boston, MA: Elsevier (p143-172)
- Movsas, T.Z., Wells, M., Mongoven, A., Grigorescu, V. (2012). Does medical insurance type (private vs public) influence the physician's decision to perform Caesarian delivery. *British Medical Journal, Journal of Medical Ethics*, Vol. 38 (8)



- Mulcahy, R., Reay, R.E., Wilkinson, R.B., Owen, C. (2010). A randomised control trial for the effectiveness of group interpersonal psychotherapy for postnatal depression. *Archives of Women's Mental Health*, 13(2), 125-139
- Müller, M.J., Preuß, C., Paul, T., Streit, F., Brandhorst, G., Seeliger, S. (2013) Serotonergic overstimulation in a preterm infant after Sertraline intake via breastmilk. *Breastfeeding Medicine*, 8(3) 327-329
- Munk-Olsen, T., Gasse, C., Laursen, T.M. (2012). Prevalence of antidepressant use and contacts with psychiatrists and psychologists in pregnant and postpartum women. *Acta Psychiatrica Scandinavica*, 125(4), 318-324.
- Munk-Olsen, T., Laursen, T.M., Pedersen, C.B., Mors, O., Mortensen, P.B. (2006). New parents and mental disorders: a population-based register study. *JAMA*, 296(21), 2582-2589
- Murray, L., Arteche, A., Fearon, P., Halligan, S., Croudace, T., Cooper, P. (2010). The effects of maternal postnatal depression and child sex on academic performance at age 16 years: a developmental approach. *Journal of Child Psychology & Psychiatry*, 51, 1150-1159
- Muzik, M., Rosenblum, K.L., Alfara, E.A., Schuster, M.M., Miller, N.M., Waddell, R.M., Stanton Kohler, E. (2015). Mom Power: preliminary outcomes of a group intervention to improve mental health and parenting among high-risk mothers. *Archives of Women's Mental Health*, 18(3), 507-521
- Myors, K.A., Johnson, M., Cleary, M., Schmied, V. (2015). Engaging women at risk for poor perinatal mental health outcomes: A mixed-methods study. *International Journal of Mental Health Nursing*, 24, 241-252
- Nagandla, K., Sivalingam, N., Yin, L.K., Abd Majeed, Z., Ismail, M., Zubaidah, S. (2016). Prevalence and associated risk factors of depression, anxiety and stress in pregnancy. *International Journal of Reproduction Contraception, Obstetrics and Gynecology*. 5(7), P. 2380(9)
- Nakku, J.E.M., Okello, E.S., Honikman, D.K.S., Ssebunnya, J., Ndyabangi, S., Hanlon, C., Kigozi, F. (2016). Perinatal mental health care in a rural African district, Uganda: a qualitative study of barriers, facilitators and needs. *BMC Health Services Research*, 16(1)
- Nakku, J.E.M., Nakasi, G., Mirembe, F. (2006). Postpartum major depression at six weeks in primary health care: prevalence and associated factors. *African Health Sciences*. 6(4), 207-214.
- Nanzer, N., Rossignol, A.S., Righetti-Veltima, M., Knauer, D., Manzano, J., Espasa, F.P. (2012). Effects of a brief psychoanalytic intervention for perinatal depression. *Archives of Women's Mental Health*, 15, 259-268

National Audit Office (2016). *Mental Health Services: preparations for improving access*. HC492: Department of Health and NHS England

National Institute for Health and Clinical Excellence (2006). *Antenatal and Postnatal Mental Health Clinical Management and Service Guidance Draft for Consultation July 2006*. National Institute for Health and Clinical Excellence, London

National Institute for Health and Clinical Excellence (2011). *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services*.

National Institute for Health and Clinical Excellence (2014). *Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance CG192* [Retrieved from <https://www.nice.org.uk/guidance/cg192> on 15th February 2018]

National Institute for Health and Clinical Excellence (2014). *Evidence uptake 61 – Service user experience in adult mental health*. [Retrieved from <https://www.nice.org.uk/guidance/cg136/evidence/evidence-update-pdf-185048029> 15th February 2018]

National Institute for Health and Care Excellence (2015). *Antenatal and postnatal mental health: clinical management and service guidance*. [Retrieved from: <https://www.guidelines.co.uk/NICE/Postnatal-mental-health/252557.article> on 26th October 2017]

National Institute for Health and Clinical Excellence, (2014 updated 2018). *Antenatal care for uncomplicated pregnancies overview*. [Retrieved from: <http://pathways.nice.org.uk/pathways/antenatal-care-for-uncomplicated-pregnancies> on 6th May 2019.

Nicolson, P. (1999). Loss, happiness and postpartum depression: the ultimate paradox. *Canadian Psychology*, 40(2), 162-178

Nhiwatiwa, S., Patel, V., Acuda, W. (1998). Predicting postnatal mental disorder with a screening questionnaire: a prospective cohort study from Zimbabwe. *Journal of Epidemiology & Community Health*. 52(4), 262–266

NHS England (2009). *NHS Constitution – the NHS belongs to us all*. [Retrieved from: [https://www.nhs.uk/NHSEngland/aboutnhs/Documents/NHS\\_Constitution\\_interactive\\_9Mar09.pdf](https://www.nhs.uk/NHSEngland/aboutnhs/Documents/NHS_Constitution_interactive_9Mar09.pdf) 13th February 2018]

NHS England (2015). *NHS Choices – Psychotherapy*. [Retrieved from <https://www.nhs.uk/conditions/psychotherapy/> 29<sup>th</sup> March 2018]

NHS Choices (2015). Psychotherapy – Availability. [Retrieved from: <https://www.nhs.uk/conditions/psychotherapy/availability/> on 6<sup>th</sup> February 2018]

NHS Choices – England (2016) Perinatal Mental Health [Retrieved from: <https://www.england.nhs.uk/mental-health/perinatal/> on 26 October 2017]

NHS Perinatal Mental Health care pathways (2018) [Retrieved from: <https://www.england.nhs.uk/wp-content/uploads/2018/05/perinatal-mental-health-care-pathway.pdf> on 27th May 2019]

Nieeminen, K., Stephansson, O., Ryding, E.L. (2009). Women's fear of childbirth and preference for caesarean section- a cross-sectional study at various stages of pregnancy in Sweden, *Acta Obstetrica et Gynecology*, 88(7), 807-813

Nilsson, T., Svensson, M., Sandell, R., Clinton, D. (2007). Patients' experiences of change on cognitive-behavioral therapy and psychodynamic therapy: a qualitative comparative study. *Psychotherapy Research*, 17, 553-566

Norhayati, M.N., Nik Hazlina, N.H., Asrenee, A.R., Wan Emilin, W.M.A. (2015) Magnitude and risk factors for postpartum symptoms: A literature review *Journal of Affective Disorders*, 175, 34-52

Noriega Gayol, G. (2004). Codependence: A Transgenerational Script. *Transactional Analysis Journal*, 34(4), 312-322

Nosek, M.P., Kennedy, H.P., Gudmundsdottir, M.P. (2010). Silence, stigma, and shame: A Postmodern analysis of Distress during the Menopause. *Advances in Nursing Science*, 33(3), e24-e36

Novellino, M. (1984). Self-Analysis of Countertransference. *Transactional Analysis Journal*, 14(1), 63-67

Novellino, M. (1990). Unconscious Communication and Interpretation in Transactional Analysis. *Transactional Analysis Journal*, 20(3), 168-173

Novellino, M. (2003). On /Closer Analysis: A Psychodynamic Revision of the Rules of Communication Within the Framework of Transactional Psychoanalysis. In C. Sills and H. Hargarden (eds) *Ego States*. London: Worth Publishing (p149-168)

Oakley, A. (1980). *Women Confined: Towards a Sociology of Childbirth*. Oxford: Martin Robertson & Co.

Oakley, A. (1981). Prologue: reflections on women and household labor. In Fenstermaker, S. Berk (Ed.), *Women and Household Labor*. Beverley Hills, California: Sage Publications

- Oates, M. (2003). Perinatal psychiatric disorders: a leading cause of maternal morbidity and mortality. *British Medical Bulletin*, 67, 219-229
- Oates, M. (2003). Suicide: the leading cause of maternal death. *British Journal of Psychiatry*, 183, 279-281
- Oates, M.R., Cox, J.L., Neema, S., Asten, P., Glangeaud-Freudenthal, N., Figueiredo, B., Gorman, L.L., Hacking, S., Hirst, E., Martin, H., Kammerer, C., Klier, M., Seneviratne, G., Smith, M., Sutter-Dally, A-L., Valoriani, V., Wickberg, B., Yoshida, K. (2004) Postnatal depression across countries and cultures: A qualitative study. *British Journal of Psychiatry*, 184 (46), s10-s16
- Office for National Statistics (2014). *Live Births in England and Wales by Characteristics of Mother 1;2013*. [Retrieved from <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/bulletins/livebirthsinenglandandwalesbycharacteristicsofmother1/2014-10-16>] on 29<sup>th</sup> May 2018.
- O'Hara, M.W., McCabe, J.E. (2013). Postpartum depression: Current status and future directions. *Annual Review of Clinical Psychology*, 9, 379-407
- O'Hara, M.W., Stuart, S., Gorman, L.L., Wenzel, A. (2000). Efficacy of Interpersonal Psychotherapy for Postpartum Depression. *Archive of General Psychiatry*, 57(11), 1039-1045
- O'Hara, M.W., Swain, A.M., (1996). Rates and risk of postpartum depression: a meta-analysis. *International Review of Psychiatry*, 8, 37-54
- O'Mahen, H., Fedock, G., Henshaw, E., Himle, J.A., Forman, J., Flynn, H.A. (2012). Modifying CBT for Perinatal Depression: What Do Women Want? A Qualitative Study. *Cognitive and Behavioural Practice*, 19(2), 359-371
- O'Mahen, H.A., Flynn, H.A. (2008). Preferences and perceived barriers to treatment for depression during the perinatal period. *Journal of Women's Health* 17(8):1301-9.
- O'Mahen, H.A., Grieve, H., Jones, J., McGinley, J., Woodford, J., Wilkinson, E. (2015). Women's experiences of factors affecting treatment engagement and adherence in internet delivered Behavioural Activation for Postnatal Depression. *Internet Interventions*, 2(1), 84-90
- O'Mahony, J.M., Donnelly, T.T. (2010). Immigrant and refugee women's postpartum depression help-seeking experiences and access to care: a review and analysis of the literature. *Journal of Psychiatric & Mental Health Nursing*, 17(10), 917-928
- O'Mahony, J.M., Donnelly, T.T., Bouchal, S.R., Est, D. (2012). Barriers and Facilitators of Social Supports for Immigrant and Refugee Women Coping with Postpartum Depression. *Advances in Nursing Science*, 35(3), e42-56

- O'Reilly, K. (2012) *Ethnographic Methods (2<sup>nd</sup> Edition)*. Routledge
- Orr, S.T., Blazer, D.G., James, S.A. (2006). Racial disparities in elevated prenatal depressive symptoms among Black and White women in eastern North Carolina. *Annals of Epidemiology*, 16, 463-468
- Palladino, C.L., Singh, V., Campbell, J., Flynn, H., Gold, K. (2011). Homicide and suicide during the perinatal period: findings from the National Violent Death Reporting System, *Obstetrics & Gynecology*, 118(5), 1056-1063
- Partington, D., ed (2001). *'Grounded theory', in Essential Skills for Management Research*. Sage: London, and Thousand Oaks, California.
- Patterson, W. (2013). Narratives of events: Labovian narrative analysis and its limitations. In M. Andrews, C. Squire, M. Tamboukou (eds). *Doing Narrative Research*, P27-46. London: Sage Publications Ltd
- Patton, G.C., Romaniuk, H., Spry, E., Coffey, C., Olsson, C., Doyle, L.W., Oats, J., Hearps, S., Carlin, J.B., Brown, S. (2015). Prediction of perinatal depression from adolescence and before conception (VIHCS): 20-year prospective cohort study. *Lancet*, 386, 875-883
- Paul, S., Haugh, S. (2008). The relationship, not the therapy? What the research tells us, in S. Haugh and S. Paul (eds) *The Therapeutic Relationship: Perspectives and Themes* (9-23). Ross-on-Wye: PCCS Books
- Pawlby, S., Sharp, D., Hay, D., O'Keane, V. (2008). Postnatal depression and child outcome at 11 years: the importance of accurate diagnosis. *Journal of Affective Disorders*, 107, 241-245
- Pearlstein, T.N., Zlotnick, C., Battle, C.L., Stuart, S., O'Hara, M.W., Price, A.B., Grause, M.A., Howard, M. (2006). Patient choice of treatment for postpartum depression: a pilot study. *Archive of Women's Mental Health*, 9, 303-308
- Perren, S., Godfrey, M., Rowland, N. (2009). The long-term effects of counselling: the process and mechanisms that contribute to on-going change from a user perspective. *Counselling and Psychotherapy Research*, 9(4), 241-249.
- Perret, V. (2017). The 'taming' of Julie and her avoidant attachment style. *International Journal of Transactional Analysis Research & Practice*, 8(2), 35-40.
- Petersen, I., Gilbert, R.E., Evans, S.J., Man, S.L., Nazareth, I. (2011). Pregnancy as a major determinant for discontinuation of antidepressants: an analysis of data from The Health Improvement Network. *Journal of Clinical Psychiatry*, 72, 979-985

Phillips, L., Thomas, D. (2015). The first antenatal appointment: An exploratory study of the experiences of women with a diagnosis of mental illness. *Midwifery*, 31, 756-764

Phoenix, A., Woollet, A., Lloyd, E. (1991). *Motherhood: meanings, practices and ideologies*. London: Sage.

Pinheiro, R.T., Botella, L., de Avila Quevado, L., Pinheiro, K.A.T., Jansen, K., Osório, C.M., Herrero, O., da Silva Magalhães, P.O.V., Farias, A.D., da Silva, R.A. (2014). Maintenance of the Effects of Cognitive Behavioral and Relational Constructivist Psychotherapies in the treatment of Women with Postpartum Depression: A Randomized Clinical Trial. *Journal of Constructivist Psychology*, 27(1), 59-68

Pink, S. (2013) *Doing Visual Ethnography: Images, Media, and Representation in Research*, 3<sup>rd</sup> edition. London: Sage

Piontelli, A. (2004 [1992]). *From Fetus to Child – An Observational and Psychoanalytic Study*. Hove, UK: Routledge

Pistrang, N., Barker, C. (2010) 'Scientific, practical and personal dimensions in selecting qualitative method', in M. Barkham, G. Hardy and J. Mellor-Clark (eds), *Developing and Delivering Practice-Based Evidence: A Guide for Psychological Therapies*. Chichester: Wiley-Blackwell. P65-90

Polatnick, M.R. (1996). Diversity in women's liberation ideology: how a black and a white group of the 1960s viewed motherhood. *Signs*, 21, 679-706

Polkinghorne, D.E. (1988). *Narrative Knowing and the Human Sciences*. Albany, NY: State University of New York Press

Polkinghorne, D.E. (1995). Narrative configuration in qualitative analysis. *Qualitative Studies in Education*, 8, 5-23

Preisig, M., Merikangas, K.R., Angst, J. (2001). Clinical significance and comorbidity of subthreshold depression and anxiety in the community. *Acta Psychiatrica Scandinavica* 104, 96-103

Prendergast, J., Austin, M. P. (2001). Early childhood nurse- delivered cognitive behavioural counselling for postnatal depression. *Australasian Psychiatry*, 9, 255-259.

Prins, M.A., Verhaak, P.F., Bensing, J.M., van der Meer, K. (2008). Health beliefs and perceived need for mental health care of anxiety and depression-The patients' perspective explored. *Clinical Psychology Review*, 28, 1038-1058

Psychological Therapy. (n.d.) *Segen's Medical Dictionary*. (2011). [Retrieved from <https://medical-dictionary.thefreedictionary.com/psychological+therapy> 13<sup>th</sup> January 2018]

Public Health England (2017). Better mental health: JSNA toolkit. [Retrieved from <https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit> 13th February 2018]

Radloff, L.S. (1977). The CES-D scale: A self report depression scale for research in the general population. *Applied Psychological Measurements*, 1, 385-401

Rallis, S., Skouteris, H., McCabe, M., Milgrom, J. (2014). The transition to motherhood: Towards a broader understanding of perinatal distress. *Women and Birth*, 27, 68-71

Rampou, A.M., Havenga, Y., Madumo, M. (2015). Parenting experiences of mothers living with chronic mental illness. *Health SA Gesondheid*, 20(1), 118-127

Rapp, R. (1999) *Testing women, testing the fetus: The social impact of amniocentesis in America*. New York: Routledge

Raymond, N.C., Pratt, R.J., Godecker, A., Harrison, P.A., Kim, H., Kuendig, J., O'Brien, J.M. (2014). Addressing perinatal depression in a group of underserved urban women: a focus group study. *BMC Pregnancy Childbirth*, 14, 336

Read, D.M.Y., Crockett, J., Mason, R. (2012). "It was a horrible shock": The experience of motherhood and women's family size preferences. *Women's Studies International Forum*, 35, 12-21

Reay, R., Fisher, Y., Robertson, M., Adams, E., Owen, C., Kumar, R. (2006). Group interpersonal psychotherapy for postnatal depression: A pilot study. *Archives of Women's Mental Health*, 9(1), 31-39

Reay, R.E., Owen, C., Shadbolt, B., Raphael, B., Mulcahy, R., Wilkinson, R.B. (2012). Trajectories of long-term outcomes for postnatally depressed mothers treated with group inter-personal psychotherapy. *Archives of Women's Mental Health*, 15(3), 217-228

Reid, C., Greaves, L., Poole, N. (2008). Good, bad, thwarted or addicted? Discourses of substance-using mothers. *Critical Social Policy*, 28, 211-234

Reinharz, S. (1992). *Feminist methods in social science research*. New York: Oxford University Press

Riessman, C. (1993). *Narrative Analysis*. Thousand Oaks, CA: Sage

Riessman, C. (2008). *Narrative Methods in the Human Sciences*. New York: Sage

Riggin, L., Frankel, Z., Moretti, M., Pupco, A., Koren, G. (2013). MOTHERISK ROUNDS: The Fetal Safety of Fluoxetine: A Systematic Review and Meta-analysis. *Journal of Obstetrics and Gynaecology Canada*, 35(4), 362-369



Robertson, E., & Lyons, A. (2003). Living with puerperal psychosis: A qualitative analysis. *Psychology and Psychotherapy – Theory Research and Practice*, 76, 411–431.

Robinson, L.A., Berman, J.S., Neimeyer, R.A., Appelbaum, M.I. (1990). Psychotherapy for the Treatment of Depression: A Comprehensive Review of Controlled Outcome Research. *Psychological Bulletin*, 108(1), 30-49

Rogers, W. (2014). 'Vulnerability and Bioethics', in C.Mackenzie, W. Rogers, and S. Dodds *Vulnerability\_ New Essays in Ethics and Feminist Philosophy*. New York: Oxford University Press

Rosaldo, R. (1989). *Culture and Truth: The Remaking of Social Analysis*. London: Routledge

Rosaldo, M.Z., Lamphere, L. (editors) (1974). *Women, Culture and Society*. Stanford: Stanford University Press

Rose, G. (2016). *Visual Methodologies: An Introduction to Researching with Visual Materials*, (4<sup>th</sup> edition). London: Sage

Rosenbaum, B., Harder, S., Knudsen, P., Køster, A., Lindhardt, A., Lajer, M., Valbak, K., Winther, G. (2012). Supportive Psychodynamic Psychotherapy versus Treatment as Usual for First-Episode Psychosis: Two-Year Outcome. *Psychiatry: Interpersonal and Biological Processes*, Vol. 75, No. 4, pp. 331-341.

Rosenfeld, H. (1987). *Impasse and Interpretation: Therapeutic and anti-therapeutic factors in the Psychoanalytic Treatment of Psychotic, Borderline, and Neurotic Patients*. London: Tavistock Publications

Rosenquist, S.E. (2013). When the Bough Breaks: Rethinking Treatment Strategies for Perinatal Depression. *American Journal of Clinical Hypnosis*, 55, 291-323

Ross-Davie, M., Elliot, S., Sarkar, A., Green, L. (2006) A Public Health role in perinatal mental health: are midwives ready? *British Journal of Midwifery*, 14, 330-334

Rouhe, H., Salmela-Aro, T., Toivanen, R., Tokola, M., Halmesmaki, E., Sisto, T. (2012). Obstetric outcome after intervention for severe fear of childbirth in nulliparous women – randomised trial. *British Journal of Gynecology*, 120(1), 75-84

Royal College of Psychiatrists - Help and Information - Puerperal Psychosis available at:  
<http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postpartumpsychosis.aspx> [accessed 17 October 2017]



- Rubertsson, C., Hellström, J., Cross, M., Sydsjö, G. (2014). Anxiety in early pregnancy: prevalence and contributing factors. *Archives of Women's Mental Health*, 17, 221-228
- Ruddick, S. (1989). "Maternal Thinking as a Feminist Standpoint" from *Maternal Thinking*. Boston, Beacon Press.
- Sackett, D.L., Rosenberg, W.M., Gray, J.A., Haynes, R.B., Richardson, W.S. (1998). Evidence-based medicine: What it is and what it isn't. *British Medical Journal*, 312, 71-72
- Sackett, D.L., Straus, S., Richardson, S., Rosenberg, W., Haynes, R.B. (2000). *Evidence-based medicine: How to practice and teach EBM* (2<sup>nd</sup> edition). London: Churchill Livingstone
- Salmon, P., Riessman, C.K. (2013). Looking back on narrative research: An exchange. In M. Andrews, C. Squire and M. Tamboukou (eds) *Doing Narrative Research*. London: Sage Publications Ltd
- Sarbin, T. (1986). *Narrative Psychology: The Storied Nature of Human Conduct*. New York: Praeger
- Schiff, A., Schiff, J. (1971). Passivity. *Transactional Analysis Journal*, 1(1), 71-78
- Schiff, J., Schiff, A., Mellor, K., Schiff, E., Fishman, J., Wolz, L., Fishman, C., Momb, D. (1975). *The Cathexis Reader: Transactional Analysis Treatment in Psychosis*. New York: Harper & Row
- Schlegel, L. (1998). What is Transactional Analysis? *Transactional Analysis Journal*, 28(4), 269-287
- Schmukler, D. (1991). Transference and transactions: Perspectives from developmental theory, object relations, and transformational processes. *Transactional Analysis Journal*, 21, 127-135
- Schonbeck, J. (2013). Psychotherapy. In B. Narins (ed) *The Gale Encyclopedia of Nursing and Allied Health*, 3<sup>rd</sup> edition, vol 5. Gale Virtual Reference Library
- Schore (2003). *Affect Regulation and Repair of the Self*. London: W.W. Norton
- Schumm, J.A., Walter, K.H., Bartone, A.S., Chard, K.M. (2015). Veteran satisfaction and treatment preferences in response to a post-traumatic stress disorder speciality clinic orientation group. *Behaviour Research and Therapy*, 6975 - 6982
- Schuermans, C., Kurrasch, D.M. (2013). Neurodevelopmental consequences of maternal distress: what do we really know? *Clinical Genetics*, 83, 108-117
- Schwandt, T. (2001). *Dictionary of Qualitative Inquiry*, 2<sup>nd</sup> ed. Thousand Oaks, CA: Sage

Scope, A., Booth, A., Sutcliffe, P. (2012). Women's perceptions and experiences of group cognitive behaviour therapy and other group interventions for postnatal depression: a qualitative synthesis. *Journal of Advanced Nursing*, 68(9), 1909-1919

Segen, J.C. (2011). *Segen's Medical Dictionary*. (2011). [Retrieved from <https://medical-dictionary.thefreedictionary.com/psychological+therapy> on 29<sup>th</sup> March 2018]

Segre, L.S., Losch, M.E., O'Hara, M.W. (2006). Race/ethnicity and perinatal depressed mood. *Journal of Reproductive and Infant Psychology*, 24, 99-106

Sermijn, J., Devlieger, P., Loots, G. (2008). The narrative construction of the self. Selfhood as a rhizomatic story. *Qualitative Inquiry*, 14(4), 632-650

Sharma V, Smith A, Khan M (2004) The relationship between duration of labour, time of delivery, and puerperal psychosis. *Journal of Affective Disorders*, 83, 215-220

Shea, M., Elkin, I., Imber, S., Sotsky, S., Watkins, J., Collins, J., Pilkonis, P., Beckham, E., Glass, D., Dolan, R., Parloff, M. (1992). Course of depressive symptoms over follow up. *Archives of General Psychiatry*, 49, 782-787

Shorrocks, M. (2015). An in-depth exploration of the experience and sense-making of transactional analyst psychotherapists working with clients who present with Internet addiction. *International Journal of Transactional Analysis Research*, 6(2), 31-44

Sikes, P. (2003). 'Making the Familiar Strange: A New Look at Inequality in Education', *British Journal of Sociology of Education*, 24(2), 243-248

Sills, C. (2001). The Man With No Name: A Response to Hargaden and Erskine. *Transactional Analysis Journal*, 31, 227-232

Sills, C., Hargaden, H. (eds) (2003). *Ego States*. London: Worth Publishing

Sit, D., Rothschild, A.J., Wisner, K.L. (2006). A review of postpartum psychosis. *Journal of Women's Health*, 15, 352-368

Skeggs, B. (2004). *Class, Self and Culture*. London: Routledge

Slade, P., Morrell, C.J., Rigby, A., Ricci, K., Spittlehouse, J., Brugha, T.S. (2010). Postnatal women's experiences of management of depressive symptoms: a qualitative study. *British Journal of General Practice*, 60(580), e440-448

Slife, B.D., Gantt, E.E. (1999). Methodological Pluralism: A Framework for Psychotherapy Research. *Journal of Clinical Psychology*, 55(12), 1453-1465

- Smith-Nielsen, J., Tharner, A., Krogh, M.T., Væver, M.S. (2016). Effects of maternal postpartum depression in a well-resourced sample: Early concurrent and long-term effects on infant cognitive, language, and motor development. *Scandinavian Journal of Psychology*, 57(6), 571-583
- Sockol, L.E., Epperson, C.N., Barber, J.P. (2011). A meta-analysis of treatments for perinatal depression. *Clinical Psychology Review* 31, 839-849
- Souza, L.H., Salum, G.I., Mosquero, B.P., Caldiero, M.A., Guerra, T.A., Fleck, M.P. (2016). Interpersonal psychotherapy as add-on for treatment-resistant depression: A pragmatic randomized controlled trial. *Journal of Affective Disorders*, 193, 373-380
- Spencer, S. (2011). *Visual Research Methods in the Social Science: Awakening Visions*. London: Routledge
- Spinelli, M. (1997). Interpersonal psychotherapy for depressed antepartum women: a pilot study. *American Journal of Psychiatry*, Jul, 154(7), 1028-1030
- Spinelli, M. (2017). *Interpersonal Psychotherapy for Perinatal Depression*. Lavergne, TN
- Spitzer, R.L., Kroenke, K., Williams, J.B., Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archive of Internal Medicine*, 166(10), 1092-7
- Squire, C. (2005). Reading narratives. *Group analysis*, 38(1), 91-107
- Squire, C. (2007). *HIV in South Africa: Talking about the Big Thing*. London: Routledge
- Squire, C. (2013). From experience-centred to socioculturally oriented approaches to narrative. In M. Andrews, C. Squire and M. Tamboukou (eds) *Doing Narrative Research*. London: Sage Publications Ltd
- Squire, C., Andrews, M., Tamboukou, M. (2013). 'What is Narrative Research.' In M. Andrews, C. Squire, and Tamboukou (eds) (2013). *Doing Narrative Research*. London: Sage
- Squire, C., Davis, M., Esin, C., Andrews, M., Harrison, B., Hydén, L.-C., Hydén, M. (2014). *What is Narrative Research?* London and New York: Bloomsbury
- Stake, R. (1995). *The Art of Case Study Research*. Thousand Oaks, CA: Sage
- Staneva, A.A., Bogossian, F., Wittkowski, A. (2015). The experience of psychological distress, depression, and anxiety during pregnancy: a meta-synthesis of qualitative research. *Midwifery*, 31, 563-573

- Staneva, A., Wittkowski, A. (2012). Exploring beliefs and expectations about motherhood in Bulgarian mothers: a qualitative study. *Midwifery*, 29, 260-267
- Stark, M. (2000). *Modes of Therapeutic Action*. New Jersey: Jason Aronson Inc
- Starks, H., Trinidad, S.B. (2007) 'Choose Your Method: A Comparison of Phenomenology, Discourse Analysis, and Grounded Theory'. *Qualitative Health Research*, 17(10), 1372-1380
- Steiner, C. (1966). Script and Counterscript. *Transactional Analysis Bulletin*, 5(18), 133-135
- Steiner, C. (1971). The Stroke Economy. *Transactional Analysis Journal*, 1(3), 9-15
- Steiner, C. (1974). *Scripts People Live: Transactional Analysis of Life Scripts*. New York: Grove Press
- Steiner, C. (2000). Radical Psychiatry. In R. Corsini (ed) *Handbook of Innovative Psychotherapies*. New York: Wiley
- Stern, D.N. (2000 [1985]). *The Interpersonal World of the Infant*. New York: Basic Books
- Stewart, C., Henshaw, C. (2002). Midwives and perinatal health. *British Journal of Midwifery*, 10, 117-121
- Stewart I. (1996). *Developing Transactional Analysis Counselling*. London: Sage
- Stewart, I. (2007). *Transactional Analysis Counselling in Action*. London: Sage
- Stewart, I., Joines, V. (1987). *TA Today: A New Introduction to Transactional Analysis*. Nottingham: Lifespace
- Stiles, W.B., Barkham, M., Twigg, E., Mellor-Clark, J., Cooper, M. (2006). Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practised in UK National Health Service setting, *Psychological Medicine*, 36, 555-566
- Stolorow, R., Brandschaft, B.J., Atwood, G. (1987). *Psychoanalytic Treatment: An Intersubjective Approach*. Hillsdale, NJ: Analytic Press
- Stone, M., Kokanovic, R. (2016). "Halfway towards recovery": Rehabilitating the relational self in narratives of postnatal depression. *Social Science & Medicine*, 163, 98-106
- Stuart, S. (2006). Interpersonal psychotherapy: a guide to the basics. *Psychiatric Annals*, 36, 542-549

- Stuart, S. (2012). Interpersonal psychotherapy for postpartum depression. *Clinical Psychology and Psychotherapy*, 19, 134–140
- Stuart, S., Koleva, H. (2014). Psychological treatments for perinatal depression. *Best Practice & Research, Clinical Obstetrics & Gynaecology*, 28(1), 61-70
- Stuart, S., O'Hara, M.W. (1995). Treatment of postpartum depression with interpersonal psychotherapy. *Archive of General Psychiatry* 52, 75–76
- Stuart, S., Robertson, M. (2003). *Interpersonal psychotherapy: a clinician's guide*. London: Edward Arnold Ltd
- Sullivan, H.S. (1953). *The interpersonal theory of psychiatry*. New York: Norton Press
- Summers, G. (2011). Dynamic Ego States. In H. Fowlie and C. Sills (eds), *Relational Transactional Analysis: Principles in Practice (p 59-67)* . London: Karnac
- Summers, G., Tudor, K. (2000). Co-creative transactional analysis. *Transactional Analysis Journal*, 30(10), 23-40
- Sweeney, A., Beresford, P., Faulkner, A., Nettle, M., Rose, D. (2009). *This is survivor research*. Ross-on-Wye: PCCS Books.
- Swift, J.K., Callahan, J.I., Vollmer, B.M. (2011). Preferences. In J.C. Norcross (ed), *Psychotherapy relationships that work* (2nd ed, p 301–315). New York: Oxford University.
- Symon, A. (2000). Litigation and defensive clinical practice: quantifying the problem. *Midwifery*, 16(1), 8-14
- Talbot, N.L., Gamble, S.A. (2008). IPT for women with trauma histories in Community Mental Health Care. *Journal of Contemporary psychotherapy*, 38, 35-44
- Tammentie, T., Paavilainen, E., Astedt-Kurki, P., Tarkka, M.-T. 2004. Family dynamics of postnatally depressed mothers - discrepancy between expectations and reality. *Journal of Clinical Nursing*, 13(1):65-74.
- Taylor, J.M., Gilligan, C., Sullivan, A.M. (1995). *Between voice and silence: Women and girls, race and relationship*. Cambridge, MA: Harvard University press
- Thomson, J., Fudge, E. (2005) *Adult mental health nurses' beliefs and practices when nursing clients who are parents of children under 18*. Stepney, Australia: Australian Infant Child Adolescent and Family Mental Health Association

- Thorne, B. (1993). *Gendered Play: Boys and Girls in School*. Brunswick, NJ: Rutgers University Press
- Tietel, E. (2000). The interview as relational space. *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research [Online Journal]* 1(3). Available at: <http://qualitative-research.net/fqs/fqs-eng.htm>
- Tilney, T. (2006[1998]). *Dictionary of Transactional Analysis*. London: Whurr Publishers Ltd
- Tobin, C.L., Di Napoli, P., Beck, C.T. (2018). Refugee and Immigrant Women's Experiences of Postpartum Depression: A Meta-synthesis. *Journal of Transcultural Nursing*, 29(1), 84-100
- Todorov, T. (1990). *Genres in Discourse*. Cambridge: Cambridge University Press
- Tol, W.A., Ebrecht, B., Aiyo, R., Murray, S.M., Nguyen, A.J., Kohrt, B.A., Ndyabangi, S., Alderman, S., Musisi, S., Nakku, J. (2018). Maternal mental health priorities, help-seeking behaviors, and resources in post-conflict settings: a qualitative study in eastern Uganda. *BioMedCentral Psychiatry*, 18, 39
- Tolin, D.F. (2010). Is cognitive-behavioral therapy more effective than other therapies? *Clinical Psychology Review*, 30, 710720
- Thompson, A.R., Chambers, E. (2012) 'Ethical Issues in Qualitative Mental Health Research.' In D. Harper, and A.R. Thompson (eds) (2012). *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners*. First Edition. Chichester: John Wiley & Sons
- Tong, R. (2000). "Radical Feminism" in L. Code (Ed) *Routledge Encyclopedia of Feminist Theories*. Abingdon: Routledge
- Toth, S.L., Rogosch, F.A., Manly, J.T., Cicchetti, D. (2006). The efficacy of toddler-parent psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: a randomized preventive trial. *Journal of Consulting and Clinical Psychology*, 74(6), 1006-1016
- Town, J.M., Abbass, A., Stride, C., Bernier, D. (2017). A randomised controlled trial of Intensive Short-Term Dynamic Psychotherapy for treatment resistant depression: the Halifax Depression Study. *Journal of Affective Disorders*, 214, 15-25
- Tseng, Y., Hsu, C., Liu, Y., Chen, C. (2008). The experiences of prenatal depression among Taiwanese women. *Journal of Advanced Nursing*. 64(5), 495-503
- Tudor, K. (2003). The Neopsyche: The Integrating Adult Ego State. In C. Sills, H. Hargarden (eds) *Ego States*. London: Worth Publishing (p201-231)

- Tudor, K., Summers, G. (2014). *Co-Creative Transactional Analysis: Papers, Responses, Dialogues and Developments*. London: Karnac
- Udechuku, A., Nguyen, T., Hill, R., Szego, K. (2010). Antidepressants in pregnancy: a systematic review. *Australian and New Zealand Journal of Psychiatry*, 44(11), 978-96.
- Ugarriza, D.N. (2002). Postpartum depressed women's explanation of depression. *Journal of Nursing Scholarship*, 34(3), 277-233
- U.S. Bureau of Labor Force Statistics, Employment Characteristics of Families 2010. Washington, DC (2012) available at: <http://www.bls.gov.salford.idm.oclc.org/news.release/famee.nr0.htm>
- VanderKruik, R., Barreix, M., Chou, D., Allen, T., Say, L., Cohen, L. S., and on behalf of the Maternal Morbidity Working Group. (2017). The global prevalence of postpartum psychosis: a systematic review. *BMC Psychiatry*, 17, 272.
- van Rijn, B., Wild, C. (2013). Humanistic and Integrative Therapy for Anxiety and Depression. Practise-Based Evaluation of Transactional analysis, Gestalt & Integrative Psychotherapy and Person-Centred Counseling. *Transactional Analysis Journal*, 43, 150-163
- van Rijn, B., Wild, C. (2016). Comparison of Transactional Analysis Group and Individual Psychotherapy in the Treatment of Depression and Anxiety: Routine Outcomes Evaluation in Community Clinics. *Transactional Analysis Journal*, 46(1), 63-74
- van Rijn, B., Wild, C., Moran, P. (2011). Evaluating the Outcomes of Transactional Analysis and Integrative Counselling Psychology within UK Primary Care Settings. *International Journal of Transactional analysis Research*, 2(2), 34-43
- van Shaik, D.J., Klijn, A.F., van Hout, H.P., van Marwijk, H.W., Beekman, A.T., de Haan, M., van Dyck, R. (2004). Patients' preferences in the treatment of depressive disorder in primary care. *General hospital Psychiatry*, 26, 184-189
- Vesga-Lopez, O., Blanco, C., Keyes, K., Olfson, M., Grant, B.F., Hasin, D.S. (2008). Psychiatric disorders in pregnant and postpartum women in the United States. *Archive of General Psychiatry*, 65(7), 805-815
- Vogel, D.L., Bitman, R.L., Hammer, J.H. Wade, N.G. (2013). Is Stigma Internalized? The Longitudinal Impact of Public Stigma on Self-Stigma. *Journal of Counseling Psychology*, 60(2), 311-316
- Wall, G. (2001). Moral constructions of motherhood in breastfeeding discourse. *Gender & Society*, 15, 592-610

- Wampold, B. (2001). *The great psychotherapy debate*. Mahway, NJ: Lawrence Erlbaum Associates
- Wampold, B.E., Mondin, G.W., Moody, M., Sticj, F., Benson, K., Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "all must have prizes". *Psychological Bulletin*, 122
- Warren, S. (2002). 'Show me how it feels to work here', *Ephemera: Critical Dialogues on Organisation*, 2, 224-265
- Webster, L., Mertova, P. (2007). *Using Narrative Inquiry as a research method*. Abingdon: Routledge
- Weedon, C. (1997) (2<sup>nd</sup> edition). *Feminist Practice & Poststructuralist Theory*. Oxford, UK: Blackwell Publishing
- Weidner, K., Bittner, A., Junge-Hoffmeister, J., Zimmerman, K., Siedentopf, F., Richter, J., Joraschky, P., Gatzweiler, A., Stöbel-Richter, Y. (2010). A psychosomatic intervention in pregnant in-patient women with prenatal somatic risks. *Journal of Psychosomatic Obstetrics & Gynaecology*, 31(3), 188-198
- Weinstein, R.M., (1982). Stigma and Mental Illness: Theory Versus Reality. *Orthomolecular Psychiatry*, 11(2), 87-99
- Weiss, E. (1950). *Principles of Psychodynamics*. New York: Grune & Stratton
- Wells, A. (2000). *Emotional Disorders & Metacognition: Innovative Cognitive Therapy*. Chichester, UK: Wiley.
- Wells, A., Matthews, G. (1994). *Attention and Emotion: A clinical Perspective*. Hove, UK: Erlbaum
- Wenzel, A., Gorman, L., O'Hara, M.W. (2001). The occurrence of panic and obsessive compulsive symptoms in women with post-partum dysphoria: A prospective study. *Archive of Women's Mental Health*. 4, 5-12.
- Wetherell, M. (1998). Positioning and interpretive repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse and Society*, 9, 387-412
- Whisman, M.A., Davila, J., Goodman, S.H. (2011). Relationship adjustment, depression, and anxiety during pregnancy and the postpartum period. *Journal of Family Psychology*, 25(3), 375-383
- WHO Commission on the Social Determinants of Health (2008). *Closing the gap in a generation: health equity through action on the social determinants of health: final report of the Commission on Social Determinants of Health*. Geneva: World Health Organization



WHO (2013). The European Mental Health Action Plan, EU/RC63/11 <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/priority-areas/stigma-and-discrimination> [accessed 28 October 2017]

Whooley, M., Avins, A., Miranda, J., Browner, J. (1997) Case-finding instruments for depression. Two questions are as good as many. *Journal of General Internal Medicine*, 12 439-445

Whooley, M.A., Simon, G.E. (2000). Managing depression in medical outpatients. *New England Journal of Medicine*, 343, 1943

Widdowson, M. (2008). Metacommunicative Transactions. *Transactional Analysis Journal*, 38(1), 58-71

Widdowson, M. (2010). *Transactional Analysis – 100 Key Points & Techniques*. Hove, UK: Routledge

Widdowson, M. (2011). 'Depression in the frame: key therapeutic tasks in the treatment of depression.' *The Transactional Analyst*, 5-11

Widdowson, M. (2012a). TA treatment of depression: a hermeneutic single-case efficacy design study – 'Peter'. *International Journal of Transactional Analysis Research*, 3(1), 3-13

Widdowson, M. (2012b). 'TA treatment of depression: a hermeneutic single-case efficacy design study - case two: 'Denise' ', *International Journal of Transactional Analysis Research*, 3(2), 3-14.

Widdowson, M. (2012c) 'TA treatment of depression: a hermeneutic single-case efficacy design study - case three: "Tom"', *International Journal of Transactional Analysis Research*, 3(2), 15-27.

Widdowson, M. (2013). 'TA Treatment of Depression - A Hermeneutic Single-Case Efficacy Design Study - 'Linda' - a mixed outcome case', *International Journal of Transactional Analysis Research*, 4(2), 3-15.

Widdowson, M. (2014). 'Transactional Analysis Psychotherapy for a Case of Mixed Anxiety & Depression: A Pragmatic Adjudicated Case Study 'Alastair', *International Journal of Transactional Analysis Research*, 5(2), 66-76.

Widdowson, M. (2015). *Transactional Analysis for Depression: A step-by-step treatment manual*. London: Routledge

Wiles, R., Clark, A., Prosser, J. (2011). 'Visual research ethics at the crossroads', in E. Margolis and L. Pauwels (eds), *The Sage Handbook of Visual Research Methods*. London: Sage, p685-706

- Williams, G. (1984). The genesis of chronic illness: Narrative re-construction. *Sociology of Health & Illness*, 6, 175-200
- Winnicott, D.W. (1953). Transitional objects and transitional phenomena. *International Journal of Psychoanalysis*, 34, 89-97
- Winnicott, D.W. (1958). Collected papers. *Through paediatrics to psychoanalysis*. London: Tavistock
- Winnicott, D.W. (1956). 'Primary maternal preoccupation' In *Through Paediatrics to Psychoanalysis: Collected Papers*. London: Karnac p300-305
- Winnicott, D.W. (1960). 'The theory of the parent-infant relationship', In D.W.
- Winnicott, D.W. (1962). The theory of the parent-infant relationship: further remarks. *International Journal of Psychoanalysis*, 43, 238-239.
- Winnicott (ed) (1990) *The Maturation Processes and the Facilitating Environment*. London: Karnac (p37-55)
- Winnicott, D.W. (1963). 'From dependence towards independence in the development of the individual', In D.W. Winnicott (ed) (1990) *The Maturation Processes and the Facilitating Environment*. London: Karnac (p83-92)
- Winnicott, D.W. (2005 [1971]). *Playing and reality*. London: Routledge
- Winterfeld, U., Merlob, P., Baud, D., Rousson, V., Panchaud, A., Rothuizen, L.E., Bernard, N., Vial, T., Yates, L.M., Pistelli, A., Ellfolk, M., Eleftheriou, G., de Vries, L.C., Jonville-Bera, A.-P., Kadioglu, J., Biollaz, J., Buclin, T. (2016). Pregnancy outcome following maternal exposure to Pregabalin may be call for concern. *Neurology* May 2016, 10.1212/WNL.0000000000002767; DOI:10.1212/WNL.0000000000002767
- Wisner, K.L., Zarin, D.A., Holmboe, E.S., Appelbaum, P.S., Gelenberg, A.J., Leonard, H.L., Frank, E. (2000). Risk-benefit decision making for treatment of depression during pregnancy. *American Journal of Psychiatry*, 157, 1933-1940
- Woodcock, C. (2016). The Listening Guide: A How-To Approach on Ways to promote Educational Democracy. *International Journal of Qualitative Methods*, January-December 2016, 1-10
- Woods, K. (1996). Projective Identification and game analysis. *Transactional Analysis Journal*, 26, 228-231
- Woody, C.A., Ferrari, A.J., Siskind, D.J., Whiteford, H.A., Harris, M.G. (2017). A systematic review and meta-regression of the prevalence and incidence of perinatal depression. *Journal of Affective Disorders*, 219, 86-92

Woollams, S., Brown, M. (1978). *Transactional Analysis*. Dexter: Huron Valley Institute

Yamashita, H., Yoshida, K., Nakano, H., Tashiro, N. (2000). Postnatal depression in Japanese women. Detecting the early onset of postnatal depression by closely monitoring the postpartum mood. *Journal of Affective Disorders*, 58 (2), 145-154

Yin, R.K. (2011). *Qualitative Research from Start to Finish*. New York: The Guildford Press

Yonkers, K.A., Wisner, K.L., Stewart, D.E., Oberlander, T.F., Dell, D.L., Stotland, N., Ramin, S., Chaudron, L., Lockwood, C. (2009). The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. *Obstetrics and Gynecology*, 114(3), 703-13.

Zambo, R., Zambo, D. (2013). Using I-poems to Hear the Voices and Understand the Actions of EdD Students Conducting Action Research. *The Qualitative Report*, 13(42), 1-17

Zigmond, A.S., Snaith, R.P. (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica*, 67, 361–370.