

Submitted in partial fulfilment of the
Lancaster University Doctorate in Clinical Psychology
May 2014

Doctoral Thesis

Postnatal mental distress: Exploring the experiences of professionals, mothers, and significant others

Caroline Wyatt
Trainee Clinical Psychologist
Division of Health Research
Lancaster University

Word count

Section	Text	Abstract, figures, tables, references and appendices	Total
Thesis abstract	299	--	299
Literature review	7,980	7,475	15,455
Research paper	7,985	6,635	14,620
Critical appraisal	3,973	1,011	4,984
Ethics	4,989	6,931	11,920
Total	25,226	22,052	47,278

Thesis abstract

This doctoral thesis explores issues related to postnatal mental health from the perspective of professionals, mothers, and significant others. It comprises a literature review, an empirical paper, a critical appraisal of relevant issues, and an ethics section. The literature review reports a meta-ethnographic synthesis of studies exploring the experiences of professionals working with women experiencing postnatal depression (PND). Five themes were identified: (a) conceptualising the label; (b) using ‘my antennae’: recognising PND; (c) ‘permission to speak’: facilitators and fears; (d) whose role is it anyway: professional confidence and expertise; and (e) ‘we’re not user friendly’: navigating the system. Clinical implications were highlighted, including the fostering of liaison between clinical psychologists and perinatal professionals, the importance of mental health training for perinatal professionals, and the development of clear care pathways for all severities of distress. The empirical paper focuses upon mothers who had experienced postnatal psychosis (PP) and their significant others. Seven dyadic interviews were conducted and analysed using interpretative phenomenological analysis. Four themes emerged: (a) ‘she wasn’t herself’: threatened relationships through loss of ‘normal’ self; (b) invalidation and isolation: relational dynamics in seeking, receiving and providing support; (c) ‘the worst life can throw at us’: shared perceptions of trust and respect following PP; (d) a double-edged sword: understanding relationships as negatively and positively influencing PP experience. The paper contributes to the evidence base by highlighting the opportunity for positive transformations in relationships following PP, despite the potential for strain within these relationships. Furthermore, it explores the novel finding that relationships can influence the content of unusual postnatal experiences. Within the critical appraisal, reflections pertinent to the empirical paper are offered. These span the three domains of conceptual, methodological, and ethical issues. The ethics section contains detailed information related to the process of gaining ethical approval for the empirical paper.

Declaration

This thesis reports research submitted in May 2014 as partial fulfilment of the requirements for the Doctorate in Clinical Psychology. The work presented is the author's own, except where due reference is made. This work has not been submitted elsewhere for the award of any higher degree.

Caroline Wyatt

Signature:

Date:

Acknowledgements

Firstly, I need to thank the wonderful mothers and their loved ones who gave their time and energy to take part in this research. I feel privileged to have met them, and their stories have been a continuous source of inspiration during the long weeks of writing.

I would also like to thank my research supervisor Craig Murray, and my field supervisors Jen Davies and Julie Jomeen. All three have encouraged and supported me throughout the process, as well as making time for the incredibly valuable process of draft reading. Thank you for sustaining my enthusiasm with your own energy and interest.

To the '2011 cohort' - thanks for being your usual wonderful selves, lightening the mood and pooling your collective knowledge in moments of uncertainty. I couldn't think of a better group of people to go through this experience with.

I am grateful to all of my wonderful family and friends for their support throughout this process. Ali Cat – I'm sure the time spent being distracted by you was more than made up for by the hours I had to work because I couldn't move you from my knee! Mutti and Vatti - thanks for always believing in me and encouraging me to chase my dreams. Thanks also for booking a holiday right over thesis hand-in, which encouraged me to get this done early! Chris - thanks for sorting out technical problems and helping me through the occasional meltdown with (thankfully un-melted) ice-cream!

Finally, I would like to thank the William Ritchie Travel Fund for awarding me a grant to present part of this thesis at the 14th World Association for Infant Mental Health World Congress in June 2014.

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Section one: Literature review

Postnatal depression from the perspective of health professionals: A qualitative meta-synthesis

Caroline Wyatt*

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Objective: This review aimed to explore professional conceptualisations of PND and whether these affect practice. Furthermore, it considered professionals' perceptions of the barriers and facilitators encountered by women when seeking support for PND.

Background: Perinatal health professionals are well positioned to assist in the early identification and support of new mothers experiencing emotional distress. It is important to explore how these professionals experience this work and how the conceptual models subscribed to influence the way in which they work with postnatal women. **Methods:** A meta-ethnographic approach was used to synthesise the findings of 19 qualitative research papers.

Results: The meta-synthesis identified five themes: (a) conceptualising the label; (b) using 'my antennae': recognising PND; (c) 'permission to speak': facilitators and fears; (d) whose role is it anyway: professional confidence and expertise; and (e) 'we're not user friendly': navigating the system. **Conclusion:** The meta-synthesis offered a detailed understanding of how professionals understand PND and the barriers and facilitators which they perceive mothers to face when seeking support. Several recommendations for clinical practice are discussed, alongside limitations and areas for further research.

Keywords: Postnatal depression; professionals; meta-ethnography; qualitative methodology

Postnatal depression from the perspective of health professionals: A qualitative meta-synthesis

Introduction

Between 10-15% of women in industrialised societies have experiences consistent with a label of postnatal depression¹ (PND; World Health Organisation [WHO], 2009). These may include exhaustion, hopelessness, and reduced enjoyment of activities (Lee & Chung, 2007). Within the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) PND is a subcategory of major depressive disorder; whether PND is clinically distinct from depression experienced at other times is debated (e.g., Whiffin, 1992).

Mothers experiencing PND may develop a withdrawn or intrusive mother-infant interactional style (Field, 2010). Reduced sensitivity within these interactions can contribute to children being classed as ‘failing to thrive’ (Patel, Rahman, Jacob, & Hughes, 2004). PND has been linked children’s poor cognitive development (e.g., Hay et al., 2001), although it may be recurrent experiences of maternal low mood which accounts for adverse outcomes (Grace, Evindar, & Stewart, 2003). It is imperative, therefore, to offer support to mothers experiencing PND and reduce the likelihood of future distress.

Alongside child development implications, PND can affect family life and relationships. Families of women experiencing PND report relationship difficulties, for example partners’ envy of each other’s role (Tammentie, Paavilainen, Åstedt-Kurki, & Tarkka, 2004). Despite the acknowledged link between maternal and paternal mental health (Bradley & Slade, 2010), few

¹ This paper focuses on research exploring experiences which have attracted a diagnosis of PND, although the difficulties inherent in any diagnostic system are acknowledged. The use of the term PND does not imply agreement with the biological “illness” model of distress often inherent within diagnostic categories.

PND interventions involve family (WHO, 2009). Furthermore, over 21% of new mothers who took their own lives between 2006 and 2008 were found retrospectively to fit a diagnosis of PND (Centre for Maternal and Child Enquiries [CMACE], 2011). Although small in comparison to the childbearing population, such consequences highlight the need for early identification of distress and timely access to support.

Early recognition

Early recognition of postnatal distress facilitates the provision of support, which can improve outcomes (Dennis & Creedy, 2004). However, postnatal women are often reluctant to discuss distressing experiences due to perceived stigma (Choi, Henshaw, Baker, & Tree, 2005). Moreover, many experiences characteristic of PND, such as exhaustion and feeling inadequate, are common during new parenthood (Rush, 2012). Consequently, specialised screening tools such as the Edinburgh Postnatal Depression Scale ([EPDS], Cox, Holden, & Sagovsky, 1987) have been developed. However, these rely upon Western conceptualisations of depression, which may differ from experiences of low mood cross-culturally (Gibson, McKenzie-McHarg, Shakespeare, Price, & Gray, 2009). Furthermore, while some women find the EPDS useful for communicating difficult emotions, others perceive it to be over-simplistic, intrusive and threatening (Shakespeare, Blake, & Garcia, 2003). Providing universally acceptable screening requires that ‘trained and empathic healthcare providers . . . provide multiple and flexible opportunities for women to disclose and discuss their emotional health’ (Armstrong & Small, 2010, p. 744).

The role of perinatal professionals

Perinatal professionals have regular contact with postnatal women and are often responsible for recognising and responding to PND. Women who disclose postnatal distress often do so to their regular perinatal professionals (Woolhouse, Brown, Krastev, Perlen, & Gunn, 2009) suggesting that discussing distress within routine appointments facilitates disclosure. Accordingly, guidelines promote the use of screening tools to assess new mothers' mental health (e.g., Beyondblue, 2011; National Institute for Health and Clinical Excellence [NICE], 2007). However, professional judgements of women as 'fed up' or 'depressed' may be more accurate at predicting PND than EPDS scores (Levertton & Elliott, 2000). Standardised measures inevitably neglect the 'meaning and understanding that women . . . attribute to psychological concepts' (Jomeen, 2012, p. 338). Thus, professionals' interactions with mothers may provide more sensitive appraisals of maternal mood than screening tools, placing them in a good position to identify and support women experiencing PND. However, the way in which professionals understand PND may affect how they perform this task.

Professional conceptualisations of PND

The biomedical model often influences societal and professional understandings of distress (Boyle, 2013). It assumes PND to be symptomatic of medical illness, caused by biological processes such as hormone imbalances or immune-inflammatory changes (Anderson & Maes, 2013). Professionals subscribing to this view may position PND within the individual and requiring of medication, as advocated by international guidelines (e.g., Atshuler et al., 2001; NICE, 2007). Moreover, they may see PND as the responsibility of mental health professionals, rather than frontline healthcare professionals.

Conversely, evidence suggests a role of non-biological factors in the development of PND (Dennis & Creedy, 2004). PND can be conceptualised as difficulty in adjusting to the changes experienced by new parents. Furthermore, parenthood may ignite unrecognised internal conflict and ambivalence (Likierman, 2003), potentially linked to mothers' experiences of being parented (Kurzweil, 2012). Those who understand PND within a psychosocial framework value the support provided by professionals and may advocate psychological approaches. For example, interpersonal psychotherapy focusing on role transition, grief, and interpersonal disputes can improve women's perception of adjustment (O'Hara, Stuart, Gorman, & Wenzel, 2000).

However, social constructivists argue that the above models pathologise women as unable to cope with their experiences. They view societal norms as failing to prepare women for new motherhood and stigmatising understandable responses (Choi et al., 2005). Although postnatal unhappiness occurs cross-culturally, it is not always labelled as an illness or requiring professional input (Oates et al., 2004). Rather than label women with PND, social constructivists highlight the need to challenge societal assumptions around parenthood. A professional subscribing to this approach may spend time normalising the experiences of mothers and feel reluctant to recommend professional input.

Barriers to accessing support

Less than half of women experiencing PND seek help from services (McGarry, Kim, Sheng, Egger, & Baksh, 2009). Stereotypes of mothers as instantly coping with motherhood may provoke guilt and shame in women experiencing distress, deterring help-seeking (Buultjens & Liamputtong, 2007). Particular cultural beliefs, for example that difficulties should be managed

within families and without professional involvement, may reinforce this (Templeton, Velleman, Persaud, & Milner, 2003). Additionally, conceptualisations of PND which do not endorse professional input as helpful or relevant make it less likely that women will seek support (McIntosh, 1993; Thome, 2003). Professional stereotypes may also create barriers, for example beliefs that professionals focus on physical health (Parvin, Jones, & Hull, 2004), child protection (Dennis & Chung-Lee, 2006) or medication (Chew-Graham, Sharp, Chamberlain, Folkes, & Turner, 2009).

Health professionals lacking in confidence or knowledge about PND may unintentionally perpetuate these barriers. Stigma may be inadvertently bolstered by professionals failing to inquire about mental health and minimisation of distress may discourage mothers from accessing services (Dennis & Chung-Lee, 2006). If professionals do not present a range of support options, women may avoid services due to a reluctance to consider medication (Turner, Sharp, Folkes, & Chew-Graham, 2008). Hence, it is important that professionals understand the barriers faced by women seeking help, in order for them to facilitate this process.

Professional awareness and knowledge

Healthcare professionals often feel unprepared to manage postnatal distress. They report having received little mental health training or believe that they have insufficient knowledge to support distressed mothers (e.g., Jones, Creedy, Gamble, & Health, 2011; Wiley, Burke, Gill, & Law, 2004). A recent review of maternal deaths in the UK highlighted the need for regular staff training in understanding, recognising and responding to perinatal mental health difficulties (CMACE, 2011). Furthermore, international guidelines stipulate that staff should receive

specific supervision and training before working with women experiencing postnatal distress (e.g., Beyondblue, 2011).

Research supports the value of mental health training for perinatal health professionals. Training health visitors in counselling techniques resulted in increased identification of postnatal distress while reducing urgent contacts (Appleby et al., 2003). Similarly, educating midwives regarding postnatal psychosocial issues increased perceptions of competence in discussing these and facilitating disclosure (McLachlan, Forster, Collins, Gunn, & Hegarty, 2011). Nurses who received training in core skills such as ‘patient centred interviewing’ and ‘handling emotions’ reported increased confidence and positivity when working with people experiencing low mood (Payne et al., 2002). Thus, knowledge about postnatal mental health can positively affect professional practice. However, the converse is also conceivable – a lack of training and knowledge may unhelpfully affect how professionals interact with postnatal women.

Current synthesis

The current synthesis builds upon quantitative literature which suggests that perinatal professionals lack confidence in supporting women experiencing PND, despite being in prime position to do so. It will extend these findings by exploring in detail how professionals experience working with women experiencing PND and how they conceptualise this. Although several studies have explored this area, to date there has been no synthesis or review of these findings.

A systematic approach to literature searching was adopted to ensure that all relevant literature was encompassed within the synthesis. This was carried out within a qualitative framework, rather than a mixed-methods approach, to allow a deeper exploration of

understanding and meaning-making. Furthermore, it was deemed important to go beyond a summary of the current literature through adding a further level of interpretation. Based on these considerations a meta-ethnographic approach to the synthesis was adopted.

The aim of the current review was to synthesise qualitative research which reports the accounts of various health professionals working with mothers experiencing PND. In particular professional conceptualisations of PND and whether these affect practice was explored alongside professionals' perceptions of the barriers and facilitators encountered by women when seeking support for PND. Synthesising the accounts of professionals who differ in their roles and responsibilities allows a wider understanding of the context within which women seek help. It is hoped that this understanding will draw attention to helpful practices utilised by professionals, as well as highlight where provision of support could be developed.

Method

Inclusion and exclusion criteria

Inclusion criteria stipulated that papers must: (a) be published within a peer-reviewed journal; (b) be published in English; (c) include healthcare professionals who have worked with mothers experiencing PND; (d) report a qualitative study, or the qualitative component of a mixed-method study, with results derived from first-hand accounts, represented in a thematic structure and evidenced by quotations; and (e) be grounded within a realist or critical-realist epistemology, with an assumption that language acts as a vehicle for understanding inner experiences.

Although Noblit and Hare (1988) caution against the synthesis of disparate qualitative methodologies, it is possible if their epistemological positions are similar (Shaw, 2012). Thus, studies using disparate analytic methods are included within this synthesis, providing that their

epistemological positions are compatible. To determine this, the method of analysis and any references to epistemology were noted for papers which met the four previous inclusion criteria. One paper, Lloyd and Hawe (2003), was excluded as it focused on language construction.

In addition, five exclusion criteria eliminated papers which: (a) focused exclusively on experiences of using PND screening tools; (b) focused solely on medication; (c) specifically explored experiences of antenatal depression (AND); (d) conducted joint analysis of service users and professionals, unless an explicit distinction was made within the results section and professionals' views were explored with supporting quotations; and (e) purely included participants whose professional role did not regularly encompass perinatal care, for example general nurses.

Search Strategy

A systematic search of seven electronic databases was performed in October 2013: PsycINFO (1929-2013)²; Web of Science (1945-2013); CINAHL (1982-2013); PubMed (1967-2013); POPLINE (1970-2013); Academic Search Complete (1887-2013); British Nursing Index (1985-2013). These encompassed a wide range of journals with multi-disciplinary contributions. No date limits were imposed and American Psychological Association index terms were consulted where appropriate (APA, 2007). Two further articles were found through hand searching reference lists of relevant studies. One paper was identified through correspondence with the lead author. Search terms were developed in consultation with an expert librarian and refined during preliminary searches. The final search terms are recorded in Table 1.

² Dates in parentheses represent searchable years

Insert Table 1 here

The initial search produced 1648 novel abstracts. The titles and abstracts of returned papers were reviewed. Over three-quarters were discounted due to their quantitative methodology. If necessary, full-text articles were reviewed to assess papers against inclusion and exclusion criteria. Subsequently, 19 papers were identified as eligible for inclusion (see Figure 1).

Insert Figure 1 here

Characteristics of the studies

The 19 papers eligible for inclusion are presented in Table 2. International perspectives were represented, with studies from England ($n=8$), Australia ($n=3$), the United States of America ($n=4$), Canada ($n=1$), Slovenia ($n=1$), Finland ($n=1$) and Brazil ($n=1$). Two of the papers included used the same English sample but analysed the data with a different focus (Chew-Graham et al., 2008; Chew-Graham et al., 2009). Some studies focused on specific professional groups, while others included a range of professionals (see Table 2). Most papers were published between 2005 and 2013, with one published in 1996. Five papers used focus group methodology, 12 used individual interviews, one used a combination of focus groups and interviews, and one incorporated observations and field diary entries alongside interviews. All papers report varying forms of a thematic approach to analysis.

Insert Table 2 here

Quality assurance

Quality assurance in research is rooted in positivist philosophy, which assumes that truth can be discovered through objective experimentation. Such systems can be viewed as incompatible with qualitative research and discouraging of novel methodologies (Sparkes & Smith, 2009). However, they can encourage policy makers to value and trust the findings of qualitative research, increasing real-world impact (Dixon-Woods, Shaw, Agarwal, & Smith, 2004). Consequently, an evidence-based checklist developed by the Critical Appraisal Skills Programme (CASP, 1999; see Appendix 1-A) was completed for each paper. However, it was felt that the CASP failed to adequately capture the level of richness within qualitative analysis and that stringent publisher word limits may unfairly influence scores. Thus, the results were not used to exclude studies. The scores were consulted during analysis, to ensure that themes were not based entirely on data from studies which gained a low score, in line with a conceptualisation of checklists as ‘reflective rather than constitutive of good research’ (Barbour, 2001, p. 1115).

All 19 papers met the CASP screening criteria with regard to the clear statement of aims and the appropriate choice of a qualitative methodology. Each paper was evaluated according to the eight quality criteria. A three-point rating system was adopted, with a maximum score of 24 (Duggleby et al., 2010). A score of one was given if the study was deemed to be weak in that area, two if some explanation was provided and three, if a strong rationale was evidenced. Several papers were scored by three fellow trainee psychologists and their ratings were compared with the initial score. Discrepancies were discussed and resolved and ratings for the remaining papers were reviewed. The results of the CASP analyses are presented in Table 3.

Insert Table 3 here

Synthesis

A meta-ethnographic approach, first conceived by Noblit and Hare (1998), was adopted. This approach compares papers, searching for underlying themes and developing new interpretations. The aim of a meta-ethnography is to generate third-order constructs (new understanding) through synthesising first-order (participants' understandings) and second-order (authors' interpretations) constructs.

The synthesis was conducted following the seven phases outlined by Noblit and Hare (1998), the first two of which are encapsulated within the processes of study selection and quality assurance. Following the CASP analysis, each paper was re-read and salient aspects of the results were noted. Participant quotes and original authors' interpretations were recorded together, to ensure that the original interpretation was retained.

To determine relationships between studies, a list of metaphors for each study was created and compared across studies. The studies were broadly similar in their focus and could be synthesised through reciprocal translation. This determined whether metaphors from one study could reasonably represent the synthesis of data from other studies (Noblit & Hare, 1988, p. 38). The order in which papers should be synthesised has been debated (e.g., Atkins et al., 2008), with no firm conclusions. The current synthesis began with an English paper, due to familiarity with the English healthcare system (see Appendix 1-B for synthesis order).

The process of synthesising studies resulted in the development of five themes. For example 'conceptualising the label' drew on themes from across 12 papers, including 'alternative understandings of maternal sadness' (Belle & Willis, 2013) and 'a diversified concept' (McConnell, Baker, & Marks, 2005). An articulation of the full translation of themes is provided

within Appendix 1-C. The process of constructing such third-order interpretations risks the imposition of researcher beliefs on the data. However, a reflective diary was kept throughout the process, which identified any existing or emerging assumptions, to facilitate the ‘bracketing’ of these during analysis. Analysis was an iterative process and the results are grounded within the original data. Additionally, it is hoped that the clear audit trail described provides a transparent account of the development of the five themes.

Results

The results are presented as five themes: (a) conceptualising the label; (b) using ‘my antennae’: recognising PND; (c) ‘permission to speak’: facilitators and fears; (d) whose role is it anyway: professional confidence and expertise; and (e) ‘we’re not user friendly’: navigating the system. Each theme is explored using illustrative quotes from participants.

Conceptualising the label

Most participants understood PND as psychosocial in nature, viewing it as resulting from the ‘quantum life shift’ (Belle & Willis, 2013, p. 157) of parenthood. Unrealistic expectations of motherhood, attributed to wider social mechanisms, were positioned as contributing to the development of PP – ‘the media plays a huge part subconsciously . . . there’s an expectation that I can have it all . . . but I think it comes at a great cost’ (Bilszta, Ericksen, Buist, & Milgrom, 2010, p. 8). Hence, giving ‘realistic expectations of life with a new baby, so it is not a shock’ (Burnett-Thomas, 1996, p. 110) was believed to reduce postnatal emotional distress.

Psychosocial understanding of PND developed through experience – ‘the more I listen to people’s stories, the more I realise “you’ve got past the stage of thinking it’s hormonal”’ (McConnell et al., 2005, p. 253). Professionals less experienced in working with PND held a

more medical understanding of it as a ‘hormonal change that can start during pregnancy’ (Santos Junior, Gualda, Silveira, & Hall, 2013, p. 1252). Thus, working with women experiencing PND challenged a purely medical conceptualisation and facilitated a more nuanced understanding. For example professionals in Slovenia saw postnatal sadness as being caused by hormones and implied that they viewed PND as different in both nature and aetiology: ‘almost every postnatal woman has sadness caused by hormone swings . . . it is very common, while real depression isn’t’ (Mivšek, Hundley, & Kiger, 2008, p. 323). However, this nuanced understanding did not always develop. Professionals interviewed by Boyd, Mogul, Newman, and Coyne (2011) discussed the difficulty in distinguishing between adverse life events and PND. This suggests that they conceptualised difficult life events as something separate from PND, rather than holding an integrative understanding of the impact of life events on mood.

Many professionals avoided medical language, for example calling PND ‘emotional turmoil rather than depression’ (Chew-Graham et al., 2008, p. 171). Participants wondered ‘whether [women are] well served by the language really . . . it’s a very medical framework, and some of the reluctance to enter into it . . . is very healthy’ (Bilszta et al., 2010, p. 9). Providing a medical understanding of PND was seen potentially to deter women from seeking help. Even general practitioners (GPs) were hesitant to use the term PND, despite their medical background – ‘I don’t want to medicalise it too much really . . . most people do recover from it if they are just given some support’ (Chew-Graham et al., 2009, p. 5). Nevertheless, some professionals believed that a label provided ‘proof of what they are saying . . . it’s a relief in most cases’ (McConnell et al., 2005, p. 253), demonstrating that a medical label may be beneficial, even if contrary to the professionals’ conceptualisation of distress.

Despite holding a psychosocial understanding, some professionals saw PND as belonging to the realm of psychiatry. Obstetricians often felt ‘like we’re diving into something that we have no business being in. We’re not psychiatrists’ (Palladino et al., 2011, p. 272). Nevertheless, they prescribed antidepressants as they felt that professional accountability mandated them to provide treatment. In Brazil, professionals similarly felt that PND was the domain of psychiatry but tended to refer on – ‘I could have started her on medication but I prefer to make the referral’ (Santos Junior et al., 2013, p. 1252). Thus, professionals advocated biomedical treatments, despite understanding PND within a psychosocial framework. They did not routinely discuss alternatives to medication and rarely spoke about psychological therapy.

This theme highlights the extent to which a psychosocial model of PND has been adopted by healthcare professionals. In particular, it identifies for the first time that professionals develop a psychosocial understanding through working with mothers experiencing PND, rather than through formal training. Despite this, professionals continued to view medication as the routine treatment for PND and did not discuss options such as clinical psychology input, which may fit better with their understanding. It was unclear as to whether this was due to a lack of knowledge about the role or value of therapeutic interventions, or because it was viewed as inappropriate.

‘Using my antenna’: recognising PND

Building an ongoing relationship was highlighted as the most important factor in encouraging disclosure of ‘things which maybe aren’t in accordance with existing social norms’ (Mivšek et al., 2008, p. 324). It was seen as beneficial if this relationship began at the antenatal stage and continued through to the postnatal stage, providing a longer period over which to build trust and

increasing opportunities for early identification of PND. Continuity of care rendered professionals comfortable to discuss distress with new mothers, whereas in settings where there was no ongoing relationship it became ‘easier not to ask, if I’m not going to see her again’ (Chew-Graham et al., 2009, p. 6). Although moves away from continuity of care were generally seen as damaging to client care, one health visitor suggested that ‘families aren’t becoming reliant on you, that’s the good thing’ (Chew-Graham et al., 2008, p. 173).

Professionals were particularly vigilant if women had histories of mental health or postnatal difficulties – ‘if I know she had a bad outcome last time . . . I will ask more often for the mood’ (Palladino et al., 2011, p. 272). Furthermore, professionals were alert for particular behaviours or statements which caused concern, for example lack of sleep, withdrawal, or admitting ‘that they are a little overwhelmed’ (Heneghan, Morton, & DeLeone, 2007, p. 336). This information could be discerned through ‘having a conversation . . . just chatting to them’ (Chew-Graham et al., 2009, p. 4), or through observing mothers’ interactions with others. Training in mother-child interaction was identified as key by those who had received it, because ‘the interaction between mother and baby tells you a lot’ (Tammentie, Paavilainen, Åstedt-Kurki, & Tarkka, 2013, p. 29).

Drawing on their psychosocial conceptualisation of PND, many professionals considered the social and economic circumstances of new mothers, for example through exploring if ‘they have a supportive partner at home [. . . or] family and friends around them’ (Belle & Willis, 2013, p. 157). The potentially negative impact of social networks was also acknowledged, with several professionals noting the importance of ‘looking at family dynamics and relationships’ (Burnett-Thomas, 1996, p. 112). Thus, the social system around the mother was used as a means of monitoring her risk of developing PND.

Informal assessments and relationship-building were prioritised over screening tools by most participants. Few professionals used screening tools routinely, some of whom felt that they provide women with ‘an opportunity to talk about what’s going on for her’ (Rush, 2012, p. 325). However, other professionals strongly believed that such tools were unhelpful and ‘may not be suitable for women from certain cultures’ (Teng, Blackmore, & Stewart, 2007, p. 98) due to different understandings of what constitutes a ‘normal’ reaction to parenthood. There was agreement, regardless of attitude towards screening tools, that a holistic approach to assessment was required. Rather than using the EPDS, many professionals relied on intuition and one reported ‘hoping that my antennae would tell me if there was a problem’ (Chew-Graham et al., 2008, p. 171). Some professionals felt confident that this method enabled them to identify women experiencing PND – ‘obviously we’re not stupid and we’d be able to detect if there was something that was not normal and seek help’ (Jomeen, Glover, Jones, Garg, & Marshall, 2013, p. 482). However, several professionals worried that only women with severe emotional distress received appropriate support – ‘we’re excellent at picking up moderate to severe PND, but I guess it’s those subtle ones . . . that we wonder if we’re missing’ (Bilszta et al., 2010, p. 9). This led to feelings of guilt, as ‘realising that there are all these other women is terrible’ (Edge, 2010, p. 19),

These observations reflect the range of ways in which professionals identify PND. The basis for recognition was a continuous, trusting relationship within which both the mother and professional felt comfortable discussing difficult topics. Professionals identified several assessment techniques which they employed through informal interactions with women. However, there was concern that women experiencing low levels of distress may not be identified through this process.

‘Permission to speak’: facilitators and fears

Participants discussed stigma on a cultural level and as internalised by the mother and her family – ‘those who admit to suffering from depression after the joyous birth of a baby . . . are labelled “crazy”’ (Teng et al., 2007, p. 96). Professionals believed that particular cultures viewed emotional distress as something which ‘should be kept in the family’ (Boyd et al., 2011, p. 4), or hidden entirely – ‘I think maybe Black women still have a pride in not expressing some of the deeper traumas’ (Edge, 2010, p. 20). Professionals identified a Western perception that mothers ‘should be able to cope’ (Bilszta et al., 2010, p. 7) and that distress was equated with ‘being a bad mother . . . “I’ve kind of failed”’ (Heneghan et al., 2007, p. 336). However, some health visitors believed that this issue was becoming less prominent – ‘there’s less stigma about it . . . people are more prepared to talk about it’ (Jomeen et al., 2013, p. 483).

The link between emotional distress and being an ‘unfit’ mother was perceived to cause mothers to hide distress - ‘they will say no because they think . . . I’m gonna be locked up and my kids will be taken away’ (Byatt et al., 2012, p. 439). Anxiety around professional interactions may prompt mothers to give ‘the answers they think are wanted’ (Tammentie et al., 2013, p. 28) and led several professionals to emphasise that their role ‘is not all about child protection, it’s about family working’ (Brown & Bacigalupo, 2006, p. 50). However, they believed that a PND diagnosis was perceived by mothers to hold long-term consequences, creating a reluctance to ask ‘for help because they feel . . . ever after there is going to be a damning comment on their notes’ (Burnett-Thomas, 1996, p. 107).

Professionals strove to overcome cultural barriers and endeavoured to develop an ‘atmosphere that here you can talk about anything at all’ (Tammentie et al., 2013, p. 28). They

emphasised collaborative working, striving ‘not to be accusatory . . . recognising . . . how the two of us can work out something’ (Heneghan et al., 2007, p. 337). Some avoided using stigma-laden terms such as ‘depression’ or ‘psychiatrist’ because ‘it can just put a barrier up’ (Burnett-Thomas, 1996, p. 108). Similarly, many highlighted the role of ‘connection, validation and normalisation’ (Bilszta et al., 2010, p. 8) in facilitating disclosure of distress. However, some health visitors believed that it was necessary for women experiencing severe distress to “‘admit” to the “non-normality” of their feelings’ (McConnell et al., 2005, p. 253).

The foundation for facilitating disclosure of distress was the trusting relationship between mother and professional – ‘it’s very much about relationships, because they are not going to talk to you if they don’t trust you, or if they haven’t got that relationship’ (Jomeen et al., 2013, p. 483). Many professionals took an informal approach to facilitating disclosure, such as ‘spending three to four minutes just interacting with the kids or asking about other things that are going on’ (Palladino et al., 2011, p. 275), noting that it ‘doesn’t have to be as mechanical as people think’ (Rush, 2012, p. 326). Alternatively, some advocated a more direct approach, although they tended to preface questions with an observation such as ‘you look like you’ve lost a lot of weight recently. Are you OK?’ (Heneghan et al., 2007, p. 336). This was seen to require courage but if done in a caring manner could facilitate disclosure. One professional reported that ‘mothers are actually relieved to have been asked and they start to talk to me’ (Tammentie et al., 2013, p. 28).

If a professional was concerned about a mother’s emotional wellbeing, offering her flexible and timely support was viewed as important, with one nurse telling mothers ‘I am here for you . . . any time you need some help you ring me up’ (Rush, 2012, p. 325). Although this ‘open-door’ policy was not explicitly adopted by other professionals, further appointments were

often arranged – ‘once you kind of know they’re in distress you don’t just give them one session, you ask them to come back’ (Chew-Graham et al., 2009, p. 6).

These comments summarise the fears that professionals perceived new mothers to hold in relation to disclosing distress. They highlight the importance of professionals having an awareness of mothers’ potential fears, which allows them to address these and create a safe and containing space. Professionals used both direct and indirect methods to encourage mothers to talk about emotional distress and offered further opportunities for this if concerned.

Whose role is it anyway: professional confidence and expertise

Many professionals were involved in postnatal care as the mothers journeyed through services – ‘she’ll be home [from hospital] within 24 hours . . . on to the community midwife . . . then they’re transferred to the health visitor’ (Edge, 2010, p. 20). Few stated that PND was their particular responsibility, with only child health nurses saying ‘this is an area that we have a level of expertise that needs to be recognised’ (Belle & Willis, 2013, p. 158). However, other professionals did consider maternal psychological well-being as a component of their role, due to its wider effects – ‘any sort of psychological problem . . . certainly it is going to have an impact on the children’ (Heneghan et al., 2007, p. 335).

Nevertheless, this involvement tended only to cover detection of distress – ‘the community service is here to recognise the problem and inform’ (Mivšek et al., 2008, p. 323). For some, this appeared rooted in the belief that they could not provide the care required and thus their role was to ‘get the best help I can for that mum . . . I am there to refer on’ (Rush, 2012, p. 325). Several professionals viewed health visitors as primarily responsible for the management of postnatal distress, believing that they offered ‘someone to talk to and listen to but

also . . . structure and some practical things to do' (Chew-Graham et al., 2008, p. 172). Some health visitors positioned themselves as an alternative to GPs or specialist services and many spoke of their role as a 'friend' to new mothers – 'although you are going in as a professional, you also become a friend and sometimes, at my age, a mother-figure' (Burnett-Thomas, 1996, p. 114). Developing a 'friendship' was seen to reduce perceived isolation and was also adopted by nurses and community health workers. It is notable that professionals who saw women within outpatient clinics did not conceptualise their relationship as both professional and a friendship.

The reliance on onwards referral appeared to reflect a lack of confidence in managing postnatal distress, for example one midwife felt uncertain of 'what to do with this cos it's just way above my head' (Jomeen et al., 2013, p. 484). Only two professional groups did not emphasise a need for improved training opportunities – GPs in England and public health nurses in Finland. Many other professionals believed that they had received an inadequate level of training to work with issues around mental health. This fostered avoidance of discussing distress, because professionals felt 'quite scared of mental health and asking the question' (Rowan, McCourt, & Bick, 2010, p. 104). Conversely, some professionals felt confident in particular aspects, such as one obstetrician feeling 'fairly comfortable with initiating oral medication' (Palladino et al., 2011, p. 274). However, although professionals in Slovenia often reported confidence in their skills – 'I think we have enough knowledge about this' (Mivšek et al., 2008, p. 322), their responses reflected common misconceptions about PND. Thus, the lack of training received may have perpetuated unhelpful stereotypes.

Specific training needs were identified, for example a desire to learn basic counselling techniques because professionals 'would like to talk about it more, but . . . do not know where to start' (Byatt et al., 2012, p. 444). Additionally, informal inter-professional learning was valued

by professionals interviewed by Rowan et al. (2010). Health visitors who received training in recognising and managing emotional distress found that this validated pre-existing experience and knowledge – ‘I did have more knowledge than I actually gave myself credit for. It empowered me to think, “no, actually, you do know”’ (Jomeen et al., 2013, p. 484). Some professionals acknowledged a shared responsibility for updating skills – ‘it’s the organisational responsibility to keep PND high on the . . . agenda . . . a health visitor’s professional and personal responsibility to keep oneself updated’ (Brown & Bacigalupo, 2006, p. 51).

A minority of professionals identified emotional aspects which influenced confidence when working with women experiencing PND. Frustration over the lack of reciprocity and reduced motivation to offer support were highlighted as potential responses. Some nurses recognised the importance of being aware of their own attachment to mothers, while health visitors recognised that ‘something about dealing with the parent and the child . . . upsets the health visitor’ (McConnell et al., 2005, p. 254). In both instances, participants spoke about the need for reflection and clinical supervision to manage the emotional impact of this work.

This theme encapsulates views held by professionals on their own and other professionals’ roles in relation to PND. Although in the UK there has been an emphasis on the need for mental health training for midwives and health visitors, this synthesis shows that this is a wider problem for many perinatal professionals. Furthermore, it suggests that many professionals do not consider the potential for their work to have an emotional impact and may therefore minimise the value of supervision.

‘We’re not user friendly’: navigating the system

Systemic issues such as time pressures were felt to deter both women and professionals from discussing emotional distress, even if professionals were concerned – ‘you’ve got three other patients waiting . . . you put it off until the next visit’ (Heneghan et al., 2007, p. 336). Time pressures forced professionals to focus on high risk issues at the expense of picking up lower levels of distress – ‘we are just like are you suicidal, homicidal’ (Byatt et al., 2012, p. 440). However, one child health nurse suggested that there were ‘many other ways that we can creatively help and support’ (Belle & Willis, 2013, p. 158), although these were not expanded upon.

The complex nature of perinatal services was particularly salient because women who may already be ‘de-motivated because of low mood . . . have to jump through hurdles’ (Chew-Graham et al., 2009, p. 6). The impact of this could be amplified for women unfamiliar with the healthcare system, such as new immigrants – ‘anything short of being highly functional and the woman is likely to abandon the process’ (Teng et al., 2007, p. 96). Some professionals also noted a tendency for referrals to be turned away if women were not deemed to require hospital admission.

Furthermore, communication between perinatal and mental health services was highlighted as lacking, reducing confidence in the competence of colleagues - ‘you never have a relationship with the person you’re referring the patient to’ (Palladino et al., 2011, p. 274). Details of the mental health assessment and treatment plan were often not shared with perinatal professionals, who felt that they ‘don’t have a clue [about] what happened’ (Byatt et al., 2012, p. 442). This left professionals feeling isolated and shouldering the responsibility of support. In

some cases, lack of confidence in the referral process led professionals to work outside of their own remit – ‘you’re supposed to offer six listening visits, but there have been ladies that I’ve supported for years’ (Jomeen et al., 2013, p. 484). It was believed that more collaborative working would allow professionals to know that ‘they haven’t got all the responsibility . . . it doesn’t all fall on them’ (Bilszta et al., 2010, p. 10). In services where communication between professionals was perceived to be well established, this was highlighted as fundamental – ‘we all complement each other, it is very important that we all get on and communicate well’ (Burnett-Thomas, 1996, p. 115). In one service, a dedicated liaison psychiatrist and counselling service facilitated good links with the wider team (Rowan et al., 2010).

Professionals consistently reported a lack of knowledge regarding available resources for women experiencing PND, despite conceptualising their role as referring women on to appropriate services – ‘it was very much . . . “where do we go to support this lady?”’ (Jomeen et al., 2013, p. 483). The belief that no options other than anti-depressants existed led to the dilemma of questioning whether there ‘is any point in identifying [women experiencing PND] if you can’t do anything with them’ (Chew-Graham et al., 2008, p. 174).

Professionals craved increased security through the implementation of protocols in relation to postnatal distress. This was believed to be particularly lacking for women who were not acutely unwell – ‘when the patients don’t have those things [suicidal-homicidal ideation], it is hard to know – who do we refer to for further care or do we just start on medication and cross our fingers?’ (Palladino et al., 2011, p. 272) This demonstrates the sense of uncertainty perceived by many professionals when working with women experiencing PND.

These comments reflect the complex and, at times, unhelpful system through which women and professionals must navigate when seeking support for PND. This impeded both the disclosure of emotional distress and the care that could be provided after such a disclosure. Time pressures impacted on the decision to raise concerns and forced professionals to focus on high-risk clients. A lack of inter-service communication engendered feelings of professional isolation. Furthermore, professionals highlighted the need for robust pathways for women experiencing distress classified as ‘mild’.

Discussion

This review aimed to explore professional conceptualisations of PND, whether these affect practice and professionals’ perceptions of the barriers and facilitators encountered by women seeking support for PND. The meta-synthesis is consistent with the findings of individual studies but reaches beyond these to develop a broader comprehension across professions, cultures, and healthcare systems. Each theme encompasses views from across the diverse sample.

A focal concern for many participants was lack of confidence and knowledge in responding to postnatal distress. This reflects concerns pertaining to the training received by perinatal professionals, for example the ‘wealth of evidence to show that the quality and quantity of education currently received [by midwives in the UK] is not good enough’ (Maternal Mental Health Alliance, 2013, p. 6). This synthesis has bolstered this concern by highlighting the dearth of mental health training reported across professions and countries, perhaps reflecting the position of mental health issues on international government agendas. Although international

guidelines place postnatal mental health screening and management within the remit of frontline staff (e.g., Beyondblue, 2011; NICE, 2007), professionals do not feel equipped to fulfil this role.

Additionally, it suggests for the first time that many professionals develop a psychosocial understanding through working with mothers, moving away from a purely biological model. However, they continued to offer biomedical solutions to psychosocially conceptualised distress, perhaps because they perceive this to be the only available option. Thus, it would be helpful to incorporate holistic and balanced discussions of mental health within professional training and introduce psychological and social approaches to managing distress. This may assist professionals to critically engage with models of emotional distress and advocate approaches which complement their understanding of PND.

Although several participants discussed the emotional effects of working with PND, the majority of participants did not. Some professionals spoke about their role as a 'friend' to mothers, echoing mothers' wishes to develop a personal relationship with midwives 'akin but not identical to friendship' (Wilkins, 2000, p. 37). Empathic engagement with clients is posited as a factor which increases the likelihood of professionals experiencing vicarious trauma (Sheen, Slade, & Spiby, 2013). Thus, perinatal professionals who view forming a relationship with mothers as integral to their role may be at higher risk of experiencing traumatic stress when working with mothers who relate difficult experiences. However, research suggests that professionals such as midwives feel compelled to maintain a professional façade of coping (Hunter & Deery, 2005) and thus feel unable to discuss their distress. Furthermore, professionals may emotionally detach from clients to manage their own responses, which can lead to burn-out and low morale (Deery & Hunter, 2010). Providing a reflective space through supervision, a role

often adopted by clinical psychologists (e.g., APA, 2013; British Psychological Society, 2008), may assist professionals in managing these emotional responses to their work.

Additionally, participants' reflections on the utility of inter-professional working support evidence that the knowledge and skills of professionals providing mental health care benefit from inter-professional education (Reeves et al., 2008). Clinical psychologists may be well placed to be involved in such collaboration. It can be argued that experiences of pregnancy, childbirth and parenthood can cause equally high levels of distress as many physical health conditions. Yet psychologists are rarely involved in maternity teams, while they are regularly employed within physical health services (Division of Clinical Psychology, 2008).

Many participants commented on the importance of continuity of care in building a relationship with mothers, something which families have also highlighted (Department of Health, 2010). The synthesis yielded the novel finding that a continuous relationship with clients provides containment for professionals and facilitates discussion of sensitive issues. However, continuity of care is becoming fragmented due to the global industrialisation of healthcare (Rastegar, 2004). Participants voiced concern that this lack of continuity impedes disclosure of distress, as well as reducing professionals' confidence in inquiring about emotional health. Professionals desired training in responding to mothers who do disclose distress. Taken together, these observations suggest that frontline staff with existing relationships with mothers may be in the best position to offer psychological support, if provided with training. Supervising professionals to work psychologically with mothers fits with the drive towards widening access to psychological therapies and enhancing capacity in primary healthcare (Onyett, 2007). A growing evidence base supports this approach, for example training public health nurses in supportive counselling techniques (Glavin, Smith, Sørsum, & Ellefsen, 2010) and health visitors

in cognitive behavioural or person centred principles (Morrell et al., 2009). Such approaches may reduce the stigma associated with seeking psychological therapy, through its provision by professionals offering routine postnatal care.

The reduction of stigma appears to be regularly considered by professionals working with postnatal mothers, who often spoke about their role in normalising experiences. The desire for normalisation has been described as a natural propensity in mothers experiencing PND (Scrandis, 2005) and, more widely, this process is the focus of many mental health campaigns. Although this is undoubtedly useful, there is also a danger that women fail to seek support for their experiences because they believe them to be an expected part of motherhood (Sword, Busser, Ganann, McMillan, & Swinton, 2008). It is important for professionals to hold this in mind when discussing emotional distress with families and highlight that while such experiences are understandable, it does not mean that mothers have to cope without support.

Similarly, delays in seeking treatment for mental health concerns is often due to a lack of mental health awareness leading clients to minimise their distress (Thompson, Hunt, & Issakidis, 2004). In the current synthesis, professionals highlighted the importance of informing families about the possibility of PND within antenatal education. Anecdotal clinical evidence also suggests that many women who experience postnatal emotional distress wish that they had received information about this earlier, to facilitate recognition. Moreover, the current synthesis highlights the importance placed by professionals upon antenatal contact in facilitating early recognition of distress and suggests that a lack of continuity of care jeopardises this. Although research evidence questions the value of antenatal education or psychosocial interventions in reducing the likelihood of developing PND (Dennis & Creedy, 2004; Webster et al., 2003), this does not account for the potential benefits gained through earlier recognition. Moreover, a recent

meta-analysis reported that a range of antenatal psychotherapeutic interventions were effective in preventing PND (Sockol, Epperson, & Barber, 2013). Thus, the value of continuity of care throughout the antenatal and postnatal period must not be diminished.

A further area of concern to professionals was the possibility that lower levels of emotional distress were less likely to be noticed than severe PND. Some felt that this was due to time constraints forcing professionals to focus on ‘severe’ distress. Others were unsure of where to refer people with lower levels of distress because protocols were believed to apply only to more distressed mothers. This concern was reflected in the most recent review of maternal deaths in the UK, which recommended the implementation of ‘priority care pathways for pregnant and postpartum women [. . . which] include a low-threshold for referral and intervention’ (CMACE, 2011, p. 132). It also appears that many professionals do not feel adequately informed about local resources available to mothers. It is important that professionals are allocated time, particularly when new to an area, to make contact with other services and ensure that they can signpost families appropriately.

Limitations

Analysis and discussions of research should always be considered within the limitations of the paper. Firstly, the comprehensiveness of the synthesis may have been compromised by the exclusion of papers written in languages other than English and published in non peer-reviewed journals. Additionally, papers focusing on AND were excluded, which may have provided useful insight into whether professionals conceptualise AND and PND similarly, particularly in light of the finding that many professionals value antenatal contact with mothers. It is also important to note that the meta-ethnographer is already two interpretative steps away from the

experience they are exploring and are thus ‘far removed from the lived experiences they are meant to faithfully represent’ (Sandelowski & Barraso, 2007, p. 237). Moreover, it is difficult to access first-order constructs from published papers, as the authors have inevitably selected particular aspects of their participants’ experiences to present within the work.

Future research

The metasynthesis has revealed several areas worthy of additional research. Firstly, further studies investigating the benefits of providing mental health training to perinatal professionals should be considered. Alongside these, studies exploring the acceptability, feasibility and effectiveness of integrating psychology liaison within primary care maternity teams would be a positive step towards incorporating psychological approaches at an earlier stage of the stepped care model. Although the evidence for psychological support for women experiencing PND is relatively well established (Sockol, Epperson, & Barber, 2011), the evidence for preventative approaches is less clear (Dennis & Creedy, 2004). Research would usefully investigate both the efficacy of antenatal education regarding PND and families’ experiences of this. Finally, the novel finding that professionals often reluctantly suggest anti-depressant medication despite this not fitting with their psychosocial conceptualisation of PND warrants further consideration. It would be particularly useful to know whether other approaches, such as clinical psychology, were not offered due to a lack of awareness or availability, or because they were not felt to be appropriate.

Conclusion

This synthesis of 19 qualitative research papers offers a detailed understanding into the conceptualisations of PND held by perinatal professionals, alongside the barriers and facilitators

which they believe mothers experiencing PND face when seeking support. Several clinical implications have been drawn from the results, including the need for clear pathways of care for all severities of distress; the demand for a greater quantity and quality of mental health training for perinatal professionals and the fostering of liaison between perinatal healthcare professionals and clinical psychologists.

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Table 1. Search terms used for systematic search

Professional title (combined with Boolean operator 'OR')		Postnatal time period (combined with Boolean operator 'OR')		Mental distress (combined with Boolean operator 'OR')		Methodology (combined with Boolean operator 'OR')
Professional* Midwi* Nurs* Health visitor* Worker* GP Physician	Combined with Boolean operator 'AND'	Postnatal Perinatal Peripartum Postpartum Pregnan* Primipara Puerperal Maternal Obstetric*	Combined with Boolean operator 'AND'	Sadness Depression Mental health Distress Dysphoria	Combined with Boolean operator 'AND'	Experience* Interview* Qualitative Grounded theory Phenomenolog* Narrative Thematic analysis Focus group

Table 2. Characteristics of papers included in synthesis

Paper	Research aim	Participants	Method of data collection	Type of analysis undertaken
1. Belle and Willis (2013)	To explore how CHNs perceive and understand women's emotional issues after childbirth, how these understandings inform their practice and how these understandings are utilised by CHNs to maintain control and authority over their specialist area.	Child and family health nurses (n = 10) Australia	Semi structured in-depth interviews	Thematic analysis
2. Bilszta et al. (2010)	To gain an in-depth understanding, from a health professional's viewpoint, of their experiences in the care and treatment of women with PND, how this has shaped their personal views and attitudes, and the context in which they place this disorder in their own practice and the wider community.	Range of health professionals (n = 16) Australia	Two focus groups	Interpretative Phenomenological Analysis
3. Boyd et al. (2011)	To gain understanding of the screening process and barriers and successes in mental health referrals for women with depression; discuss the strategies for screening and assisting low-income women with PPD to initiate mental health services	Community health workers (n = 16) USA	Three focus groups	Content analysis
4. Brown and Bacigalupo (2006)	To determine the processes health visitors in primary care trusts use to identify PND, and the implications these have for practice.	Health visitors (n = 6) England	Interviews	Thematic analysis

5. Burnett-Thomas (1996)	To investigate non-psychiatric professionals' attitudes to post-natal psychological disorders and to investigate practice by health visitors and midwives in the education of parents about post-natal psychological disorders and the antenatal and post-natal assessment of mothers.	Health visitors (n = 6) Midwives (n = 6) England	Semi structured interviews	Grounded theory
6. Byatt et al. (2012)	Gather preliminary information on barriers and facilitators to addressing perinatal depression from the perspective of perinatal health care professionals.	Perinatal health care professionals (n = 28) USA	Four focus groups	Grounded theory
7. Chew-Graham et al. (2008)	To explore the views of GPs and health visitors on the diagnosis and management of postnatal depression.	General Practitioners (n = 19) Health visitors (n = 14) England	In-depth interviews	Thematic analysis with an iterative approach
8. Chew-Graham et al. (2009)	To explore general practitioners', health visitors' and women's views on the disclosure of symptoms which may indicate postnatal depression in primary care.	General Practitioners (n = 19) Health visitors (n = 14) England	In-depth interviews	Thematic analysis with an iterative approach
9. Edge (2010)	To investigate health professionals' views about perinatal mental healthcare for Black and minority ethnic women	Range of healthcare professionals (n = 42) England	Individual interviews Focus groups	Framework analysis

10. Heneghan et al. (2007)	To assess paediatricians' beliefs about discussing maternal depressive symptoms during a paediatric visit, and methods paediatricians use to identify mothers with depressive symptoms.	Paediatricians (n = 23) USA	In-depth telephone interviews	Standard qualitative techniques
11. Jomeen et al. (2013)	To explore health visitors' experiences of assessing women's psychological health across the perinatal period	Health visitors (n = 5) England	Focus groups	Thematic analysis
12. McConnell et al. (2005)	To examine how health visitors understand and make sense of PND.	Health visitors (n = 8) England	Semi-structured interviews	Grounded theory
13. Mivšek et al. (2008)	To explore Slovenian midwives' and nurses' knowledge of, and attitudes towards, post-natal mood disorders.	Midwives Nurses (n = 10) Slovenia	Two focus groups	Thematic analysis
14. Palladino et al. (2011)	To understand how prenatal care providers perceive influences on their delivery of perinatal depression care.	Prenatal care providers (n = 20) USA	Semi-structured interviews	Thematic analysis
15. Rowan et al. (2010)	To follow-up the findings of a previous survey that explored the extent to which policy recommendations had been implemented in practice in two strategic health authorities.	Relevant health professionals (n = 8) England	Semi-structured interviews	Framework approach

16. Rush (2012)	To improve understanding of the experience of MCH nurses responding to women at risk of PPD.	Maternal & child health nurses (n = 8) Australia	In-depth interviews	Phenomenological method
17. Santos Junior et al. (2013)	Reports experiences of Brazilian physicians and nurses caring for women with postpartum depression in primary healthcare settings.	Nurses (n = 10) Physicians (n = 7) Brazil	Open-ended interviews Observations Field diary records	Inductive content analysis
18. Tammentie et al. (2013)	To investigate public health nurses' interaction with families in the child health clinic setting where the mother is at risk of postnatal depression.	Public health nurses (n = 14) Finland	Interviews	Grounded theory
19. Teng et al. (2007)	To identify potential barriers to care that recent immigrant women may encounter, as perceived by healthcare workers, and to identify challenges healthcare workers felt that they faced as providers of care to this population.	Healthcare workers (n = 16) Canada	Semi-structured interviews	Constant comparative analysis

Table 3. Critical appraisal of study quality using the CASP appraisal tool for qualitative studies

Study	Research Design ^a	Sampling	Data collection	Reflex-ivity	Ethical issues	Data analysis	Findings	Value of research	Total score
Belle and Willis (2013)	3	2	2	1	2	3	2	2	17
Bilszta et al. (2010)	1	2	2	1	1	2	2	2	13
Boyd et al. (2011)	1	3	2	1	2	2	2	2	15
Brown and Bacigalupo (2006)	3	2	2	1	2	1	2	2	15
Burnett-Thomas (1996)	3	1	2	1	1	2	2	3	15
Byatt et al. (2012)	1	2	2	1	1	2	3	2	15
Chew-Graham et al. (2008)	2	2	2	1	1	3	3	2	16
Chew-Graham et al. (2009)	2	2	3	1	1	2	3	3	17
Edge (2010)	2	2	2	1	2	2	3	3	17
Heneghan et al. (2007)	2	3	3	1	2	2	3	2	18
Jomeen et al. (2013)	3	1	3	1	2	3	3	2	18
McConnell et al. (2005)	3	2	3	1	2	3	3	1	18
Mivšek et al. (2008)	3	3	3	2	3	2	3	2	21
Palladino et al. (2011)	1	2	3	1	2	3	3	3	18
Rowan et al. (2010)	2	2	2	1	3	1	2	3	16
Rush (2012)	2	2	2	1	2	2	2	3	16
Santos Junior et al. (2013)	3	3	2	1	2	3	3	2	19
Tammentie et al. (2013)	2	2	2	1	2	3	3	2	17
Teng et al. (2007)	3	2	2	1	2	2	3	3	18

^a Columns 2-9 correspond to items on the CASP tool. A score of 1 = weak (little or no justification or explanation of a particular issue); 2 = moderate (addressed issue but didn't fully elaborate, e.g., justification for use of method but no procedure); 3 = strong (extensively justified and explained issues, e.g., semi-structured interviews, transcribed, sample interview questions) (Duggleby et al., 2012).

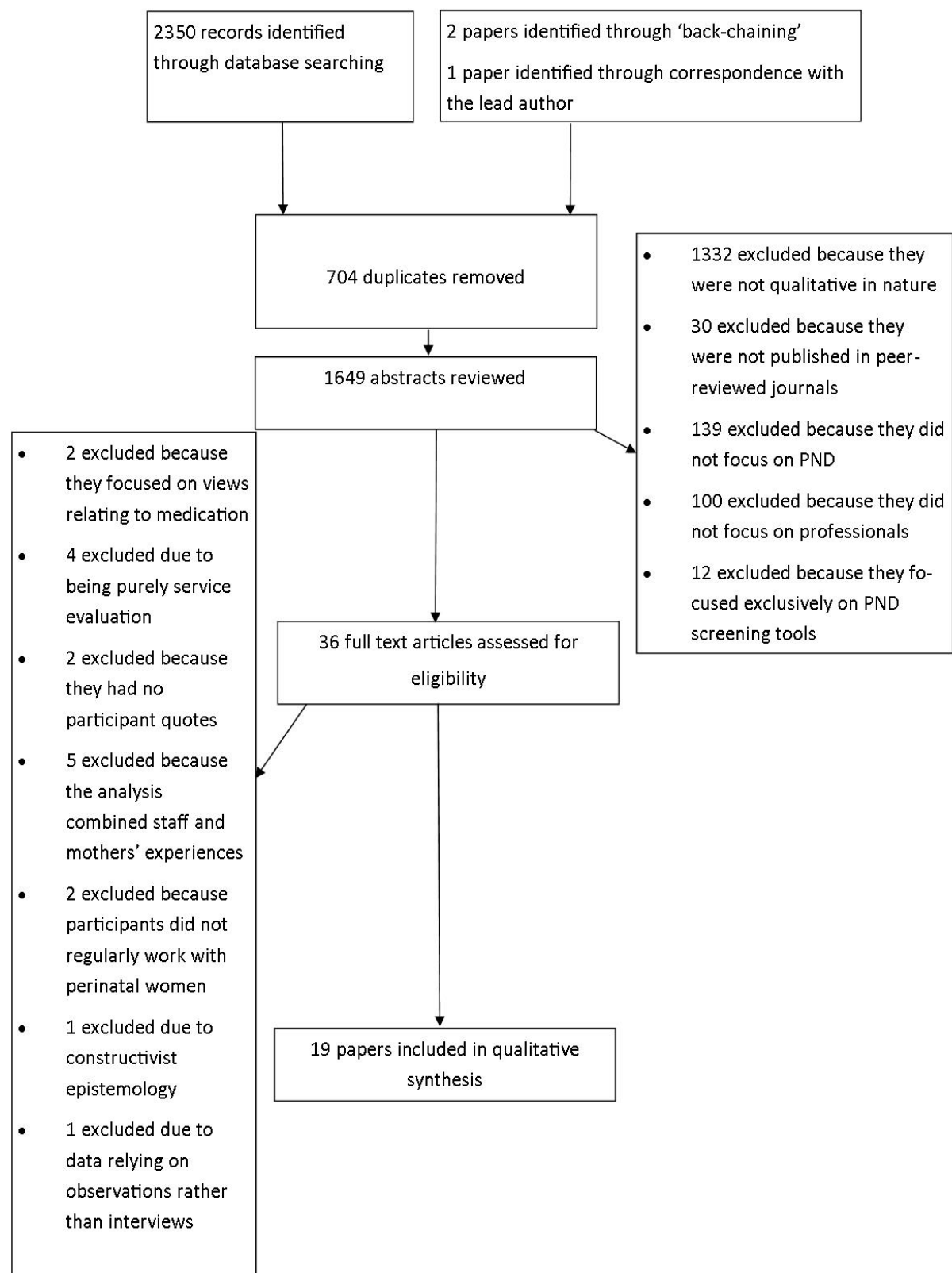


Figure 1. Flowchart depicting study selection process

Appendix 1-A. Questions included in CASP analysis

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Were the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into account?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

Appendix 1-B. Order in which studies were included within the synthesis

1. Rowan et al. (2010)
2. Edge (2010)
3. Chew-Graham et al. (2009)
4. Chew-Graham et al. (2008)
5. Brown and Bacigalupo (2006)
6. McConnell et al. (2005)
7. Burnett-Thomas (1996)
8. Belle & Willis (2013)
9. Rush (2012)
10. Biltzsa et al. (2010)
11. Byatt et al. (2012)
12. Palladino et al. (2011)
13. Boyd et al. (2011)
14. Heneghan et al. (2007)
15. Teng et al. (2007)
16. Santos Jnr et al. (2013)
17. Tammentie et al. (2013)
18. Mivsek et al. (2008)
19. Jomeen et al. (2013)

Appendix 1-C. Translation of original study themes into meta-synthesis

	Conceptualising the label	Using ‘my antennae’: recognising PND	‘Permission to speak’: facilitators and fears	Whose role is it anyway? Professional confidence and expertise	‘We’re not user friendly’: navigating the system
Belle & Willis (2013)	Alternative understandings of maternal sadness	Alternative understandings of maternal sadness Technicality, indeterminacy and tacit knowledge		Boundary work and professionalism	Technicality, indeterminacy and tacit knowledge
Bilszta et al. (2010)	Expectations of motherhood Framing the issue of perinatal depression	Screening and identification	Coping and failure Treatment experiences	Treatment experiences Assistance for health professionals	Assistance for health professionals Treatment experiences
Boyd et al. (2011)	Life events Support	Screening and referral Support	Culture and language Barriers to referral Support	Screening and referral	Screening and referral Barriers to referral
Brown and Bacigalupo (2006)		Visiting patterns Identification of PND: <i>establishing a relationship; The EPDS; Experience</i>	Barriers to identifying PND	Training issues Barriers to identifying PND	Barriers to identifying PND

Burnett-Thomas (1996)	<p>Depth of education</p> <p>Partners and family education</p> <p>Assessment of circumstances</p>	<p>Assessment of feelings and mental state</p> <p>Assessment of circumstances</p> <p>Assessment of relationships</p> <p>Taking a psychiatric history</p> <p>The EPDS</p>	<p>Stigma</p> <p>Assessment of relationships</p>	<p>Depth of education</p> <p>Roles and advocacy</p> <p>In the know: <i>academic background;</i> <i>Update</i></p> <p>Nobody's baby</p> <p>Liaison</p>	<p>Partners and family education</p> <p>Roles and advocacy</p> <p>Nobody's baby</p> <p>Liaison</p>
Byatt et al. (2012)	<p>Patient-level barriers: <i>Women's concern about the risk of antidepressant use during the perinatal period</i></p>		<p>Patient-level barriers: <i>Complex psychosocial factors and stigma result in limited initiative to seek treatment</i></p> <p>Patient-level facilitators: <i>encourage help-seeking through support from peers and health care professionals</i></p>	<p>Provider-level facilitators: <i>Counselling and motivation enhancement techniques; Targeted training in diagnosis, triage, referral, counselling and treatment and assessment, diagnosis, and treatment of depression</i></p> <p>Provider-level barriers: <i>Limited mental health training and knowledge; Limited resources,</i></p>	<p>Provider-level barriers: <i>Limited resources, motivation and confidence</i></p> <p>Provider-level facilitators: <i>Appropriate utilisation of resources for triage and referral</i></p> <p>System-level barriers: <i>Lack of communication and continuity between perinatal and mental health professionals; Limited access to mental health care</i></p>

				<i>motivation and confidence</i>	System-level facilitators: <i>improved access to mental health care via integration of perinatal and mental health care</i>
Chew-Graham et al. (2008)	Making the diagnosis Labelling affects management	Ways of working Making the diagnosis Is an established relationship important?		Perceptions of others' roles Whose responsibility is the management of postnatal depression?	Whose responsibility is the management of postnatal depression? Labelling affects management
Chew-Graham et al. (2009)	Understanding postnatal depression Making the diagnosis	How the system of care hinders disclosure Making the diagnosis	Disclosure and hindering disclosure Making the diagnosis	How the system of care hinders disclosure	Ways of working How the system of care hinders disclosure Making the diagnosis
Edge (2010)		Antenatal contact and missed opportunities Professional practice and perinatal mental health care	Black Caribbean women and perinatal mental healthcare	Professional practice and perinatal mental healthcare	Antenatal contact and missed opportunities Professional practice and perinatal mental healthcare

Heneghan et al. (2007)		Recognition of maternal depressive symptoms by observation	Mothers' fear of judgement	Acknowledgements of maternal well-being	Barriers in discussing maternal depressive symptoms: <i>Time</i>
		Inquiring about mothers' support systems	Strategies for intervention: <i>Improve paediatrician-mother communication</i>	Inquiring about mothers' support systems	Barriers in discussing maternal depressive symptoms: <i>Lack of knowledge of appropriate resources</i>
		Continuity of the relationships	Recognition of maternal depressive symptoms by observation	Barriers in discussing maternal depressive symptoms: <i>Training</i>	
Jomeen et al. (2013)		Questioning and identification	Mothers' fear of judgement Questioning and identification	So what do I do now? The importance of support to promote effective assessment	So what do I do now? The importance of support to promote effective assessment
				Recognising the problem	
McConnell et al. (2005)	A diversified concept Diversified roles	Diversified roles	Diversified roles	A diversified concept Diversified roles	A diversified concept
Mivšek et al. (2008)	Nurses' and midwives' knowledge about post-natal depression	Perceived problems and possible solutions in the health care of post-natally depressed women		Role in the treatment of post-natal depression Nurses' and midwives' knowledge about post-	Perceived problems and possible solutions in the health care of post-natally depressed women

		Nurses' and midwives' knowledge about post-natal depression		natal depression	
Palladino et al. (2011)	<p>Roles and Responsibilities: <i>Role identity</i></p> <p>Provider perceptions of patient norms: <i>views of motherhood</i></p>	<p>Experiential influences upon decision making: <i>Prior encounters</i></p> <p>Experiential influences upon decision making: <i>engagement style</i></p>	<p>The provider's "toolbox": <i>General knowledge from training and education</i></p> <p>Provider perceptions of patient norms: <i>views of motherhood</i></p> <p>Provider perceptions of patient norms: <i>Views of treatment</i></p>	<p>The provider's "toolbox": <i>General knowledge from training and education</i></p>	<p>Certainty around delivering depression care: <i>Trust and Comfort</i></p> <p>The provider's "toolbox": <i>logistical resources</i></p> <p>The provider's "toolbox": <i>system coordination</i></p> <p>Provider perceptions of system norms: <i>health system norms</i></p>
Rowan et al. (2010)		<p>Screening for mental health needs</p> <p>Liaison between the multi-professional team</p>		Training of health professionals	<p>Referral pathways</p> <p>Liaison between the multi-professional team</p>
Rush (2012)	The importance of treatment options: <i>External to council</i>	<p>How MCH nurses recognize symptoms of PPD</p> <p>The role of rapport</p>	How MCH nurses respond when recognizing new cases of PPD	How MCH nurses recognise symptoms of PPD	The importance of treatment options: <i>Internal to council</i>

			The role of rapport	Acknowledging the limits of MCH nurses in responding to PPD	Acknowledging the limits of MCH nurses in responding to PPD
Santos Junior et al. (2013)	Limited professional exposure to PPD: <i>Limited knowledge and recognition of postpartum depression</i> PPD is the domain of psychiatry			Limited professional exposure to PPD: <i>Limited knowledge and recognition of postpartum depression</i> PPD is the domain of psychiatry Challenges in dealing with PPD	Challenges in dealing with PPD PPD is the domain of psychiatry
Tammentie et al. (2013)	Discussions with the family: <i>Assessing the situation of the family</i>	Professionalism: <i>observing interaction; raising issues with sensitivity</i>	Discussion with the family: <i>frank and trusting interaction; listening to the parents; assessing the situation of the family</i> Meeting the family: <i>discussing issues</i> The relationship between the PHN and family: <i>Being flexible</i>	Information and counselling: <i>providing information to parents</i> Professionalism: <i>Training</i>	Professionalism: <i>Offering concrete help</i>
Teng et al. (2007)		Challenges for HCW's: <i>Inadequate assessment tools</i>	Culturally determined barriers Practical barriers	Challenges for HCW's: <i>Fear of incompetence</i>	Practical barriers

Appendix 1-D. Instructions for authors submitting to Journal of Reproductive and Infant Psychology

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Section two: Empirical paper

Exploring how women and their significant others understand relationships within the context of
postpartum psychosis

Caroline Wyatt*

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Objective: To explore how women and their significant others make sense of their experience of postpartum psychosis (PP), their relationships, and the mutual influence of these. **Background:** Although previous studies have highlighted the potential strain placed on relationships by an experience of PP, none have explored shared perceptions of relationships during this time. **Methods:** Seven women who had experienced PP were interviewed, alongside a significant other of their choosing. Data were analysed using interpretative phenomenological analysis (IPA), paying particular attention to understandings shared or disputed by the dyad. **Results:** Four themes emerged from the data: (a) 'she wasn't herself': threatened relationships through loss of 'normal' self; (b) invalidation and isolation: relational dynamics in seeking, receiving and providing support; (c) 'the worst life can throw at us': shared perceptions of trust and respect following PP; (d) a double-edged sword: understanding relationships as negatively and positively influencing PP experience. **Conclusion:** The results highlight the complexity of interactions between the experience of PP and close relationships. Although PP can create difficulties within relationships, ultimately the experience can result in stronger connections with significant others. Supportive relationships can play an important role in recovery from PP. Methodological limitations, clinical implications and areas for further research are considered.

Keywords: Postpartum psychosis; mothers; significant others; dyadic interviews;
interpretative phenomenological analysis

Exploring how women and their significant others understand relationships within the context of postpartum psychosis

Introduction

In every 1000 new mothers, one to two experience a severe form of distress labelled postpartum psychosis (PP; Sit, Rothschild, & Wisner, 2006). Experiences of PP can include confusion, paranoid thoughts, mood fluctuations and unusual perceptual experiences (Twomey, 2009).

Women with experience of psychiatric hospitalisation are at increased risk (Valdimarsdóttir, Hultman, Harlow, Cnattingius, & Sparén, 2009), particularly if they have received a diagnosis of 'bipolar' or 'schizoaffective' disorder (Kemp, Bongartz, & Rath, 2003). However, almost half of women who experience PP have had no previous contact with mental health services (Valdimarsdóttir et al., 2009).

Although PP is often attributed to physiological changes such as hormonal imbalances (Boyce & Barriball, 2010) research suggests that social, psychological and biological factors interact within a stress-vulnerability framework (Glover, Jomeen, Urquhart, & Colin, 2014). Although women often regain high levels of social and occupational functioning after experiencing PP (Pfuhmann, Stoeber, & Beckmann, 2002), further distress outside of the postnatal period is likely (Nager, Szulkin, Johansson, & Sundquist, 2013). In a sample of postnatal women experienced extreme distress, 75% experienced further distress and many remained on medication (Robling, Paykel, Dunn, Abbot, & Katona, 2000).

Experiencing PP can hold consequences for the mother, child and family. A recent report urges services in the UK to consider the impact of postnatal distress on the family (Hogg, 2013). National Institute for Health and Clinical Excellence (NICE) guidelines stipulate that

professionals should ‘assess and, where appropriate address . . . the impact of any mental disorder on [a mother’s] relationships with her partner, family members and carers’ (2007, p. 11). Within one study 18% of marriages ended within three years of the woman experiencing PP (Blackmore et al., 2013), with the breakdown often being ascribed to changes in the relationship or partners’ inability to cope with their wife’s distress. Marks, Wieck, Checkley and Kumar (1992) studied psychological and social factors implicated in the experience of women with histories of affective difficulties who were labelled ‘psychotic’ during the postnatal period. Single women were disproportionately represented, and women in relationships often identified an area of serious difficulty within that relationship. Although causality cannot be inferred, these results suggest that interpersonal relationships may affect, or be affected by, the experience of PP.

Previous qualitative research emphasises the strain on relationships created by the lack of support for partners of women experiencing PP and highlights the importance of understanding women’s informal networks during and after PP (Robertson & Lyons, 2003). This was supported by Doucet, Letourneau, and Blackmore (2012), who explored women and partners’ support preferences during PP. Women reported a preference for friends and family, rather than professionals, to provide affirmative, instrumental and emotional support. Although partners identified their own support needs they were reluctant to seek help due to issues of pride and privacy.

Feeling supported by partners may reduce the length of hospitalisation for women experiencing postnatal distress (Grube, 2005). However, partner narratives of postnatal distress reveal complex emotional responses including fear, confusion and anger (Engqvist & Nilsson, 2011). This highlights the potential difficulties for partners attempting to provide support while

managing their own distress. Nevertheless, the importance of this support extends beyond shortening hospital stays. Research suggests that a lack of supportive communication between parents when the mother has experienced PP may be associated with disrupted parent-child interactions (Philipp, Fivaz-Depeursinge, Corboz-Warnery, & Favez, 2009).

Furthermore, women who have experienced PP report shifts in relationships with friends and family, such as feeling unable to relax around each other (Robertson & Lyons, 2003). These shifts can be exacerbated by others' lack of understanding of mental health difficulties (Glover et al., 2014). Similarly, pervasive feelings of loss across relationships have been disclosed by women who experienced depression during the postnatal period (Beck, 2002). Resentment, lack of emotional connection, anxiety and an unwillingness to share distress contributed to experiences of loss.

Research related to first-episode psychosis outside of the postnatal period may also illuminate the effects of unusual experiences on relationships. Research has identified high distress in families of people experiencing first-episode psychosis, irrespective of whether they lived together (Addington, Coldham, Jones, Ko, & Addington, 2003). This suggests that the wider families of women experiencing PP may experience distress. Furthermore, Addington et al. (2003) reported an association between the well-being of family members and their appraisal of the consequences of psychosis. PP is likely to be viewed as having particularly dramatic consequences, due to its timing and the likelihood of separation of the mother and baby from the family.

Despite the potential for relational difficulties, the perceived impact of PP on relationships is not always detrimental. The support provided by friends and family of women

experiencing PP can foster new appreciation of these relationships (Robertson & Lyons, 2003). Relatives of people experiencing first-episode psychosis highlighted a number of factors which deepened this relationship, including honesty and attempting to understand their relatives' experiences (McCann, Lubman, & Clark, 2011). Nevertheless, receiving care from family members can elicit mixed emotions. Women who experienced PP reported gratitude towards family members but experienced guilt through perceiving themselves as a burden (Heron et al., 2012). Thus, relationships were seen as an important supportive resource but could also cause additional worry.

Rationale and aims

National guidelines for postnatal mental health emphasise the importance of family networks (NICE, 2007) and research suggests that the experience of PP may affect, and be affected by, relationships. However, the way in which women and their significant others understand the role of relationships within their experience of PP has not been explored.

The current study will add to the research base by exploring the meaning ascribed to relationships by mothers who have experienced PP and their significant others. It is hoped that this understanding will inform clinical practice by developing an understanding of how mothers' relationships may be utilised within their recovery, and how these relationships may need to be supported. In particular, the research aimed to explore how women and their significant others make sense of their experience of PP, their relationships, and the mutual influence of these.

Method

Design

An interpretative phenomenological approach enabled exploration of participants' perspectives. The inductive processes of interpretative phenomenological analysis (IPA) complemented the aim to explore experiences, while the phenomenological and interpretative aspects suited the focus on participants' understandings (Smith, 2004). Non-prescriptive guidelines for IPA (Smith, Flowers, & Larkin, 2009) were adapted to ensure that agreements and discrepancies between the dyad were attended to in the analysis.

Semi-structured interviews allowed exploration of topics pertinent to the research questions, while enabling participants to introduce topics of personal importance. Dyadic interviews complemented the focus on relationships, and allowed participants to articulate converging and diverging understandings (Morgan, Ataie, Carder, & Hoffman, 2013). Interviewing mothers and significant others developed an understanding of the shared meanings ascribed to relationships and experiences. Although these experiences were different for mothers and significant others, much can be learnt from the collective meanings attributed to these (Taylor & de Vocht, 2011, p. 1577).

Inclusion and exclusion criteria

The following inclusion and exclusion criteria were adopted when selecting participants.

Experience of PP

Women who have received a diagnosis of PP (also known as puerperal or postnatal psychosis) from a psychiatrist or other appropriately qualified health professional were eligible to take part.

For women recruited through the NHS this criterion was assessed through medical records by the clinician identifying potential participants. Women recruited online self-reported their diagnosis and provided consent for this to be verified with their general practitioner (GP).

Women were eligible to participate regardless of whether PP was their first experience of mental distress or occurred within the context of a long-term mental health difficulty.

Significant others were eligible to participate if they had a relationship with the mother at the time that she experienced PP.

Time frame

No time limit was placed on the length of time since the onset of PP. Where the timeframe is recorded, this relates to the onset of distress.

Current distress

Women who were deemed to be experiencing high levels of mental distress at the time of recruitment were excluded. For NHS recruitment this was assessed by the staff member identifying potential participants, in consultation with their team. For online recruitment this was assessed through conversations with the potential participants and with their GP. Each GP was contacted and none raised any concerns regarding risk. Women who were resident at a mother-and-baby unit (MBU) or other inpatient psychiatric service at the time of recruitment were not eligible to take part due to the likelihood of high levels of mental distress.

Sampling

Participants were recruited through the National Health Service (NHS, $n = 1$) and online ($n = 6$).

NHS

Three perinatal mental health services acted as participant identification centres. Identification of potential participants was performed by a clinician who had permission to access medical records as part of their role. A recruitment pack was sent to the home address of each potential participant by the clinician, which included the participant information sheets, opt-in form and covering letter. Participants were able to contact the chief investigator by post, telephone or email if they were interested in learning more about the study.

Online

Study information was distributed via social media and message boards. These included Twitter, Action on Postpartum Psychosis and several Facebook groups. Permission from the administrators of groups and charities was sought before the information was shared. Potential participants were asked to contact the chief investigator by telephone, email or social media to discuss the research. Participant information sheets were sent via post or email according to participant preference and participants were subsequently contacted by telephone to discuss these. Participants were informed that they would be asked for verbal consent for their GP to be contacted to assess risk and provide verification of their PP experience. All participants consented to this contact and provided their GP with written consent.

Participants

Seven dyads were interviewed, with an age range of 28 to 33 for mothers and 29 to 39 for significant others. All participants resided in England, although one participant was not born a British citizen. No mothers had previously experienced significant mental health difficulties, although two reported a history of emotional distress for which they had not accessed services.

All women had experiences consistent with a label of PP, with onset between five months and four years prior to interview. All had experienced PP with their first child; two had subsequent pregnancies, neither had experienced a recurrence of PP.

IPA studies seek homogeneity within the sample to allow detailed examination of convergence and divergence (Smith et al., 2009). However, factors such as the rarity of PP and the wide interpretation of ‘significant other’ made recruiting a homogenous sample difficult. Nevertheless, the sample was homogenous in relation to the most pertinent defining characteristic: all participants had shared an experience of PP. Demographics were recorded to ensure that areas of heterogeneity were acknowledged (see Table 1). The largest area of heterogeneity was the relationship between mother and significant other. Five significant others were the mothers’ romantic partner and father to her child. One mother participated with her sister and another with a close female friend; both remained in a relationship with their child’s father.

Insert Table 1 here

Data collection

Interviews were conducted in the participant’s home or a local building, depending on preference. Prior to the interview the information sheet was reviewed and time for questions was provided. Informed consent was gained and participants were aware that they could stop the interview at any point. Consent was gained for the researcher to contact the participant’s GP if any risk issues arose during the course of the interview.

A semi-structured interview schedule was followed. This included questions related to the dyad's experience of the postnatal period (e.g., 'can you tell me what it was like after the baby was born') and perceptions of their relationship (e.g., 'how would you describe your relationship with each other during that period?') Prior to commencing the study the interview schedule was shared with a woman with experience of PP. This mother would not have been eligible to take part in the study, as she was not a British resident. No changes were suggested, indicating that the questions were considered appropriate. Following the first interview the schedule was discussed with the academic and field supervisors. Several changes were made, including the addition of prompts which encouraged participants to consider relational aspects of pregnancy and childbirth. Additionally, questions related to wider relationships were asked later in the interview, to maintain focus on the dyadic relationship. All interviews were digitally audio-recorded and transcribed verbatim, and lasted between 60 and 85 minutes ($M = 69$ minutes). A debrief sheet was provided following the interview, along with time for questions.

Data Analysis

Each transcript was analysed in detail before moving to the next, reflecting the idiographic approach of IPA. Knowledge developed during the analysis was 'bracketed' when reading the next transcript (Ahern, 1999). Transcripts were read thoroughly and exploratory comments noted (see Appendix 2-A). These were reviewed and organised into conceptually cohesive emergent themes with accompanying narratives (see Appendix 2-B for an example).

Super-ordinate themes were identified through comparing emergent themes across transcripts (see Appendices 2-C and 2-D). Super-ordinate themes were reviewed to ensure internal and external homogeneity; data within themes appeared coherent, and conceptual

distinctions were apparent between them (Patton, 2002). Transcripts were re-read to ensure that no further relevant data could be extracted and that no novel data had been overlooked.

Credibility of analysis

Yardley's (2008) guidelines for assessing quality in qualitative research were considered throughout. The principles of 'sensitivity to context' and 'commitment and rigour' are evidenced through the use of verbatim quotes and the inclusion of quotes from each dyad within each theme. This exceeds the minimum sampling recommendation of extracts from at least three participants being evidenced within each theme (Smith, 2011). The principle of 'transparency and coherence' is demonstrated through the substantial methodological section and delineation of the decision-making process. Furthermore, the coherence between the underlying epistemology of IPA and the research process has been discussed. The focus on the clinical implications of the research demonstrates the principle of 'impact and importance'.

In addition, a peer discussion group comprising five trainee psychologists reflected on the analytic process. Short excerpts of transcripts were coded by each trainee and compared. No stark differences emerged, and the resultant discussions informed future coding.

Ethical considerations

Approval was granted by a NHS Research Ethics Committee and the Research Directorates of NHS services (see section four). Professional guidelines regarding conduct and ethics were adhered to throughout (British Psychological Society, 2010; Health & Care Professions Council, 2012).

Participants were introduced to the aims of the study and dissemination strategy prior to interview. Pseudonyms were employed to safeguard anonymity. Informed consent was gained following the approved protocol and facilitated through providing opportunities for questions. Participants were informed that they could withdraw at any point. They were given time to reflect on the interview; feedback was positive and no participants disclosed any significant distress elicited by the process.

Reflexivity

Adopting an interpretative phenomenological approach inevitably affected the research focus. No specific hypotheses were formed and the development of a theory was not sought. Additionally, awareness of the ‘double hermeneutic’ was required; acknowledging that the researcher constructs their own interpretation of participants’ understandings (Smith, 2004). Hence, researchers must acknowledge biases and preconceptions throughout the research (Hamill & Sinclair, 2010). This was made particularly difficult due to time constraints which resulted in the introduction being written concurrently with data collection and analysis. This risked the development of expectations in line with previous research. An example of how this may have affected the research process, and how this was managed, is provided in Appendix 2-E. Methodological decisions, opinions and feelings related to the topic were recorded within a reflective diary and reflective notes were made after each interview (see Appendix 2-F).

Researcher characteristics

Within IPA it is acknowledged that the researcher brings their own biases and preconceptions to the research and that these will inevitably influence their interpretation of the data (Smith, 2004). The researcher was a White British trainee clinical psychologist. She was female, aged 26 and

had not experienced pregnancy or childbirth. The psychological lens which she brought to the research may have shaped both the focus of the research and her interpretation of the data. For example, beliefs around the meaningful nature of unusual experiences or the biopsychosocial understanding of mental health may have influenced the interpretation of data or the presentation of themes. However, maintaining awareness of these assumptions through the use of a reflective diary and reflective interview notes assisted in the bracketing of these assumptions.

Results

The analysis identified four themes: (a) ‘she wasn’t herself’: threatened relationships through loss of ‘normal’ self; (b) invalidation and isolation: relational dynamics in seeking, receiving and providing support; (c) ‘the worst life can throw at us’: shared perceptions of trust and respect following PP; (d) a double-edged sword: understanding relationships as negatively and positively influencing PP experience. These are presented alongside indicative quotes from participants.

‘She wasn’t herself’: threatened relationships through loss of ‘normal’ self

Women experiencing PP were perceived to differ from their ‘normal’ character, by their own and significant others’ judgement:

Lucy: It was about eight to ten days when my sister—and I think Robert as well—noticed that I was behaving not like myself. I was getting excited over like food and going out and

Rob: Wanting to go out loads and being very hyper

Lucy: Loads of energy, I was up cleaning in the night, I wouldn’t sleep

Rob: Yeah, not being bossy but . . .

Lucy: Very direct

Rob: . . . things like that which wasn't like yourself really, them little things just started to piece together really, things weren't right.

Several forms of loss were experienced: of culturally-informed expectations of the postnatal period; physical loss of each other due to the mothers' (and often babies') hospital admission; and a perceived temporary loss of their relationship – 'there wasn't a relationship really at that point [when Fiona was acutely distressed]' (Matt). Significant others strived to relate to the mother, who felt like a 'different person' (Fiona). This process was facilitated by prior experience of witnessing the mother's distress:

Rich: It wasn't like you suddenly went from someone who had no kind of anxieties whatever to that . . .

Amy: I'd always had panic attacks

Rich: So that's why at the time I thought it's just Amy having a low period . . . it all just seemed like an escalation of what Amy went through beforehand.

Being able to maintain a sense of relationship throughout PP is reflected in Amy's use of the phrase 'you would love me through anything', whereas other participants spoke about their partner 'staying with' them. Similarly, the sisterly dyad did not perceive the departure from 'normality' as threatening to their relationship, perhaps due to their prior experience of supporting each other through difficult experiences – 'in the past when she's been hurt . . . I wanted to look after her and make it right but then similarly she's been there for me when I've needed it' (Georgina). Despite this role also being apparent in Kate and Hina's narrative, Kate

acknowledged the tension between wanting Hina's support and not wanting her to witness her distress - 'I told Hina to fuck off because I didn't want her to see me in the state I was in, thinking I was dying'. This attempt to protect relationship boundaries was not apparent within other interviews, and may suggest that women felt that their relationships with partners or family members were more able to endure the experience of witnessing their extreme distress.

Communication challenges were also inherent to the experience of PP, leaving dyads feeling as though their relationship was not functioning as normal. Mothers believed that they could not communicate their distress, and negative responses to attempted communication could reinforce this:

Ana: So I tried to tell him . . . and he was quite nasty, you remember, you were quite

Joe: Look, from my point of view

Ana: I was quite obviously worried about it and he became quite nasty . . . I stopped communicating with him.

Throughout the interview Joe attempted to communicate his experiences, as Ana struggled to integrate his comments into her narrative. This appears reminiscent of Ana's experiences while experiencing PP and if this reflects Ana's usual pattern of communication, may explain why her experience of being unable to communicate was particularly difficult to manage. Other mothers spoke about trying to find different ways to communicate - 'I thought I couldn't talk, so I started writing on bits of paper' (Fiona). Open communication was undermined by significant others feeling forced to conceal actions, for example covertly bottle feeding when the mother was unable to breastfeed (Joe) or arranging admission to hospital (Rob). This contributed to

significant others' sense that they were unable to maintain their close connection through the familiar processes of talking and sharing experiences – 'you couldn't have a normal conversation . . . it was hard in that sense' (Matt).

Physical communication between dyads was also compromised. Significant others longed for physical expressions of care and intimacy but often found that they were unable to maintain this aspect of their relationship during PP:

All I wanted to do was hug her and tell her that I was there . . . she was in this space that you couldn't get in so [voice breaking], I couldn't even touch you, you just pushed me away. (Hina)

Interruptions to the physical relationship between partners was not easily resolved – 'it's probably affected our sex life a little bit erm but like not irreversibly but erm, it took a while when I came home from hospital to have a normal relationship again in that way' (Lilian). However, where physical intimacy was able to be maintained, this created a shared experience which dyads could look back on: 'you took me into the bathroom and shaved my legs for me, do you remember [both laugh]' (Amy).

Recovery and return to 'normalcy' was mirrored by a recapturing of fundamental aspects of relationships. This process was facilitated by dyads sharing postnatal experiences with each other, thus constructing a shared conceptualisation of this individually-experienced time:

Fiona: I think there was one point where I passed out

Matt: You didn't pass out, you

Fiona: I threw myself

Matt: You threw yourself on the floor . . . she literally just went loose and just
fell on the floor

This demonstrates the turn-taking evident within interviews, despite events being experienced differently at the time. However, some topics remained difficult to discuss – ‘it’s hard for me to say, especially in front of Rich because I get upset but I know the moment they held [son] up, I remember feeling a bit underwhelmed by him’ (Amy). The exception to this shared narrative was Kate and Hina, who asked each other questions about their experiences during the interview and stated that they had not shared these previously. This process of sharing experiences during the interview was felt to be cathartic by both Kate and Hina.

The PP experience was characterised by the majority of dyads as a sense of difference and non-normalcy, both of the mother and the relationship. This perception of loved ones as different created difficulties in maintaining their usual intimate bond, both physically and emotionally. Significant others who had a long-standing care-giving relationship with the mother, or who recognised her experiences as similar to her normal self, did not perceive their relationship to be threatened by PP. Sharing experiences and developing a joint narrative may have helped dyads retrospectively to maintain a sense of relationship throughout the postnatal period.

Invalidation and isolation: relational dynamics in seeking, receiving and providing support

Mothers commonly experienced their distress as being unrecognised or minimised by others – ‘it was very difficult with my mum because when I started to feel ill I got lots of comments like “postnatal depression didn’t exist in my day, you just had to get on with it”’ (Amy). Such comments invalidated mothers’ distress, and they felt frustration at the suggestion to ‘pull

yourself together' (Marie). In some instances these relationships could be repaired, particularly if mothers believed that a positive attitude shift had occurred. For example, Amy's mum realised that she was not 'the baby of the family, incapable of doing . . . things'. However, in cases where support was not offered, and the mother perceived a lack of interest in understanding her experience, reparation was difficult:

Rob: Although [Lucy's brother has] been told stage by stage everything he's just, he hasn't really took much of it in and, the relationship's changed like

Lucy: Completely

Partners saw themselves as responsible for the family triad, and providing support for the mother was viewed as part of their role – 'it's not like I had a lot of choice really. It was what it was and, just trying to get us all through it' (Dan). This was reflected within mothers' accounts of receiving support, which rarely ascribed any retrospective blame towards their partner for their role in hospital admission, although this was sometimes experienced at the time.

Conversely, Ana experienced Joe as unsupportive due to his reluctance to seek professional support and attributed this to her increased distress – 'because you refused to take me, it kind of deteriorated'. Thus, it was seen as Joe's role to both provide and seek support, and Ana's perception of him as failing in this role caused resentment. The assumption that seeking support was inherent within the role of 'partner' made it difficult for other family members or friends to step in:

I wish I'd said something sooner, because the whole week I could feel that there was something wrong 'cause your status updates on Facebook were getting a bit

more erratic [laughing through tears] . . . it's a time for the parents, you don't want to intrude but I wish I'd, I wish I'd come up sooner. (Hina)

Hina understood the role of a friend as implying less responsibility than a partner, and this led her to believe that she was 'taking decisions that should have been [Kate's partner's]'. This sense of uncomfortable responsibility was also apparent for Georgina, and both experienced intense guilt about their role in their loved one's hospital admission – 'even though I knew it was the right thing, I also felt as if I was betraying her' (Georgina).

In order to provide the support required, significant others needed a support network. The experience of PP engendered feelings of isolation in both significant others and mothers – 'they took a big family picture . . . that awful picture, everyone's laughing and I'm in tears in it' (Amy). For partners, the loss of their normal relationship with the mother exacerbated this – 'Fiona is my family erm, so to not have that person to bounce off or anything like that, I just felt completely isolated' (Matt). Moreover, partners experienced an unexpected role shift in the postnatal period:

Joe: I was under a lot of pressure as well

Ana: Oh right, OK

Joe: Which you don't appreciate do you, 'cause I mean I'm literally the one left holding the baby and obviously, I was expecting her to do everything and look after it.

Ana struggled to witness Joe's experience of being under pressure, both at the time and retrospectively. This may have increased Joe's feelings of isolation, particularly within the

context of cultural expectations of gendered emotional responses to new parenthood, within which the new father is expected to provide support to the mother who is under pressure. One way in which feelings of isolation could be reduced was through the provision of practical support – ‘I would come home from [the MBU] and there’d be a lasagne in the oven and stuff for us . . . her best friend, she was great, she was always there for us’ (Rob). Others were able to draw comfort through sharing the emotional journey with others – ‘I know my relationship with your mother’s got a lot stronger . . . from having her here and her going through the same sort of emotions that we’ve all been going through’ (Matt).

Georgina and Hina provided an alternative viewpoint, from the perspective of those providing the additional support. Both felt as though their role was to support the partner, as well as the mother – ‘I knew there had to be like a support structure in place for [Kate’s partner]’ (Hina). For Georgina, however, this clashed with her role within her own family:

Marie: I think that was quite hard for you, wasn’t it, because it was like your
loyalty to me and your wanting to be with me but you also had to put
[daughter] and your family first which

Georgina: But I didn’t, they, they went on a back burner really. And luckily I’ve
got a supportive husband who . . . held the fort.

Thus, significant others outside of the immediate family triad experienced an internal conflict. They understood their supportive relationship with the mother as inherently conflicting with their role within their own family, due to both the time and emotional commitments which supporting the mother entailed. Furthermore, happiness in their own life contrasted sharply with the life of

the mother, and made it difficult to witness her extreme distress – ‘I was in such a happy place and you were having such a difficult time, that was hard’ (Hina).

Postnatal distress was often first recognised by significant others, who were then able to seek support for their loved one. However, if they did not respond in an empathic or timely way mothers felt that their experiences were invalidated. This caused ruptures in relationships, which could not always be repaired. Partners automatically viewed themselves as responsible for seeking and providing support. However, they felt isolated and required the emotional and practical support of others in order to fulfil this role. Those providing this additional support could feel torn between their own life and their responsibility to support the mother and her partner, and found it difficult to witness distress while returning to a ‘happy’ life of their own.

‘The worst life can throw at us’: shared perceptions of trust and respect following PP

Dyads described positive changes in relationships, which were seen as explicitly linked to their experience of PP – ‘you can’t go through something like we did and it not to have changed your relationship . . . fortunately it only changed it for the better’ (Marie). Although participants assumed that all new parents experienced changes, PP was felt to intensify these – ‘things change when you’re having a baby anyway . . . but we’ve, especially Robert, had the extra pressure of not having his daughter at home, or his wife’ (Lucy). Dyads emphasised their close relationship prior to experiencing PP, suggesting that existing trust and respect were drawn upon, and potentially grew, through the experience. PP was viewed as an obstacle successfully faced together:

Marie: We have always been close but we definitely are closer.

Georgina: Definitely

Marie: And I think it is because, well we couldn't have got any lower than we were, so the only way is up really. And I think it's shown, hasn't it, that no matter what, we will get through it.

Understanding PP as an obstacle fortified feelings of trust and respect. A sense of security was fostered due to the belief that experiencing PP could have irreparably damaged the relationship:

There were periods where I was so unwell that I must have done and said things that would have been really hard for Dan to experience and [. . . I was] just really grateful to Dan for sticking by me. (Lilian)

Perceptions of trust were entwined with experiences of support provided by significant others. The trust inherent within receiving this support was particularly salient for Hina:

You could have phoned anybody but you phoned me. And, for me that's like, it's like the biggest amount of trust that you put in me to take care of you at a time when you didn't really know how to do it yourself.

Perhaps due to this trust, responses which left mothers feeling invalidated or misled created difficult emotions, which were hard to forget:

Joe: I don't think our relationship's changed; it's just that that point we've still never resolved

Ana: No, I think it has, I think in a way yeah, because it's just a side of you I never knew, I didn't think you'd be like that.

Ana's sense of invalidation made it difficult for the couple to share postnatal experiences, hindering the development of a joint narrative of the experience of PP. In contrast, containing

responses to distressing thoughts and feelings promoted mothers' confidence in the relationship – 'if I've shared things like that with you, then there isn't really anything that I couldn't' (Marie). This open, honest communication was evident within interviews, during which dyads disclosed distressing thoughts and feelings openly – 'I know I don't need to feel bad about this—we've talked about it before—Rich's mum drove me insane sometimes when we stayed with them' (Amy). For many, openness had always been an important quality in their relationship but PP reinforced this:

Rob: We were obviously very close and open with each other but I do think possibly we'd be more open with each other now just 'cause of what's happened and

Lucy: We've got to be, haven't we?

The extreme and distressing nature of PP for the mother increased significant others' respect for her:

The fact that she's gone through, not just gone through the birth but gone through all of the, all of that aspect of it as well erm, it's made me respect you a lot more.
(Matt)

Similarly, mothers appreciated the gravity of the experience for their significant other, and respected their relationship as stronger and more enduring because of PP:

I think I've got a lot more respect for Dan, not that I didn't respect him before but just for what he went through and coped with and you know, I think he's . . . a really strong person which maybe I didn't appreciate enough before. And I think,

yeah the fact that we got through such a horrible period together, it probably made us stronger. (Lilian)

Both mothers and significant others re-evaluated their beliefs about each other based on the way in which they reacted to the experience of PP. Although some mothers evaluated significant others' actions negatively at the time, these tended to be understood more positively in retrospect. When such an understanding was unable to be reached, this became a contentious topic which continued to impact on their relationship and contradicted the positive effects experienced by other dyads.

A double-edged sword: understanding the influence of relationships on PP experience

Relationships were seen to have a direct influence on unusual postnatal experiences.

Experiences labelled as 'delusions' were often grounded within interpersonal reality, for example fears of relatives' ill health due to the stress of PP. Experiences of PP were characterised by high anxiety, often related to relationships – 'I ran out of the house in my dressing gown after you and said you can't go, please don't go, please don't leave me' (Amy). Although Amy spoke about this fear of abandonment in a temporary sense, many mothers feared their partner leaving the relationship entirely. These fears altered the way in which couples interacted:

Obviously I wanted to be there all the time and do as much as I could but I also didn't want to make it any worse just by being there or you know, appearing to be tired or, I don't know, troubled or anything. (Dan)

Wider relational experiences also influenced unusual experiences. For Kate, many of her beliefs centred on death and the process of dying, which she linked to a recent bereavement:

I'd had a close friend die of cancer [long pause, begins to cry] and she was really scared that in her dying moments she would lose control of everything. And I hadn't been able to grieve for her properly because I didn't want to affect [son] 'cause they say all the emotions pass through to the unborn child.

Close relationships also influenced mothers' perceptions of themselves as a mother, and could increase distress. Like many mothers, participants felt pressure to be 'perfect' – 'Ana felt under a lot of pressure, because her mother was there she wanted to do everything, be seen to be doing everything correctly' (Joe). Mothers tried to maintain this façade, despite the extreme levels of distress they were experiencing. For example, although Amy was afraid of spending time alone with her son, her partner was unaware of this:

Amy: I was still feeding him but I was scared to be near him, I couldn't be in a room on my own with him, could I?

Rich: Again, it wasn't . . . it didn't seem like anything was unusual to me.

Furthermore, the mothers felt guilty about their partners' separation from their baby while they were in hospital. Discussions around this were often followed by attempts to mitigate sadness, suggesting that the women felt a need to assuage these feelings:

Dan: Obviously I was sad that I missed out on so much in those early days . . .

Lilian: He's so much, as a baby he's so much more fun now than he was when he was really little. Babies when they're really little they kind of, you know, they don't really do an awful lot, it's just a matter of you know, caring for them.

Additionally, mothers worried about letting others down:

Lucy: It was just really awkward, I felt guilty when people were coming 'cause I thought you know

Rob: You were feeling guilty as well for people travelling that far, when you weren't much company type of thing

Thus, the impact of the mother's experiences on her loved ones could cause her additional distress during PP and beyond. Thus, on one edge of the relationship 'knife', a mother's experiences of relationships during the postnatal period could lead her to hide distress, affect her mood, and influence her fears and anxieties:

It's interesting how the illness is so, kind of feeds off the relationships you've got and some of your delusions and things can be directly related to other relationships you've got with different people. But also it's your relationships with your family and your spouse that will eventually help you get better. (Lilian)

As Lilian describes, mothers also highlighted the importance of relationships within their recovery. The presence of a supportive and containing other provided a sense of security - 'I can remember hearing Hina's voice and I can remember really relaxing and thinking, Hina's here, it's OK' (Kate). Moreover, mothers could feel contained by significant others while also experiencing negative emotions - 'I felt resentment, I felt angry but most of all I think I just felt supported' (Marie).

For some, separation from their partner led them to realise the importance of this relationship and motivated them within their recovery:

Matt: I wrote you an A4 poster thing saying these are the things you need to do to come home . . . and then you just sort of stuck to those . . .

Fiona: And it did really scare me being in hospital but it kind of gave me a kick up the bum and a bit of a reality check that, you know, this is my life, I've got to sort it out and get on with it and get better to get home to be with [daughter] and Matt.

Such concrete advice from significant others was useful in assisting mothers to focus on the process of recovery. Similarly, Richard's inclusion in psychological therapy allowed him to utilise helpful strategies to manage Amy's distress, and their relationship became an integral part of Amy's recovery:

If I say I feel anxious, Rich will say, 'are you on your period, are you this, are you this?' I think I've been really fortunate that you've been very involved in my care, so Rich has always had known the kind of things to do to make me feel better.

In summary, mothers experienced relationships as having the potential both to negatively and positively influence their PP experience. Some relationships increased feelings of pressure, and induced mothers to hide their feelings from others. Many of the unusual experiences encountered by mothers revolved around fears and anxieties rooted in their relationships. In contrast, mothers highlighted the importance of close relationships in their journey through PP and valued the support and containment offered by these.

Discussion

This study is the first known qualitative exploration of relationships within the context of PP. It aimed to explore how women and their significant others make sense of their experience of PP, their relationships, and the mutual influence of these. The results reiterate the important role of support networks in recovery from PP (McGrath, Peters, Wieck, & Wittkowski, 2013). It confirms the potentially negative impact of PP on relationships (Blackmore et al., 2013) and provides novel insights into how these may develop. Conversely, it has provided the first in-depth understanding of the potential for positive transformations in relationships. Furthermore, it suggests that many unusual postpartum experiences may be understood as being rooted in understandable fears and concerns regarding close relationships.

Mothers and significant others experienced the mother as differing from her usual self during their experience of PP. This sense of becoming ‘like a stranger’ is experienced within the first days of PP (Engqvist & Nilsson, 2013, p. 85) and has been linked to partner distress (Robertson & Lyons, 2003). The current study suggests that this sense of non-normalcy threatens relationships through disrupting communication, restricting physical affection and altering expected roles. This is particularly pertinent when significant others have not previously witnessed the mother experiencing intense emotional distress.

Despite the relationship threat of PP most participants believed that their relationships became stronger. Positive changes in relationships have received brief mention within research pertaining to mothers’ experiences of PP (McGrath et al., 2013). The current study highlights that these are also experienced by significant others and emphasises particular increases in trust and respect. This experience of positive transformation is akin to the concept of posttraumatic

growth, defined as the ‘experience of positive change that occurs as a result of the struggle with highly challenging life events’ (Tedeschi & Calhoun, 2004, p. 1). Improvement in relationships has been consistently identified within studies of posttraumatic growth (e.g., Dunkley, Bates, Foulds, & Fitzgerald, 2007; Taku, Cann, Calhoun, & Tedeschi, 2008). It is postulated that the disruption of beliefs about the self, others, and world facilitates new perspectives to develop which incorporate the trauma experienced (Calhoun & Tedeschi, 2006). Families who experience PP may re-evaluate their relationships in light of the responses and reactions of others, which can lead to a deeper sense of trust and appreciation. Furthermore, the development of a shared narrative around the experience of PP facilitated the process of recovery for participants in the current study. Moreover, this process may also have been integral in growth experiences within recovery. Research suggests that people who discuss their experiences of psychosis are more likely to experience posttraumatic growth and less likely to experience posttraumatic stress symptoms than those who do not (Pietruch & Jobson, 2011).

A further novel finding is the connection between relationships and the content of unusual postnatal experiences. Women’s experiences often revolved around fears regarding her relationship with her baby, partner or others. This is consistent with unusual experiences outside the postnatal period, which are often largely influenced by life experiences and the environment (Suhail & Cochrane, 2002). Difficult life events can have a direct influence on the themes of unusual experiences (e.g., Raune, Bebbington, Dunn, & Kuipers, 2005) or may exert a more subtle influence through changing people’s beliefs about themselves, others or the world (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2011). Experiences such as hearing voices are increasingly understood as messages regarding difficult life events and thus as providing the individual with an opportunity to resolve underlying conflicts (Longden, Corstens, & Dillon,

2013). The experiences of women within the current study are also cohesive with a material-discursive-intrapsychic approach to distress, within which ‘the cause of women’s madness is not deemed to be inside or outside the woman but rather reflects a mediated “both”’ (Ussher, 2011, p. 108). Thus, unusual experiences reflect a sense-making process of life events, material conditions and societal discourses. Emotions such as anxiety, elation and guilt may play a central role in the development and content of delusions in experiences labelled as ‘psychotic’ (Freeman & Garety, 2003). New mothers are likely to experience complex emotions related to relationships which may hold insights into the meaning of their unusual experiences.

Clinical implications

Women who experience PP are often not considered for psychological therapy due to the predominance of a biomedical understanding of their experiences. However, this research suggests that therapeutic approaches may be beneficial to women and their families. The interview process highlighted the importance of the development of a shared understanding of the postnatal period between mothers and their significant others and the potential for professionals to facilitate the development of this. Not only may this aid the recovery process but evidence suggests that it may help to facilitate posttraumatic growth (Pietruch & Jobson, 2011). This could be achieved through involving significant others within therapeutic sessions and through the use of techniques such as circular questioning to encourage the consideration of others’ perspectives (Campbell, Draper, & Crutchley, 1991).

Currently, postnatal experiences labelled as ‘psychotic’ tend to be treated as random and inexplicable events by both professionals and families. Therapeutic work which facilitates understanding of women’s unusual experiences as meaningful and potentially useful may allow women to relate differently to their experiences and reduce distress. This approach is advocated

by clinicians with personal experience of unusual beliefs and experiences (e.g., Knight, 2009; May, 2010).

Limitations and future research

These findings must be considered within the context of methodological limitations. Participants were predominantly White-British, and all were long-term residents in England. Considering the cultural variations in both family roles and mental health, it is important to encompass a wider perspective in future research exploring relationships within the context of PP.

The use of joint interviews pre-determined that only participants with an ongoing relationship were interviewed. Moreover, it is likely that the dyads who took part felt comfortable in openly communicating with and in front of each other. Thus, the results are likely to be skewed, particularly those which relate to the strengthening of relationships. Further research utilising separate interviews with women and significant others whose relationship was not maintained after experiencing PP would provide a useful comparison.

Women who have no previous experience of mental health difficulties form only a subsection of women who have experienced PP (Valdimarsdóttir et al., 2009). However, none of the women in the current study reported previous contact with mental health services. It is likely that relationships which exist within a context of long-standing mental health difficulties will be affected differently to those explored within the current study.

The length of time since the experience of PP ranged from five months to four years. However, dyads were interviewed on only one occasion, so it is difficult to draw conclusions regarding the evolution of relationships over time. It would therefore be useful for future research to take a longitudinal approach to exploring relationships after an experience of PP.

Conclusion

This study highlights the complex interactions between the experience of PP and close relationships. Experiencing such extreme mental distress at a pivotal moment in a woman's life can create difficulties within interpersonal relationships but ultimately can result in a stronger connection with significant others. These findings emphasise the extra strain that interpersonal relationships may pose during the experience of PP, for both the mother and her significant others. However, it also draws attention to the role of relationships in facilitating recovery. Thus, professionals working in perinatal mental health should be aware of the relational context of mothers with whom they work. This will enable them to assist significant others in providing a supportive environment which facilitates recovery and minimises the potential for difficulties in the relationship.

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Table 1

Demographic features of participating dyads

Pseudonyms	Relationship of significant other to mother	Approximate time since onset of difficulties	Time spent in Mother and Baby Unit (MBU) or psychiatric unit	Any subsequent deliveries?	Child present in interview?	Recruited from
Lucy & Robert	Spouse	6 months	2 MBU admissions (6 weeks / 2 months)	No	Yes	MBU
Ana & Joe	Spouse	3 years	Psychiatric unit (1 week)	Yes, no recurrence of PP	Yes	Online
Lillian & Daniel	Spouse	1 year	MBU (3 months)	No	Yes	Online
Fiona & Matt	Spouse	5 months	Psychiatric Unit (10 days)	No	Yes	Online

Amy & Rich	Spouse	4 years	MBU (1 week)	No	No	Online
Marie & Georgina	Sister	4 years	Psychiatric unit (8 days), MBU (1 month)	Yes, no recurrence of PP	No	Online
Kate & Hina	Friend	2 ¼ years	Psychiatric unit (16 days)	No	No	Online

Appendix 2-A. Excerpt of coded transcript

Key:

Blue text = descriptive comments

Standard typeface = mother

Red text = conceptual comments

Italics = partner

Green text = linguistic comments

Underlined = joint narrative

Narrative	Comments
Ana: I don't think, it's not that the relationship's different, it's just	<u>Sense that relationship is different, but difficult to describe in what way</u>
Joe: You see me different	
Ana: Not really, it's just, I mean we do have disagreements but every couple has disagreements when children are involved, especially when you're from different cultures,	Culture impacting on disagreements
Joe: I didn't mind having disagreements with her over children, but I used to get annoyed more with disagreements with her mother taking over, cause I thought well I should, it's my child, whether I'm right or wrong, at the end of the day, I should have the say of how she's dressed or what we do	Normal to have disagreements <i>Fathers right to have a say – taken away by mother-in-law</i>
Ana: I just think, what was I going to say. I've forgotten what I was going to say. My memory ... one thing after having children, my short term really, after that you know, it's just collapsed	Memory affected since having children
Int: You were saying something about disagreements...?	
Ana: Yeah, we're bound to have disagreements, but I thought it was important kind of, like an important event, I understand you did it because you didn't know the information about it, you wasn't informed about these things, but I just thought you should have, you kind of, the close person, obviously we're married and I live here, it's not my country, so an important decision I had	Understands that Joe didn't know about PP, but still feels should have acted differently Feels more vulnerable because not in home country?

<p>to rely on you and I couldn't rely on you in this very important event, therefore I was thinking right if we have something else important, if I can't rely on you, if you treated me like this, what's going to happen? So in this respect, yeah.</p>	<p>Needed to rely on Joe but couldn't</p> <p>Worried that can't rely on Joe in future</p>
<p>Joe: Yeah.</p>	
<p>Ana: But then again, I suppose that was quite erm, obviously, traumatic for him as well. So I'm not saying, I understand why he acted like that, but it's just at the time, and it's still difficult because it's just the way, you treat yeah if your woman is alcoholic or has drug problems, then you say look if you don't sort yourself out, you have children you have to stop it, you treated me the same way how obviously you should treat people like that, with drug problem or alcohol problem who don't want their children. So, that's why it's difficult for me to say right, let's forget about it.</p>	<p>Recognises that traumatic for Joe too</p> <p>Sees drug / alcohol problems as under control of mother possible to stop for children's sake, PP different.</p> <p>Difficult to forget about how Joe treated her</p> <p><i>"You'll deny this" – expects Ana to deny, but doesn't. Haven't discussed this before?</i></p>
<p>Joe: But also I think, going back to your parents being there too, and you'll deny this but Ana felt under a lot of pressure, because her mother was there she wanted to do everything, be seen to be doing everything correctly.</p>	<p>Pressure to be "perfect"</p>
<p>Ana: Yeah</p>	
<p>Joe: And we also had problems because the breastfeeding wasn't working was it, the milk wasn't coming and her mother was like well you're not breastfeeding, ooh you can't go on the bottles, you've got to breastfeed. And obviously because of the psychological problems the milk wasn't coming</p>	<p>Breastfeeding problems exacerbated by pressure from mother-in-law</p>
<p>Ana: Yeah I think it was related</p>	<p><u>Breastfeeding difficult due to psychological problems</u></p>

Appendix 2-B. Example emergent theme table (Kate and Hina)

Into the war zone: First impressions of PP		
Notations	Narrative	Indicative quotations
<p><u>Kept in touch throughout pregnancy – Hina spoke to bump</u></p> <p><i>Wishes had said something sooner – knew early on that something was wrong</i></p> <p><u>Relationship as source of comfort – Hina soothing Kate</u></p> <p><i>High levels of distress when went home after first day</i></p> <p><i>Other friend nervous about seeing Kate – kept it light (coping strategy) but was disturbed</i></p> <p><i>Stressful seeing Kate for first time – just wanted to hug her. Importance of physical touch and connection?</i></p> <p><i>“war zone” – violent, dramatic nature of PP</i></p>	<p>This theme reflects the relational dynamics which were present when Hina was asked for support and first saw Kate after the birth of her son. It explores the emotional impact this had on Hina, as well as Kate’s reactions to having a friend witness her distress.</p> <p>Hina’s story of her involvement begins before Kate and her partner contacted her for support. She noticed that Kate’s updates on a social networking site were out of character and began to worry. However, she was wary of becoming involved because of her conceptualisation of the postnatal period as a time for the parents and baby to bond. In retrospect, she regrets not becoming involved earlier.</p> <p>The story of Kate and her partner contacting Hina was told differently by Kate and Hina. Kate described ringing and telling Hina they were struggling, whereas Hina remembers the phone call as chaotic and demonstrating distress, but not eloquently communicating this. This reflects Kate’s interpretation of events within a framework of how she may usually respond, rather than how she was in fact responding at the time. Hina used the strong imagery of “entering a war zone” to describe her first impressions of Kate’s</p>	<p>K: We rang you in a state and said we’re not coping I need to</p> <p>H: You didn’t say that at all [laughs]</p> <p>K: Well, we said it without needing to verbalise it, we demonstrated it!</p> <p>H: Well, you verbalised a lot but</p> <p>K: You tell this bit, cause you probably remember better than me what happened</p> <p>H: I knew something was wrong when it was [partner] that was on the phone and his voice was quite shaky and, I wish I’d [begins to cry], I wish I’d said something sooner, because the whole week I could feel that there was something wrong</p> <p>K: Oh [holds Hina’s hand]</p> <p>H: Cause, your status updates on Facebook were getting a bit more erratic [laughing through her tears] and I was like ahh, and you kind of, you don’t wanna, it’s a time for the parents, you don’t want to intrude, but I wish I’d, I wish I’d come up sooner.</p> <p>K: Oh don’t feel like that</p>

<p><u>Rang Hina – joint narrative about how Kate and partner were coping</u></p> <p>Relaxed and thought “it’s OK” when Hina arrived</p> <p><u>Wasn’t prepared for seeing Kate – huge difference from normal. Kate tries to explain, show that not irrational?</u></p> <p><i>Difficult because Hina was happy & Kate having hard time</i></p> <p><u>Partner couldn’t care for Kate – Kate explains why difficult. Potential for conflict?</u></p> <p><u>Hina describes phone call from Kate – Kate medicalises – “pressure of speech”</u></p> <p><u>Excusing self?</u></p> <p><i>Didn’t want to intrude early on</i></p> <p><i>Some “symptoms” were exaggerations of normal self – “typical Kate”</i></p> <p><i>Very different to normal Kate</i></p>	<p>home. This reflects the violent and dramatic nature of PP, which was emphasised by the departure from character for Kate, who was normally very organised and tidy. Kate justifies why the house was a mess, suggesting that she sees this as unusual and embarrassing.</p> <p>Although seeing Kate was distressing for Hina, for Kate it created a sense of calm and allowed her to relax. Nevertheless, although she had called Hina, she did not want to see her because she worried that she was dying. This worry was drawn from Kate’s own experience of her best friend’s worries during the late stages of a terminal illness, particularly around becoming incontinent in her final moments. Thus, on some level Kate knew that she felt safe and contained by Hina’s presence, but on the surface she was agitated and upset. Hina’s immediate reaction to witnessing Kate’s distress was to provide physical comfort, and the fact that Kate was unable to accept this created deep distress in Hina.</p> <p>Kate’s presentation seemed at times to be described as an exaggeration of her usual self, but at other times as being very different to how she normally behaved. Kate was keen to explain the reasons why she did certain things, perhaps hoping to make them seem less unusual and scary.</p>	<p>H: I was just sat at the red light with my head on the steering wheel crying [...] and then on my way home I stopped at a friend’s and she opened the door and I just burst into tears</p> <p>K: So I told Hina to fuck off because I didn’t want her to see me in the state I was [laughs] thinking I was dying in bed</p> <p>H: So what did you call me up for [both laugh]. But it was, it was quite, it was quite stressful because it wasn’t so much the words, all I wanted to do was hug her and tell her that I was there and you know, it was going to be OK, even though I didn’t know what we were dealing with.</p> <p>H: And I asked where Kate was and he said she’s upstairs in the bedroom, so I went up to see her and, I wasn’t, I mean I knew something was wrong, but I wasn’t really prepared for, for</p> <p>K: I think I told you to fuck off didn’t I [laughs]</p> <p>H: You did, you did. It’s a good job I’ve got thick skin</p> <p>K: Well I didn’t want her seeing me in the state I was in, and I was going through something psychotic which, I thought I was physically dying. And I thought I’d lost control of my bowels.</p>
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Appendix 2-C. Emergent themes contributing to each super-ordinate theme

Participants	Emergent themes	Themes (following order of presentation within the paper)			
		1	2	3	4
Ana & Joe	A living nightmare: Shared and disputed narratives of PP				
	Misunderstood and ignored: Conflicting attitudes to help-seeking				
	The aftermath of PP: Return to normality but unable to forgive				
Amy & Rich	Bonding with bump but not with baby: Feeling unprepared for the birth of a healthy son				
	“Everyone’s laughing and I’m in tears”: Feeling less important than baby				
	From feeling trapped to relishing parenthood: The positive impact of PP on the family triad				
	“We’re different in a positive way”: Retaining a strong sense of couplehood throughout PP				
Fiona & Matt	From a busy pregnancy to feeling like a ghost: Shared experiences of pregnancy, birth and the onset of PP				
	Missed connections				
	“There wasn’t a relationship” – loss and reconstruction of couplehood				
Lilian & Daniel	“It’s definitely had negative impacts” but “it’s probably made us stronger”				
	Co-constructing a positive narrative to mitigate guilt and sadness				
	Relationships as a double-edged sword: Supportive but fuelling delusions				
Lucy & Robert	Vigilance and blame: co-constructing the experience of help-seeking				
	From secrecy to honesty: the value of open communication jeopardised but fortified				
	Making sense of disrupted plans: Shared expectations of becoming parents				
	Loss of “normal” self and shifting sense of couplehood				
	Making sense of relationships: affecting and affected by postpartum distress				
Kate & Hina	Failing to thrive – Narratives of separation, guilt and PP				
	Into the “war zone”: first impressions of PP				
	Making decisions that weren’t mine to make				
Marie & Georgina	The ripple effect: Experiencing PP as a family				
	Necessary coping: The role of being a big sister in providing support				
	“There’s the guilt again”: The emotional aftermath of PP				
	Becoming closer or cutting off: Evolving relationships through experience of PP				

Note: Cells coloured green indicate that this emergent theme contributed to the theme.

Appendix 2-D. Example of theme development

A quote from the interview with Fiona and Matt has been selected to illustrate the process of theme development:

Fiona: I would see Matt and I would know that I trusted him but there's a lot that I didn't tell him at the time because I, I knew didn't sound, I wasn't making sense, like you know I think I probably said to him I think I'm dying and he turned around and said "don't be silly of course you're not" and I was like but that is how I felt and, the, the feelings were so realistic it was just so strange to get your head around, but it was so strong that I really did think I was dying. And

Matt: To somebody who feels relatively normal, to hear things like that . . . those irrational, those aren't normal thoughts, so you're just trying to, you're trying to comfort someone but in your mind it was kind of "oh they're suppressing me, they're not listening to me"

Fiona: Yeah, that's what I was thinking

During the initial reading of the transcript, I was struck by the dyad's joint understanding of the communication difficulties they experienced during the postnatal period. This appeared to fit with Matt's experience of wanting to care for and support Fiona but feeling as though their usual relationship had been lost during this time. Likewise, although Fiona continued to trust Matt, she felt as though he wasn't able to understand her distress and she therefore stopped sharing this.

This quote therefore contributed to an emergent theme which centred on the perceived changes within the couple relationship – 'there wasn't a relationship': loss and reconstruction of couplehood. This encompassed the difficulty that Matt experienced due to absence of their

‘normal’ relationship, for example opportunities for conversations and physical affection.

However, it also incorporated their belief that their relationship had become stronger through the joint experience of PP.

After comparing across transcripts, aspects of this emergent theme contributed to a number of super-ordinate themes. For example, a number of participants spoke about changes in communication and physical affection during the postnatal period, and this formed the basis of the theme entitled ‘she wasn’t herself’: threatened relationships through loss of ‘normal’ self. However, aspects of the emergent theme which related to the strengthening of the dyadic relationship were incorporated within a separate theme, entitled ‘the worst life can throw at us’: shared perceptions of trust and respect following PP’. Thus, as the above quote contained references to both difficulties in communication and trust, it was considered cohesive with and relevant to a number of super-ordinate themes.

Appendix 2-E. Excerpt from reflective diary

I noticed that I felt surprised during the interview when Marie spoke about her positive experience of childbirth (although she later spoke about a traumatic past experience related to this). This made me realise that I had developed an opinion through reading, and earlier interviews, that women who had experienced PP would also have experienced traumatic perinatal events. I now realise that I held this preconception during previous interviews but didn't realise this at the time because the stories told within these were consistent with my belief. I need to be aware of this belief during future interviews so that it doesn't guide my questions. Also, I need to become more aware that this may happen in relation to other aspects of the research.

Appendix 2-F. Example of reflective notes

Participants: Ana & Joe	Notes
<p>What seemed particularly significant? Narrative threads?</p>	<ul style="list-style-type: none"> • Impact on Joe of having in-laws around during postnatal period • Will Joe let her down again – impact of experiences on trust
<p>What did I feel went well? Any difficulties overcome?</p>	<ul style="list-style-type: none"> • Felt I was more able to pick up on relational issues and ask them to expand on these than in previous interviews • More successful at creating a dialogue between the dyad
<p>What didn't I feel go as well? Any problems encountered?</p>	<ul style="list-style-type: none"> • Both participants went off on tangents at time – difficult to bring back • Felt uncertain as to how to manage the interview when one partner left the room
<p>What might I do differently next time?</p>	<ul style="list-style-type: none"> • Try to be more confident about interjecting if an important point is raised • Discuss beforehand with participants whether interview will be paused if one leaves the room
<p>How did I feel throughout the interview? Towards the person? About the content? Did my feelings change?</p>	<ul style="list-style-type: none"> • Felt a bit chaotic – Ana spoke quickly and thoughts leapt around a bit. • Felt pulled into psychologist role re: Ana & Joe not understanding each other's positions
<p>What did participants feel about the interview? My perception of this? Their comments during debrief? Did this change?</p>	<ul style="list-style-type: none"> • Said that the conversations had within the interview were regularly discussed, didn't feel distressed by the heated discussions.
<p>What was the dynamic between participants?</p>	<ul style="list-style-type: none"> • Ana could be quite dominant in conversation – would butt in, speak over Joe. Found it difficult to acknowledge his distress?

Has this affected my thoughts / assumptions on this topic?	<ul style="list-style-type: none">• Interesting inversion of first interview – Ana wanted hospital and blamed Joe for not taking (whereas in previous interview mother blamed partner for admission)
What have I learned? Take forward to next interview?	<ul style="list-style-type: none">• Saying, “Can I stop you there for a minute?” was an effective way to interrupt discussions
Initial ideas on key themes from this interview?	<ul style="list-style-type: none">• Trust• Pressure – self-to-self and from others

Appendix 2-G. Instructions for authors submitting to Journal of Reproductive and Infant Psychology

Instructions for authors

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Manuscript preparation

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- Manuscripts are accepted only in English. Please use single quotation marks, except where ‘a quotation is “within” a quotation’. Long quotations of 40 words or more should be indented without quotation marks.
- Use British spelling (e.g. colour, organisation) but note the journal’s use of ‘fetal’ not ‘foetal’. Use British punctuation conventions. Initials and acronym (e.g. US, BBC) do not have full points between them.
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Section three: Critical appraisal

Caroline Wyatt*

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Critical Appraisal

Within this paper I will briefly summarise the findings of the empirical paper before critically reflecting upon methodological and ethical aspects of my research. Firstly I will consider methodological issues including the use of dyadic interviews and selecting a homogenous sample when using interpretative phenomenological analysis (IPA). Secondly I will reflect upon ethical dilemmas including the involvement of general practitioners (GPs) and those produced by the blurred boundary between research and therapeutic encounters. Through these discussions I will illustrate the strengths and limitations of the research and suggest avenues worthy of future exploration. Throughout I will illustrate my reflections with participant quotations and excerpts from my reflective journal, which I began while planning the research.

Summary of results

The empirical paper provided an exploration of the understanding held by mothers and their significant others regarding the role of relationships within their experience of postpartum psychosis (PP). Participants spoke about the sense of difference during the postnatal period, both of the mother and of their relationship. This divergence from normality threatened relationships and recovery was mirrored by the recapturing of central relational qualities, for example physical affection. Mothers and their partners often felt isolated while experiencing PP and looked to wider family to support them. However, this could cause conflict for family members due to the intense nature of this support. Despite the threat to relationships many participants felt that they had developed an increased trust and respect for the other person through the experience of PP. Furthermore, relationships were seen as integral to the recovery process. However,

participants also acknowledged the influence of relationships on unusual experiences and the distress which could be caused through difficult interactions with loved ones.

The results highlight the complexity of interactions between the experience of PP and close relationships. Although PP can create difficulties within relationships ultimately the experience can result in stronger connections with significant others. Clinical implications of these findings include providing opportunities for mothers and their significant others to develop a shared understanding of the postnatal period, perhaps through the inclusion of significant others within therapeutic encounters. Mothers and their significant others may also value the opportunity to explore the meaning behind unusual experiences. Future research would usefully adopt a longitudinal approach to explore the evolution of relationships over time following an experience of PP.

‘Two heads are better than one’ - dyadic interviewing, homogeneity and the use of IPA

Whether decisions regarding data collection and analysis should precede or follow research question formulation is debated (e.g., Smith, Flowers, & Larkin, 2009; Willig, 2008). However, all three are interrelated and it is necessary to consider each throughout research design. My wish to explore how people understood relationships within the context of PP was based upon an epistemological belief that people can share how they make sense of experiences; and thus was consistent with IPA. After determining that the research aim and IPA rested on similar epistemological tenets I was able to refine my research questions to ensure that they focused on ‘*how* participants understand and make sense of experiences and relationships’ (reflective journal excerpt). Next, I considered which data collection methods complemented the research questions and provided data appropriate for IPA.

Selecting an interview method

Individual interviews exploring relationships hold inherent limitations, providing ‘one-sided perspectives on phenomena that often involve two sides’ (Eisikovits & Koren, 2010, p. 1642). Moreover significant others are often unexpectedly invited into interviews (Morris, 2001). I reflected on my own experience of this during a previous project and wondered whether it would be even more likely within a project explicitly focused on relationships.

One option was to conduct separate interviews with mothers and significant others, which can capture unique perspectives (Taylor & de Vocht, 2011). However, such an approach may suggest that participants hold secrets from each other (Morris, 2001). I also wondered about the feasibility of ‘bracketing’ information between interviews. Additionally, confidentiality within interviews and when disseminating findings may have been compromised (Forbat & Henderson, 2003).

Consequently I considered joint interviews, which can be particularly useful when investigating shared experiences such as childbirth (Eisikovits & Koren, 2010). Furthermore, joint interviews facilitate men’s disclosure of personal information, while increasing women’s references to shared experiences (Seale, Charteris-Black, Dumelow, Locock, and Ziebland, 2008). Both benefits appeared pertinent to my research and were apparent within interviews:

Many collective pronouns were used – ‘we got pregnant’ and ‘we were so happy’ At times Daniel was reticent about discussing sensitive topics but Lilian took the lead before asking his opinion. (Reflective journal excerpt)

Furthermore, joint interviews enable 'sharing and comparing' (Morgan, Ataie, Carder, & Hoffman, 2013) which can extend pre-existing narratives, or re-direct conversations. This was evident throughout my interviews:

Rich: It does to me feel like you're so aware that you had these funny feelings
for him at the beginning . . . you're kind of making up for it

Amy: Yeah, I think you're right

Rich: With how you are now. Well, it's never like you rejected him outwardly
but

Amy: But I did very inwardly, a lot of how I was with him was because I didn't
want people to perceive me as being shit, because then he would have
been taken away from me . . .

Rich: That is something which you're still kind of conscious of that . . . you
seem to be quite mindful of people thinking you're a bad mum,
understandably

Amy: Yeah, I think you're definitely right, which I wouldn't have had at all
actually if I hadn't gone through the psychosis.

Here, Richard suggests that Amy compensates for her son's early experiences and Amy expands upon this. Richard then mentions Amy's continuing fears about judgement and Amy realises the link between this and her experience of PP. Although Richard may have mentioned this in an individual interview, it would have been difficult to corroborate without breaking confidentiality. Furthermore, Richard may have been reticent to mention this without Amy being present.

A growing corpus of studies combines IPA and dyadic interviewing. Nevertheless, IPA usually provides focuses on an individual's experience (Smith et al., 2009), rather than a dyad. Furthermore, phenomenological perspectives may not be cohesive with multiple-informant interviews (Webb, 2003). However, IPA does not attempt to collect data 'uncontaminated' by human perspectives and thus is compatible with joint research methodologies (Bradbury-Jones, Sambrook, & Irvine, 2009). Moreover, interpretative phenomenologists consider context as integral to experience (Taylor & de Vocht, 2011); this should therefore include the dyadic context when exploring experiences of relationships.

Practical considerations

It was important to consider practical implications of conducting dyadic interviews. One potential difficulty was feeling 'stuck in the middle' of a dyad with differing views (Forbat & Henderson, 2003), particularly if disagreement was indicated by subtle cues such as body language (Valentine, 1999). It was important to make participants aware that their perspective may be sought but that they could choose whether to answer such questions.

Another consideration was data recording and analysis. A method of coding was required which captured both individual and shared understandings (Seymour, Dix, & Eardley, 1995). Smith et al. (2009) recommend distinguishing levels of comments through typeface. I adapted this by varying font options to indicate whether comments related to the mother, significant other, or a joint narrative (see Appendix 3-A). This provided a visual measure of views incorporated into themes, ensuring that no voices were lost. Furthermore, it safeguarded against mistaking persistent comments from one participant as a shared dyadic understanding (Morgan et al., 2013). The similarities between this process and tradition IPA surprised me –

‘analysing dyadic data doesn’t feel as different from individual data as expected – I’m still looking for contradictions and echoes; but these are between rather than within narratives’ (reflective diary excerpt).

Homogeneity

One important consideration when selecting a sample for IPA research is the level of similarity between participants, also known as homogeneity. Selecting a homogenous sample allows the researcher to explore convergences and divergences more confidently (Smith et al., 2009). However, the definition of homogeneity may differ depending on the study. A large range of factors must be kept homogenous when exploring the experiences of a large population, whereas studies based on a smaller population can afford to be more selective and determine which factors are likely to have the biggest impact on homogeneity (Smith et al., 2009). Due to the relative rarity of PP I believed that this experience itself was the most pertinent and therefore the most important to remain homogeneous. However, two particular characteristics of the sample may be viewed as detrimental to its overall homogeneity - the diversity in relationship between mother and significant other and the length of time since the onset of PP. I will discuss each of these in turn, reflecting on how they may have influenced the results of the research.

One early methodological decision was to allow participants to define ‘significant other’. I believed that it was important for this not to be constrained by my own assumptions but to be a personal choice made by the woman who had experienced PP. However, this decision inevitably increased the level of heterogeneity within the sample. Five of the women chose to be interviewed with the father of their child, with whom they lived and remained in a romantic relationship. One woman chose to participate with her sister (Georgina) and one with her best

friend (Hina). Although both women remained in a relationship with the father, their partners preferred not to take part in the research. Such diversity may be viewed as diluting the focus of the research and therefore as a limitation of the study.

Although I strove to consider all perspectives within the analysis, this was made more complex by the gender difference which existed between ‘partners’ and those who held a different relationship with the mother. Thus, some of the divergences highlighted between significant others may feasibly be explained by gender, rather than role, differences. Nevertheless, I believe that including a range of relationships added to the strength of the research by providing opportunities to develop a more nuanced understanding of the experiences discussed. For example, the dual insight provided by the heterogeneous sample demonstrated a shared understanding of the role and value of friends and family during the experience of PP. However, I acknowledge the small number of friends and family interviewed and believe that their experiences should be explored in greater depth through further research. Furthermore, a wider range of relationships should be explored, with one area of particular interest being the relationship between a woman who has experienced PP and her own mother. Research suggests that relationships between new parents and their own parents experience significant changes during the postnatal period (Dun, 2010) and it is therefore likely that an experience such as PP may impact on this process.

A second decision which affected the level of homogeneity in the sample was to include any women who had experienced PP regardless of when this had occurred, in order to maximise recruitment. The final sample included women who had experienced the onset of PP between five months and four years previously. This variability may be seen as a limitation due to the potential for women to be at different stages of recovery. I considered this possibility throughout

the analysis but found no stark differences between dyads who had experienced PP recently and those who had experienced it a number of years earlier. Although there were differences in how relationships had been affected by the experience of PP, this seemed to relate more to experiences of each other during the postnatal period than the length of time since PP. This may reflect the rapid ‘recovery’ time from the acute experiences of PP, with women often regaining a high level of social and occupational functioning (Pfuhmann, Stoeber, & Beckmann, 2002). However, research suggests that people may develop a more integrative recovery style from first-episode psychosis over time (Thompson, McGorry, & Harrigan, 2003). It follows, therefore, that women who experience PP may begin to view this as part of their life experience and seek to identify positives from it as time goes on. Future research taking a longitudinal approach may help to illuminate whether the impact on and influence of close relationships also changes over the course of recovery from PP.

The research was strengthened by the interdependent development of the research questions, data collection techniques and approach to analysis. This ensured that the data collected was able to answer the questions posed in an ethical and methodologically sound manner. Furthermore, the inclusion of a range of significant others led to a more nuanced understanding of the role of relationships within the experience of PP and has highlighted several pertinent areas for future research. Likewise, the apparent similarity of dyads that had experienced PP more or less recently may reflect the rapid recovery time after experiencing PP but also merits further exploration.

Ethical considerations*Contacting GPs*

One ethical issue warranting exploration was the decision to contact GPs to discuss risk issues and verify the diagnosis of PP. This decision was taken following discussions with colleagues who had conducted similar studies and a service user researcher at a mental health research centre. I felt that the verification of participant experience lent strength to the research design as it ensured the most important aspect of homogeneity, the experience of PP. Furthermore, I was aware that online recruitment posed unique difficulties for assessing and managing risk prior to interview. When recruiting through NHS services I asked clinicians to exclude people who they believed may experience significant distress through taking part in the research or who may pose a danger to me as a lone researcher. One way in which I could safeguard me and participants recruited online was to gain consent to contact their GP prior to arranging interviews.

A staged approach to gaining this consent was devised. Participants were informed that I would need to contact their GP during our first contact, before they had been provided with participant information sheets. These were then provided and further contact was arranged to discuss the research in detail. At this point participants were asked for consent for their GP to be contacted and the rationale for this was reiterated. In retrospect, it may have been useful for this information to have been included within the participant information sheets. However, as participants were aware of this process prior to receiving the participant information sheets, none expressed surprise when asked for consent.

Contacting GPs held several potential limitations. I was concerned that it may result in disengagement; however all of the women who were interested in the study appeared

comfortable with this taking place. Nevertheless, I was keenly aware that it may feel disempowering to women and negate their expertise in whether they felt able to participate. For this reason I explained the process as an ethical procedure rather than a sign that I did not trust their judgement. Although this disempowerment is perhaps more visible within this method of recruitment, I believe that it occurs in any research where a gatekeeper is asked to assess the suitability of clients to be invited to the research. One further disadvantage was the potential difficulty and time it could take to contact GPs. Participants were required to provide written consent to their GP prior to me making contact and I often had to make arrangements to be available for the GP to return my call. With good planning this was not problematic and I was able to arrange interviews with participants shortly after they opted into the study.

In retrospect, I wonder whether contacting GPs was a necessary step to ensure the safety of me and participants. Although this was something which was commented on positively by the ethics committee I believe that the study could have been carried out safely and effectively without this extra safeguard. However, I believe that the benefits of reducing risk and verifying experiences were at least equal to the limitations discussed and I would choose to err on the side of caution in assuring the safety of participants. I would consider the balance of these factors in any future study before deciding whether or not to employ a similar strategy.

Research and therapeutic encounters – a contested distinction?

During several interviews I was struck by similarities with therapeutic work, particularly when participants developed a more nuanced understanding of the experience or communicated previously unshared experiences. The therapeutic potential of research interviews has been noted by both interviewers (e.g., Dickson-Swift, James, Kippen, & Liamputtong, 2006) and

interviewees (Lowes & Gill, 2006). Lilian's response to her partner describing their relationship as stronger provides a pertinent example:

That's amazing if Dan thinks that, because I just feel like I was a terrible burden . . . but I guess there's another part of me that recognises that what happened to me . . . wasn't my fault.

Here, Lilian reflects on her experiences in light of Dan's perspective and develops a tentative new conclusion about her culpability.

Therapeutic effects may begin during early stages of research, as participants self-identify with the group being recruited and feel empowered by the invitation (Berger & Malkinson, 2000). My recruitment occurred online, meaning that women who replied underwent this process of self-identification. Furthermore, talking about past experiences may provide an opportunity to make sense of events (Murray, 2003) and integrate these into life stories (Shamai, 2003). Although I did not adopt specific interviewing techniques to promote therapeutic benefits (Nelson, Onwuegbuzie, Wines, and Frels, 2013) any qualitative interview has the power to 'change, shift, and broaden storied lives' (Haene, 2010, p. 8). Reflecting on why particular participants find interviews valuable can aid our understanding of the data (Ortiz, 2001). Within my research, Kate and Hina reported that they had not discussed their experiences and this gave the interview cathartic benefits. Where dyads had already explored the experience in detail together, it felt as though the interview held fewer cathartic moments.

I began a new clinical placement in the midst of conducting the interviews, after a three-month research block. I became more aware of my dual role within interviews, that of a trainee psychologist working as a researcher. Before reflecting on this specifically I present a brief

overview of differences and similarities between research and therapeutic interviews, which influence how therapists negotiate the researcher role.

One salient difference between research and therapeutic relationships is often the manifestation of power (Shamai, 2003). Seeking help from a professional may engender feelings of hopelessness (Shamai, 2003), whereas being asked to participate in research grants clients a powerful position of expertise. Furthermore, research participants perceive the researcher's role as understanding experiences rather than 'fixing' problems (Gale, 1992). Additionally, the focus of research is not on setting goals or engendering change (Haene, 2010). These fundamental differences provide distinctive contexts within which research and therapeutic interviews occur.

Nevertheless, similarities between research and therapy are apparent. Both involve one person's disclosure of personal information, while another makes sense of this (Hart & Crawford-Wright, 1999); thus the position of researcher parallels that of therapist (Birch & Miller, 2000). Furthermore, ideally both researchers and therapists seek to empower their participant or client (Bourdeau, 2000) and both may seek to create a shared construction of meaning (Haene, 2010). I believe that these common factors contributed to my awareness of the blurred boundary between 'trainee psychologist' and 'qualitative researcher'.

The boundary between clinician and researcher

I was conscious throughout the interviews of inadvertently slipping into the role of therapist. I found myself formulating experiences, as revealed in my reflective diary:

The happiness of the birth was muted when her son was rushed away without
Kate meeting him . . . Kate's health did not allow her to visit her baby

immediately and may have ignited fears about death which stemmed from a recent bereavement.

This awareness allowed the focus to remain on participants' understandings, rather than the conversation being led by my formulation. In the example above, Kate's friend linked the separation from her son and the development of PP; I felt confident that I had not influenced this.

Similar skills are essential within therapy and research, perhaps heightening the difficulties of boundary management (Dickson-Swift et al., 2006). Both involve rapport-building, active listening and empathy. I also found that positioning the participant as 'expert' felt similar to therapeutic work, whereas some clinicians perceive this as a very different role (Nelson et al., 2013). Furthermore, participants may inadvertently draw researchers into their alternative role, for example through asking questions related to clinical issues during or following interviews (Lowes & Gill, 2006). This felt pertinent when one participant inquired about having another baby:

I was aware of wanting to reassure and encourage Fiona to further consider this, perhaps as I had interviewed two women who had gone on to have more children. However, I was not in a position to facilitate a thorough consideration of this and would have been stepping outside of my researcher role. I told Fiona that some of the women I had interviewed had more children, while others had, similarly to her, decided that they did not wish to.

I also found it challenging to avoid questions which I believed may have been beneficial to participants but were not specifically relevant. I was particularly aware of this within one interview where I was tempted to ask circular questions (Campbell, Draper, & Crutchley, 1991)

to guide consideration of other perspectives. However, the participants had not provided informed consent to partake in a therapeutic session; it was therefore unethical to ask questions solely for therapeutic reasons.

Furthermore, I grappled with the competing needs of interested parties. Batchelor and Briggs (1994) highlighted this issue, which felt particularly pertinent when conducting research for a thesis. I encountered a dilemma between prioritising potential benefits for participants and gaining quality data. Thus, at times when the conversation did not feel directly relevant to my research question, it was difficult to interrupt when it felt cathartic or therapeutic. After an early interview in which I felt I directed the conversation very little, I decided to broach this prior to interviews. I explained that, while it was helpful for participants to have a conversation with each other, I may sometimes take a more directive stance. After this discussion, I felt more able to ask further questions and less at risk of invalidating the experiences under discussion.

In summary, I believe that the decision to contact GPs prior to arranging interviews strengthened the research through reducing the potential risk for me and the participants and through verifying the most important inclusion criteria, the experience of PP. However, this approach should not be adopted without a thorough consideration of the strengths and limitations of this. Upon reflection, consideration of the similarities and differences between my role as a trainee psychologist and researcher may have been valuable prior to beginning the research. However, I believe that I was able to minimise the ethical and practical dilemmas presented, through reflecting upon this throughout data collection. I believe that it is appropriate for research to hold therapeutic value for participants but do not believe that these opportunities should be deliberately sought, particularly without consent from participants. Although I

focused on my researcher role, I responded empathically and thus in a similar way as I would within a therapeutic session.

Conclusion

Within this paper I have critically appraised several issues pertinent to my empirical paper. I have explored the interconnected decisions made regarding research questions, data collection, and analysis. I have reflected upon the definition of ‘homogeneity’ within IPA studies and how the current research was strengthened by the inclusion of a less homogeneous sample. I explored my decision to gain consent from participants recruited online to contact GPs prior to arranging an interview and considered the strengths and potential limitations of this approach. Finally, I contemplated the blurred boundary between my roles as a trainee clinical psychologist and qualitative researcher and considered some of the dilemmas this created.

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Appendix 3-A. Example of coding strategy

Key:

Blue text = Descriptive comments	Standard typeface = mother
Red text = conceptual comments	<i>Italics</i> = partner
Green text = linguistic comments	<u>Underlined</u> = joint narrative

Transcript	Comments
<p>Dan: I didn't really know what to do. I sort of tried to get her to speak to me erm, and then erm, Lilian will probably remember this but erm, I was worried that she wasn't really eating anything, erm, so I tried to get her to write down on a piece of paper what she wanted for breakfast, erm and it took ages but she did write Weetabix on the piece of paper.</p> <p>Lil: I've still got the piece of paper!</p> <p>Dan: I mean that was quite a big relief that she was still in there, I mean I had no idea whether, you know we're not medically trained or anything, I had no idea what was going on, so it was worry you know whether it was something physical you know, if she'd had a stroke or something from the operation erm</p> <p>Lil: I remember you being there, I remember you like sitting by the side of my bed and I just like staring at you trying to get you to understand what I was feeling but not able to say it because I didn't really know like what was real and what ... yeah, I guess, just completely erm. I remember, I think by that point my little sister had arrived hadn't she?</p>	<p><i>Sense of not knowing what to do- tried different approaches</i></p> <p><u>Importance of & relief at first communication - indicated by keeping the paper</u></p> <p><i>"still in there" – perception of Lilian as somewhere else / different at this time?</i></p> <p><i>Worry re: physical – see physical as more dangerous / bigger implications?</i></p> <p>Remembers Dan being there</p> <p>Wanted to communicate feelings but struggled</p>

Section four: Ethics

Caroline Wyatt

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

NHS Research Ethics Committee (REC) Application Form

NHS REC Form

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13/NW/0625

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Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please enter a short title for this project (maximum 70 characters)
Puerperal psychosis - exploring the role of relationships. Version 1

1. Is your project research?

☒ Yes ☐ No

2. Select one category from the list below:

- ☐ Clinical trial of an investigational medicinal product
- ☐ Clinical investigation or other study of a medical device
- ☐ Combined trial of an investigational medicinal product and an investigational medical device
- ☐ Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
- ☐ Basic science study involving procedures with human participants
- ☐ Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- ☒ Study involving qualitative methods only
- ☐ Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
- ☐ Study limited to working with data (specific project only)
- ☐ Research tissue bank
- ☐ Research database

If your work does not fit any of these categories, select the option below:

☐ Other study

2a. Please answer the following question(s):

- a) Does the study involve the use of any ionising radiation? ☐ Yes ☒ No
- b) Will you be taking new human tissue samples (or other human biological samples)? ☐ Yes ☒ No
- c) Will you be using existing human tissue samples (or other human biological samples)? ☐ Yes ☒ No

3. In which countries of the UK will the research sites be located?(Tick all that apply)

- ☒ England
- ☐ Scotland
- ☐ Wales
- ☐ Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

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- ☒ England
☐ Scotland
☐ Wales
☐ Northern Ireland
☐ This study does not involve the NHS

4. Which review bodies are you applying to?

- ☒ NHS/HSC Research and Development offices
☐ Social Care Research Ethics Committee
☒ Research Ethics Committee
☐ National Information Governance Board for Health and Social Care (NIGB)
☐ National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D offices, the CI must create Site-Specific Information Forms for each site, in addition to the study-wide forms, and transfer them to the PIs or local collaborators.

5. Will any research sites in this study be NHS organisations?

- ☐ Yes ☒ No

6. Do you plan to include any participants who are children?

- ☐ Yes ☒ No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

- ☐ Yes ☒ No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the NIGB Ethics and Confidentiality Committee to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

- ☐ Yes ☒ No

9. Is the study or any part of it being undertaken as an educational project?

- ☒ Yes ☐ No

Please describe briefly the involvement of the student(s):
Chief Investigator

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

- ☒ Yes ☐ No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

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☐ Yes ☒ No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

☐ Yes ☒ No

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Integrated Research Application System
Application Form for Research involving qualitative methods only**Application to NHS/HSC Research Ethics Committee**

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting [Help](#).

Please define any terms or acronyms that might not be familiar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Puerperal psychosis - exploring the role of relationships. Version 1

Please complete these details after you have booked the REC application for review.

REC Name:**REC Reference Number:**
13/NW/0625**Submission date:**
16/08/2013**PART A: Core study information****1. ADMINISTRATIVE DETAILS****A1. Full title of the research:**

The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title	Forename/Initials	Surname
	Miss	Caroline	Wyatt
Address	C12 Furness College	Lancaster University	Lancaster
Post Code	LA1 4YG		
E-mail	c.wyatt@lancaster.ac.uk		
Telephone	01524 593378		
Fax			

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Give details of the educational course or degree for which this research is being undertaken:

Name and level of course/ degree:
Doctorate in Clinical PsychologyName of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title Forename/Initials Surname
	Dr Craig Murray
Address	Doctorate in Clinical Psychology C12 Furness College Lancaster University
Post Code	LA1 4YG
E-mail	c.murray@lancaster.ac.uk
Telephone	01524 592730
Fax	

Please state which academic supervisor(s) has responsibility for which student(s):

Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)	Academic supervisor(s)
------------	------------------------

Student 1 Miss Caroline Wyatt

☒ Dr Craig Murray*A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.***A2-2. Who will act as Chief Investigator for this study?**

- ☒ Student
- ☐ Academic supervisor
- ☐ Other

A3-1. Chief Investigator:

	Title Forename/Initials Surname
	Miss Caroline Wyatt
Post	Trainee Clinical Psychologist
Qualifications	BSc Psychology
Employer	Lancashire Care NHS Foundation Trust
Work Address	C12 Furness College Lancaster University Lancaster
Post Code	LA1 4YG
Work E-mail	c.wyatt@lancaster.ac.uk

Date: 16/08/2013

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* Personal E-mail c.wyatt@lancaster.ac.uk
 Work Telephone 01524 593378
 * Personal Telephone/Mobile
 Fax

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.
 A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.*

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and R&D reviewers that is sent to the CI.

	Title Forename/Initials Surname
	Debbie Knight
Address	Research Ethics Officer, Research Support Office University House, Lancaster University, Lancaster
Post Code	LA1 4YW
E-mail	ethics@lancaster.ac.uk
Telephone	01524 592605
Fax	01524843087

A5-1. Research reference numbers. Please give any relevant references for your study:

Applicant's/organisation's own reference number, e.g. R & D (if available):
 Sponsor's/protocol number:
 Protocol Version: 1
 Protocol Date: 12/08/2013
 Funder's reference number:
 Project website: N/A

Additional reference number(s):

Ref.Number	Description	Reference Number
------------	-------------	------------------

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

☐ Yes ☒ No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

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A6-1. Summary of the study. Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, this summary will be published on the website of the National Research Ethics Service following the ethical review.

This study aims to explore experiences labelled as puerperal psychosis from the perspective of mothers and their significant others. The study will particularly focus on the role of relationships within this experience. Previous research suggests that relationships with partners, family, friends and children may be affected for mothers who have experienced significant levels of mental distress after giving birth. It is also likely that their experience of their relationships plays a role in how mothers and their significant others make sense of this period. There is an emphasis in professional guidelines on involving the family in the mother's care, both to facilitate a supportive environment upon discharge and to ensure that the impact on the family is recognised and addressed, if appropriate. It is hoped that the study will allow professionals to consider how they can utilise the supportive nature of close relationships, how the experience of puerperal psychosis may affect significant others, and develop a deeper understanding of the context into which women are discharged from hospital. The study is funded by Lancaster University and participants will be recruited through services across Great Britain, as well as through online support groups. Women who have received a diagnosis of puerperal psychosis will be eligible to participate, along with a significant other of their choosing. Participants will be interviewed with their significant other for approximately one hour. Interviews will be semi-structured in nature, allowing participants to discuss issues which they deem to be of importance to the research question.

A6-2. Summary of main issues. Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, R&D office or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Purpose and Design

This study aims to explore participants' experiences of relationships in the context of living through a period of significant mental distress after childbirth. As any relationship is experienced by both parties, it is appropriate to interview participants as dyads. It is hoped that this design will provide a rich understanding of the role of relationships, through both the consensus and disparities of opinion which are likely to occur during the interview. Semi-structured interviews will ensure that participants are able to discuss important aspects of their experience which may not have been highlighted by previous research and therefore may not be explicitly noted within the interview schedule. Research staff and members of a service-user involvement group from Lancaster University were involved in the development of this proposal through their inclusion on the panel at a 'proposal presentation day'.

Recruitment

Recruitment will be carried out as a staged process through the NHS and non-NHS methods, as described below.

Stage 1

Identification of potential participants will be carried out by a clinical or admin team member at various national Mother and Baby Units, acting as Participant Identification Centres. This team member will already have permission to access medical records as part of their role and will use their clinical judgement as to whether each woman would be in a safe place emotionally to take part in an interview. A recruitment pack will be sent to the individual's home address by this team member. Included within the recruitment pack will be a participant information sheet, opt-in form and contact details for the chief investigator. Participants will be asked to contact the chief investigator via the opt-in form, by phone or by email if they are interested in learning more about the study. Interviews will take place either in the participant's home or in a local community building. They will not take place at the Mother and Baby Unit to protect the participant's anonymity. The chief investigator will work in accordance with Lone Worker policies.

Stage 2

If, after one month participants are still required, recruitment will move to stage 2. Information regarding the study will be posted on a number of support group message boards, with permission from the administrators. Adverts will also be placed in local newspapers and on social media websites. To do so, the chief investigator will set up a research profile which will not contain any personal details except for their email address and contact phone number. Potential participants will be asked to contact the chief investigator by either phone, email or via the social media site. Upon initial contact, they will be asked to provide consent for the chief investigator to contact their GP and/or care co-ordinator. If this is not given, they will be informed that unfortunately they cannot take part in the study. If consent is gained, the chief investigator will contact the GP or care co-ordinator to inform them that the person is interested in

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taking part in the research and to assess the risk to either the participant or the researcher of taking part.

Issues relevant to both stages of recruitment:

No incentives will be offered for taking part in the research, but travel expenses will be reimbursed. There will be no upper limit on the length of time since the participant experienced puerperal psychosis, as it is expected that women who feel that they are unable to remember the details around this sufficiently will not volunteer to participate. Participants will not be interviewed whilst they are staying within an inpatient Mother and Baby Unit, but could be interviewed after discharge, whilst still receiving outpatient care. Participants will be interviewed either at their home or in a local community building. They will also be offered the option of a telephone interview if they do not wish to be interviewed face-to-face.

Consent

Potential participants will be provided with the participant information sheet within the recruitment pack. If they express an interest in taking part in the study, the chief investigator will telephone them to discuss the information sheet with them in detail, allowing time for any questions to be answered. Prior to the interview taking place, the chief investigator will go through the information sheet with both the mother and their significant other and ensure that any further questions are answered. Participants will be reminded that they can withdraw their consent at any time without providing a reason, including during the interview. Both the mother and their significant other will then be asked to sign a consent form, which will include their consent for the interview to be audio-recorded. Participants will also be asked to give consent for their home address to be kept securely by the researcher until the end of the study, if they wish to receive a copy of the report. Consent will be gained from all of the mothers who have experienced puerperal psychosis for the researcher to contact their care co-ordinator or GP if any issues arise during the interview which are of concern to the interviewer. They will be informed about this prior to arranging an interview. Participants who have been recruited through online methods will be asked for their consent for the researcher to contact their GP or care co-ordinator prior to arranging an interview. For women who have been recruited through Mother and Baby Units, this is not necessary as the member of staff identifying participants will be asked to exclude women who the team feel would be at risk if they took part in the research.

Risks and Benefits

Experiencing mental distress during the postnatal period is inherently a painful experience and discussing this may be a difficult experience for participants. To ensure that the risk of distress is minimised, participants will be informed that they can withdraw or take a break from the interview at any point. Participants will also be given a time to discuss any difficult emotions brought up by the interview during the debriefing stage, where they will also receive a debrief sheet which will signpost them to relevant services. Participants will be asked to provide consent for the chief investigator to contact their GP or care co-ordinator if anything of significant concern is discussed during the interview. If this situation arises, the researcher will discuss their course of action with the participants before contacting their GP or care co-ordinator.

The study does not intend to provide any therapeutic benefits to individuals taking part. However, it is hoped that the understanding gained through the research could provide clinical implications for professionals working with women experience mental distress in the postnatal period.

Confidentiality

The Caldicott Principles and the Data Protection Act (1998) have been consulted during the design of this research. No personal information will be recorded until an individual opts-in to the research. Interviews will be audio-taped and transcribed – both the audio recordings and transcriptions will be stored on a password-protected computer using encryption software. Audio recordings will be destroyed after the corresponding transcription is completed and within 3 months of the data being collected. Participants will be asked to choose their own pseudonym which will then be used within the transcripts and in all subsequent analysis and reporting. Transcripts will be stored securely on the Lancaster University network for 10 years after the study is completed. Participants will be informed prior to the interview that confidentiality may have to be broken if the chief investigator deems the participant or others to be at significant risk.

Conflict of Interest

No conflicts of interest have been identified for the chief investigator. At the end of the study, participants who have given consent to be contacted will receive a brief report summarising key findings and implications.

A6-3. Proportionate review of REC application *The initial project filter has identified that your study may be suitable for proportionate review by a REC sub-committee. Please consult the current guidance notes from NRES and indicate whether you wish to apply through the proportionate review service or, taking into account your answer to A6-2, you consider there are ethical issues that require consideration at a full REC meeting.*

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☐ Yes - proportionate review ☒ No - review by full REC meeting

Further comments (optional):

Note: This question only applies to the REC application.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. Please tick all that apply.

- ☐ Case series/ case note review
- ☐ Case control
- ☐ Cohort observation
- ☐ Controlled trial without randomisation
- ☐ Cross-sectional study
- ☐ Database analysis
- ☐ Epidemiology
- ☐ Feasibility/ pilot study
- ☐ Laboratory study
- ☐ Metanalysis
- ☒ Qualitative research
- ☒ Questionnaire, interview or observation study
- ☐ Randomised controlled trial
- ☐ Other (please specify)

A10. What is the principal research question/objective? Please put this in language comprehensible to a lay person.

How do women and their significant others experience their relationship after living through the post-birth period, during which the mother received a diagnosis of puerperal psychosis?

A11. What are the secondary research questions/objectives if applicable? Please put this in language comprehensible to a lay person.

Do women and their significant others experience qualitative changes in their relationships?

Do women and their significant others believe that their relationships have an impact on their postnatal experience?

A12. What is the scientific justification for the research? Please put this in language comprehensible to a lay person.

The postnatal period is time during which women can experience many social and emotional changes. For some women this is a rewarding and positive experience, however many also experience some degree of distress. Those women who experience significant levels of mental distress may be given a diagnosis of postnatal depression or puerperal psychosis. A label of puerperal psychosis would be considered if a woman experiences wide fluctuations in mood and appears to have unusual experiences such as hearing voices.

There are very few qualitative studies involving women with a diagnosis of puerperal psychosis. However, research which has explored the experiences of women with a diagnosis of postnatal depression has highlighted the sense of loss which many women experience in relation to close relationships during the postnatal period. Similarly, one study which interviewed women with a diagnosis of puerperal psychosis described the strain placed on close relationships. However, participants within this study also recognised some positive effects of their experiences, for example through developing a new appreciation of their close relationships.

Services and professional bodies have recognised the need to involve family members in the care of women experiencing postnatal distress. Guidelines for mother-and-baby units (where women who would benefit from inpatient care can do so whilst remaining with their infant) highlight the importance of engaging mothers' families in

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their care. They recognise the useful input of family members in supporting the mother, as well as the potential impact of the experience on wider family systems. However, there has been little research which explores how these relationships can be affected by the experience of mental distress which is severe enough to gain a diagnosis of puerperal psychosis. Equally, little is known about how existing relationships can affect the experience of postnatal mental distress.

Therefore, this study aims to explore the role of relationships from the perspective of both the mother and her significant others. It is hoped that the knowledge gained from this research can assist professionals in understanding the context into which women are discharged from mother-and-baby units, consider the utility of working with the family prior to discharge, and recognise the need to hold the impact of the family in mind whilst working with the mother.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

A qualitative methodology was deemed appropriate as the study aims to illuminate the experiences and perspectives of participants. As the research aims to explore the role of relationships between mothers and their significant others, a dyadic interview design has been chosen. This will allow participants to explore their joint experiences of relationships, which are by their very nature shared experiences. Semi-structured interviews were chosen to gather the qualitative data as this allows the researchers to include areas of particular interest, as suggested by previous research, but also provides the participants flexibility in what they wish to discuss.

Population

Potential participants will be recruited through a number of national Mother and Baby units. Potential participants will be receiving outpatient care from the Mother and Baby unit after having been discharged from their inpatient services. Participants may also be recruited from online support forums. Individuals who have received a diagnosis of puerperal psychosis and have spent time as an inpatient within a Mother and Baby unit will be suitable for inclusion. 'Significant others' will be defined as somebody whom the mother deems to have had a significant role in their lives during the time at which she received a diagnosis of puerperal psychosis. Both the mothers and their significant others must be 18 years of age or over and live within the United Kingdom.

Recruitment

Potential participants will be provided with an information pack, either by the Mother and Baby Unit or by the chief investigator (either electronically or via post) if they see the study advertised and wish for further information. This information pack will contain a letter introducing the study, a participant information sheet and an opt-in form. Potential participants can express interest in the study through returning the opt-in form, emailing or calling the chief investigator. They will then receive a phone-call from the chief investigator to discuss the participant information sheet and to answer any questions. The participant will be asked to confirm whether a significant other has also expressed an interest in the study. If both participants are willing to be interviewed, a date and location for the interview will be agreed.

Interviews

Participants will be asked to be interviewed together for approximately one hour. Participants will choose whether they would like to be interviewed at their own home or at a community building, which the chief investigator would attempt to source. Before beginning the interview the chief investigator will discuss the participant information sheet and answer any remaining questions. A written consent form will be completed by both the mother and her significant other at this point. This will include consent for the interview to be audio-recorded. It is anticipated that these interviews will be conducted between October 2013 and January 2014. During the interview participants will be asked questions in line with the interview schedule. This schedule is semi-structured to allow participants to discuss issues which they feel are pertinent to the research questions. At the end of the interview participants will be given time to discuss anything brought up by the interviews and will be provided with a debrief sheet. This will include a thank you to participants for taking part in the study and point them towards independent sources if support.

Analysis

After all interviews have been completed the chief investigator will analyse the transcripts using interpretative phenomenological analysis (IPA), providing that the sample is deemed homogenous enough for this approach. If the sample is not homogenous, a thematic analysis will be undertaken. The final report will be prepared from January 2014 and submitted as part of the chief investigator's Doctorate in Clinical Psychology in May 2014.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

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- ☒ Design of the research
☐ Management of the research
☐ Undertaking the research
☐ Analysis of results
☐ Dissemination of findings
☐ None of the above

Give details of involvement, or if none please justify the absence of involvement.

A local service-user involvement group was represented on the panel to which the chief investigator presented the initial proposal for this research. The feedback received from this presentation was incorporated into the design of the research.

A women who experienced significant mental distress in the postpartum period, had received a diagnosis of puerperal psychosis and spent time in a Mother and Baby unit has reviewed the supporting documents. Any suggestions were discussed with the chief investigator and incorporated into the documents to ensure that they are understandable to a lay person.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Participants must have received a diagnosis of puerperal psychosis (mother only). There will be no time limit set on when this diagnosis was made, although women who have had this experience within the last 15 years will be prioritised if a large number of women express an interest in participating in the study.

Participants (both the mother and significant other) must be aged 18 or over.

Participants (both mother and significant other) must be a resident of the United Kingdom.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

Women who are currently being cared for as an inpatient within a Mother and Baby unit will not be eligible to participate.

Women who are currently experiencing levels of mental distress which may mean that participation in the interview is an unsafe experience will be excluded from the study. To achieve this, care co-ordinator's and GP's will be asked to give their clinical judgement as to whether it is an appropriate time for women to be interviewed.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. These include seeking consent, interviews, non-clinical observations and use of questionnaires.

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Telephone call from Chief Investigator to discuss Participant Information Sheet, answer questions and arrange interview	1	0	20 minutes	Chief Investigator By Phone

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Seeking consent	1	0	20 minutes	Chief Investigator Participant's home or NHS Trust site
Interview	1	0	60 minutes	Chief Investigator Participant's home or NHS Trust site

A21. How long do you expect each participant to be in the study in total?

Participants will provide informed consent directly before being interviewed. Interviews are planned to take place from October 2013. Participant's last contact with the research team is predicted to be June 2014, when a short summary of the findings of the research will be sent to participants who have consented to this. Therefore, it is expected that participants will be involved in the study for up to 9 months.

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

Participants will be asked to discuss their experiences of relationships within the context of postnatal mental distress. This may be a sensitive topic for participants and their significant others, and may not be something which they have discussed together. To minimise the risk of distress, participants will be informed prior to the interview that they are able to take a break or discontinue the interview at any point. They will also be provided with a debrief sheet which gives details of relevant organisations should they feel that they require further support. Participants will be offered time after the interview to discuss any emotions brought up by the process. They will also be asked prior to the interview to provide consent for the researcher to contact their GP or care co-ordinator, and it will be explained that they may need to be contacted if the chief investigator has any concerns. Therefore, if the chief investigator is concerned for the participants safety, or that of others, they will explain to the participant that they must breach confidentiality and will then disclose these concerns to their GP or care co-ordinator. The participants will be involved in this process as much as is possible.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

☒ Yes ☐ No

If Yes, please give details of procedures in place to deal with these issues:

The interviews may contain topics that could be distressing to participants. The chief investigator is a trainee clinical psychologist who has experience in working with individuals within highly emotive contexts. The field supervisor is a qualified clinical psychologist with experience of working with risk and will be available to provide support for the chief investigator. Any disclosures which require action during the study will be discussed with the participant where possible, before contacting their GP, care co-ordinator or a relevant safeguarding team.

If participants disclose any information which causes concern over clinical practice, the chief investigator will discuss this immediately with their academic and/or field supervisors.

A24. What is the potential for benefit to research participants?

There are no direct therapeutic benefits anticipated for participants, although the process of talking about their experiences may be a positive experience for some.

A26. What are the potential risks for the researchers themselves? (if any)

If the researcher is conducting an interview at the participant's home, they must work in accordance with the employing trust's (Lancashire Care NHS Foundation Trust) Lone Worker Procedure (Policy Number HS 007) and/or the NHS Trust through which the participant was recruited. The researcher will provide details of each visit to another member of the research team and will make safety calls to this person after completing the interview. A protocol will be in place to be followed if a safety call is not

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The chief investigator recognises that completing the interviews is likely to be emotionally challenging at times. The chief investigator will receive regular supervision from the research team to manage this risk.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).

Recruitment will follow a staged process, as outline below.

Recruitment procedure A

Participants will be recruited through Mother and Baby Units, identified as Participant Identification Centres (PIC). At each PIC, a member of the staff team will be designated to identify potential participants who fit the inclusion criteria. They will be asked to use their clinical judgement (or that of the client's care co-ordinator if they do not have clinical contact with the client) as to whether the potential participant would be safe to take part in the interview. An information sheet detailing the research process will be posted to the potential participants' home address, along with a covering letter. This will be undertaken by a named staff member or administrative staff. Included within this information will be the telephone number, postal address and email address of the chief investigator, which can be used to request further information. An opt-in slip and stamped addressed envelope will also be provided for both the mother and significant other, which potential participants can return to register their interest in the study.

Recruitment procedure B

Recruitment procedure B will be employed if enough participants have not been recruited after one month. This will involve recruiting participants via online support groups, internet forums and websites. Some of these online recruitment sources are specific to puerperal psychosis whilst others provide support for mothers who have experienced a range of difficulties during the puerperal period. A message will be posted on forums and websites (with the site administrator's consent) which outlines the research and asks people to contact the researcher for further information. The researcher will also create a research profile on the website Facebook and post a message about the research on the pages of groups created for people affected by postnatal mental health difficulties. The profile will not contain any identifying details of the researcher other than those already provided to participants (name and university email address). Advertising materials will be publicised through the Lancaster University Press Office. Snowball sampling will also be used, with potential participants asked to "spread the word" about the study and circulate the researcher's details if they feel that this is appropriate.

If the researcher is contacted by potential participants they will be screened according to the inclusion/exclusion criteria and, if appropriate, they will be provided with a participant information sheet and covering letter (either by post or email depending on their preference). They will then be asked to opt-in to the study if they are interested in doing so.

Participants who are recruited through this method will be asked to provide consent for the researcher to contact their GP or care co-ordinator during the initial telephone conversation. They will be informed that this is to think about whether now is the best time for them to participate in this research. Care co-ordinator's and GP's will be sent an information letter which advises them that their client has agreed to take part in the study. The researcher will also contact the care co-ordinator or GP by telephone to discuss whether participating in the research will pose any risks for the potential participant or the researcher. If any risks are raised the researcher will contact the potential participant to advise them that their GP / care co-ordinator has raised concerns and discuss this with the participant. The final decision as to whether the participant may be interviewed will be taken by the chief investigator after liaison with both their field and research tutor at Lancaster University. If the potential participant does not give consent for their GP or care co-ordinator to be contacted, they will be unable to take part in the research.

Common aspects to both procedures

If, after receiving the information pack, women are interested in taking part in the study they will be asked to return an opt-in form or contact the researcher directly. The researcher will then contact them by telephone to answer any questions and arrange an initial date and time to conduct the interview. The fact that this research is to be conducted with both the mother and a significant other will be made explicit within the participant information sheet. Upon initial contact with the potential participant the researcher will ask whether they have discussed the information sheet with a significant other. If they have not, the researcher will request that they do so and arrange a further opportunity to

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discuss the research after this time.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?☒ Yes ☐ No*Please give details below:*

For participants recruited through a Mother and Baby unit, the medical notes of potential participants will be screened to ensure that they meet the inclusion criteria. This will be carried out by a member of the direct care team within that Mother and Baby unit and therefore have access to these records as part of their role.

Participants who are recruited through online sources will not have their medical records accessed. The study will rely on self-report of the participant meeting the inclusion criteria, although this can be checked with the GP after the participant has provided consent for the chief investigator to contact them.

A27-4. Will researchers or individuals other than the direct care team have access to identifiable personal information of any potential participants?☐ Yes ☒ No**A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?**☒ Yes ☐ No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

Information relating to the study will be posted on discussion forums of several websites designed for women who have received a diagnosis of puerperal psychosis. This information will also be made available on the corresponding Facebook pages of these websites. This will be done with the permission of site administrators.

Local newspapers may also be approached to advertise the study. This will be achieved through the Lancaster University Press Office.

A29. How and by whom will potential participants first be approached?

Recruitment packs will be sent to potential participants by post to their home address, if recruited through a Mother and Baby unit. If recruited online, participants can request an information pack be sent to them either by post or via email.

A30-1. Will you obtain informed consent from or on behalf of research participants?☒ Yes ☐ No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

Potential participants will be provided with a written information sheet within their recruitment pack which provides comprehensive information regarding the research and their role within this. They will have the opportunity to discuss this with the Chief Investigator before opting to take part in the study and again immediately before the interview. At this time, the information sheet will be verbally explained by the Chief Investigator and participants will be given time to ask any questions. They will then be asked to sign a consent form, a copy of which will be kept by both the participant and the researcher.

In accordance with the Department of Health's guidance for social scientists on the Mental Capacity Act, capacity will

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be assumed by the act of consenting to participate. However, the Chief Investigator will use their judgement to determine whether the individual has fully understood the information provided and has been able to make a fully informed, non-coerced decision. The researcher is a trainee clinical psychologist who has experience of seeking consent from a range of individuals in clinical practice.

Potential participants will be informed that participation is entirely voluntary and accepting or declining to participate will not affect their care in any way.

If you are not obtaining consent, please explain why not.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

☒ Yes ☐ No

A31. How long will you allow potential participants to decide whether or not to take part?

It is anticipated that recruitment will run from September 2013 to February 2014. Participants will be able to register their interest in the study during this time period. However, they will be made aware that, due to time constraints, only a limited number of participants will be interviewed.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?(e.g. translation, use of interpreters)

The sponsor will fund translation and interpreter services if and when necessary, to allow individuals who may otherwise struggle to engage in the interviews to participate. This will be in line with those services provided for the individual during appointments at the Mother and Baby unit or GP surgery.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? Tick one option only.

- ☐ The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- ☒ The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- ☐ The participant would continue to be included in the study.
- ☐ Not applicable – informed consent will not be sought from any participants in this research.
- ☐ Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

Participants' capacity will be assessed immediately prior to the interview. Shortly after the interview transcripts will be produced which use pseudonyms and do not include identifiable information and audio-recordings will be deleted.

If you plan to retain and make further use of identifiable data/tissue following loss of capacity, you should inform participants about this when seeking their consent initially.

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

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A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)? (Tick as appropriate)

- ☐ Access to medical records by those outside the direct healthcare team
- ☐ Electronic transfer by magnetic or optical media, email or computer networks
- ☐ Sharing of personal data with other organisations
- ☐ Export of personal data outside the EEA
- ☒ Use of personal addresses, postcodes, faxes, emails or telephone numbers
- ☒ Publication of direct quotations from respondents
- ☐ Publication of data that might allow identification of individuals
- ☒ Use of audio/visual recording devices
- ☒ Storage of personal data on any of the following:
 - ☐ Manual files including X-rays
 - ☒ NHS computers
 - ☐ Home or other personal computers
 - ☒ University computers
 - ☐ Private company computers
 - ☐ Laptop computers

Further details:

Participants' personal addresses will be used by the direct care team to provide them with recruitment packs. Participants recruited online will also need to provide consent for the researcher to have access to their personal address in order to provide them with a recruitment pack. If participants opt to be interviewed in their own home, they will be asked to provide their home address to the researcher. Participants will also be offered the option to receive a brief report of the findings of the research. If they wish to receive this, they will be asked to provide consent for the researcher to keep a record of their address until this has been posted.

Direct quotations from participants used in publications will be anonymised using pseudonyms chosen by the participants.

Participants will be asked to provide consent for their interview to be recorded using an audio device. Audio files will be deleted from the audio device as soon as they have been transferred to a computer. They will be stored in an encrypted format on a password-protected computer and will be destroyed following transcription and analysis.

A38. How will you ensure the confidentiality of personal data? Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.

Personal data will be handled in accordance with the confidentiality model described in the NHS Code of Confidentiality (protect, inform and provide choice):

Protect - care will be taken to record personal data accurately. This data will be kept securely, hard copies will be kept in a locked filing cabinet on Lancaster University premises until it is entered into an electronic document, at which point hard copies will be destroyed as confidential waste. Electronic data will be stored on a password-protected and encrypted computer. Electronic copies of personal data will be destroyed following the last contact with the participant (this may be after their interview, or after the study has ended if they have provided consent to receive a summary report).

Inform - participants will be made aware of which members of the research team will see their personal data. They will also be made aware that anonymised quotes may be used when disseminating the research findings before consent is gained.

Provide choice - participants will complete a consent form which allows them to state whether they are happy for their data to be used in an anonymised format within publications.

A40. Who will have access to participants' personal data during the study? Where access is by individuals outside the

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direct care team, please justify and say whether consent will be sought.

Personal data will be accessed by members of the direct care team during the recruitment process. The chief investigator will only have access to personal data if the individual opts into the study and provides this information. Participants will be advised as to who will have access to their personal data within the participant information sheet.

Storage and use of data after the end of the study

A43. How long will personal data be stored or accessed after the study has ended?

- ☒ Less than 3 months
☐ 3 – 6 months
☐ 6 – 12 months
☐ 12 months – 3 years
☐ Over 3 years

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

- ☒ Yes ☐ No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.
 Participants will receive reimbursement of any travel expenses up to a total of £10. This will be at public transport rate or 25p per mile if using their own transport.

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

- ☐ Yes ☒ No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

- ☐ Yes ☒ No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

- ☒ Yes ☐ No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

A49-2. Will you seek permission from the research participants to inform their GP or other health/ care professional?

- ☒ Yes ☐ No

It should be made clear in the participant's information sheet if the GP/health professional will be informed.

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PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

☐ Yes ☒ No

Please give details, or justify if not registering the research.

This project is undertaken as part of an educational doctoral research programme. The chief investigator is not aware of any suitable register for this type of research.

Registration of research studies is encouraged wherever possible.

You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.

A51. How do you intend to report and disseminate the results of the study? Tick as appropriate:

- ☒ Peer reviewed scientific journals
- ☒ Internal report
- ☒ Conference presentation
- ☐ Publication on website
- ☐ Other publication
- ☐ Submission to regulatory authorities
- ☐ Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- ☐ No plans to report or disseminate the results
- ☐ Other (please specify)

A53. Will you inform participants of the results?

☒ Yes ☐ No

Please give details of how you will inform participants or justify if not doing so.

Participants will be given the option to consent to receiving a brief report which will highlight the main findings and implications of the research.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? Tick as appropriate:

- ☐ Independent external review
- ☐ Review within a company
- ☐ Review within a multi-centre research group
- ☒ Review within the Chief Investigator's institution or host organisation
- ☒ Review within the research team
- ☒ Review by educational supervisor
- ☐ Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:

The initial proposal for this research was presented to a panel of trainee clinical psychologists, research staff and service users at Lancaster University. Feedback from this presentation was then incorporated into the proposal by the

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chief investigator. Both the academic and field supervisor have reviewed the research and supporting documents.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? *How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.*

Total UK sample size: 10
Total international sample size (including UK): 10
Total in European Economic Area: 10

Further details:

A sample size of 10 pairs of participants was chosen to ensure that a rich understanding of their experience can be achieved. It is also felt that 10 pairs of participants will provide a range of responses and experiences, although it is difficult to predict data saturation when using qualitative methods.

A60. How was the sample size decided upon? *If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.*

As the aim of qualitative research is to gain a rich understanding of the participants' experience it is considered acceptable to have a small number of participants. Recent studies have suggested that saturation of data can occur in as few as 6 interviews, however it is also acknowledged that predicting the saturation point before conducting qualitative research is problematic.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

The chief investigator will use interpretative phenomenological analysis (IPA) to analyse the data, if the sample is homogeneous. If the sample is not deemed homogenous enough for IPA, thematic analysis will be used.

The analysis will be carried out by the chief investigator, under the supervision of the academic supervisor. Analysis will involve reading through each transcript several times to become familiar with the data. Important aspects of the text will be noted and developed into an 'emergent theme', which will reflect both the participants' words and the researcher's interpretation of these. These themes will be drawn together to create groups of themes. This process will occur separately for each transcript, before comparing the themes across transcripts to look for patterns or discrepancies. Each theme will be given a name which captures the essence of the data which it describes

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. *Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.*

	Title Forename/Initials Surname
	Dr Jenny Davies
Post	Clinical Psychologist; Clinical Tutor
Qualifications	
Employer	Lancaster University
Work Address	C12 Furness College
	Lancaster University
	Lancaster
Post Code	LA1 4YG
Telephone	

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Fax
Mobile
Work Email

A64. Details of research sponsor(s)**A64-1. Sponsor****Lead Sponsor**

- Status: ☐ NHS or HSC care organisation
☒ Academic
☐ Pharmaceutical industry
☐ Medical device industry
☐ Local Authority
☐ Other social care provider (including voluntary sector or private organisation)
☐ Other

Commercial status:

*If Other, please specify:***Contact person**

Name of organisation Lancaster University
Given name Debbie
Family name Knight
Address Research Ethics Officer, Research Support Office
Town/city University House, Lancaster University, Lancaster
Post code LA1 4YW
Country UNITED KINGDOM
Telephone 01524 592605
Fax 01524843087
E-mail ethics@lancaster.ac.uk

Is the sponsor based outside the UK?

- ☐ Yes ☒ No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

- ☐ Funding secured from one or more funders
☐ External funding application to one or more funders in progress
☒ No application for external funding will be made

What type of research project is this?

- ☒ Standalone project
☐ Project that is part of a programme grant

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- ☐ Project that is part of a Centre grant
☐ Project that is part of a fellowship/ personal award/ research training award
☐ Other

Other – please state:

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

- ☐ Yes ☒ No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A69-1. How long do you expect the study to last in the UK?

Planned start date: 02/09/2013

Planned end date: 02/06/2014

Total duration:

Years: 0 Months: 8 Days: 1

A71-2. Where will the research take place? (Tick as appropriate)

- ☒ England
☒ Scotland
☐ Wales
☐ Northern Ireland
☐ Other countries in European Economic Area

Total UK sites in study 1

Does this trial involve countries outside the EU?

- ☐ Yes ☒ No

A72. What host organisations (NHS or other) in the UK will be responsible for the research sites? Please indicate the type of organisation by ticking the box and give approximate numbers of planned research sites:

- ☐ NHS organisations in England
☐ NHS organisations in Wales
☐ NHS organisations in Scotland
☐ HSC organisations in Northern Ireland
☐ GP practices in England
☐ GP practices in Wales
☐ GP practices in Scotland
☐ GP practices in Northern Ireland
☐ Social care organisations
☐ Phase 1 trial units
☐ Prison establishments
☐ Probation areas
☐ Independent hospitals

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<input checked="" type="checkbox"/> Educational establishments	1
<input type="checkbox"/> Independent research units	
<input type="checkbox"/> Other (give details)	
Total UK sites in study:	1

A76. Insurance/ indemnity to meet potential legal liabilities

Note: in this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? Please tick box(es) as applicable.

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

- ☐ NHS indemnity scheme will apply (NHS sponsors only)
☒ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? Please tick box(es) as applicable.

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- ☒ NHS indemnity scheme will apply (protocol authors with NHS contracts only)
☒ Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply
The Chief Investigator holds a substantive contract with the NHS.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- ☒ NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
☒ Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Lancaster University legal liability cover will apply

Please enclose a copy of relevant documents.

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PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.

Research site		Investigator/ Collaborator/ Contact	
Institution name	Lancaster University	Title	Miss
Department name	Doctorate in Clinical Psychology	First name/ Initials	Caroline
Street address	C12 Furness College	Surname	Wyatt
Town/city	Lancaster University		
Post Code	LA1 4YG		
Participant Identification Centre(PIC)-Collaborator/ Contact			
[REDACTED]			
[REDACTED]			
[REDACTED]			
[REDACTED]			
[REDACTED]			
[REDACTED]			
[REDACTED]			

PART D: Declarations**D1. Declaration by Chief Investigator**

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
 - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
 - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
 - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
 - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
 - May be sent by email to REC members.
10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication(Not applicable for R&D Forms)

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

- ☒ Chief Investigator
- ☐ Sponsor

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- ☐ Study co-ordinator
☐ Student
☐ Other – please give details
☐ None

Access to application for training purposes *(Not applicable for R&D Forms)**Optional – please tick as appropriate:*

☒ I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

Signature:

Print Name: Caroline Wyatt

Date: 12/08/2013 (dd/mm/yyyy)

NHS REC Form

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D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Signature:

Print Name: Trevor McMillan

Post: Pro-Vice-Chancellor for Research

Organisation: Lancaster University

Date: 13/08/2013 (dd/mm/yyyy)

NHS REC Form

Reference:
13/NW/0625

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D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.
2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.
3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.
4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

Signature:

Print Name: Craig Murray

Post: Acting Research Director / Senior Lecturer in Research Methods

Organisation: Lancaster University

Date: 15/08/2013 (dd/mm/yyyy)

Appendix 4-A. Thesis protocol

TITLE

The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships

APPLICANTS

Caroline Wyatt – Trainee clinical psychologist, Lancaster University

Dr Craig Murray – Senior lecturer in qualitative research methods & acting research director, Lancaster University

Dr Jenny Davies – Clinical psychologist and clinical tutor, Lancaster University

INTRODUCTION

The post-birth period, whilst often a joyful and rewarding experience, can be a stressful time with inherent lifestyle changes (McConachie, 2008). For some women it can also involve confusion, wide fluctuations in mood and unusual perceptual experiences such as seeing visions or hearing voices. These women often receive a diagnosis of puerperal psychosis, a label given to one to two new mothers in every 1000 (Kendell, 1987; Valdimarsdóttir, 2009). These experiences are rare for mothers with no previous mental health difficulties, although first-time mothers are at a higher risk of requiring inpatient care in the postpartum period than at any other point in their lives (Munk-Olsen, 2006). The risk of experiencing overwhelming emotions after giving birth appears to be higher for women who have already had contact with mental health services. For example, it is estimated that up to 38% of new mothers with a diagnosis of bipolar disorder will experience symptoms associated with puerperal psychosis (Jones, 2001). In addition, recent psychiatric admission has been found to predict the experience of postpartum mental distress in the form of psychosis (Marks, 1992). Women who have previously received a diagnosis of puerperal psychosis are also at a high risk of subsequent episodes of puerperal mental health difficulties (Robertson, 2005). Furthermore, these women are at risk of experiencing mental health difficulties outside of the time immediately before and after birth, also known as the perinatal period (Nager, 2013).

The above research suggests that a range of women can face experiences after the birth of their child which may lead to them receiving a diagnosis of puerperal psychosis. However, research into mental distress in the postnatal period has been hampered by the search for whether these experiences should be categorised as “pure” diagnoses or as part of broader mental health difficulties (National Collaborating Centre for Mental Health [NCCMH], 2007). Within the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-V; American Psychiatric Association, 2013), these experiences are not categorised as a separate entity, but are specified by their “postpartum onset”. This may help to explain the dominance of biological explanations for the experiences categorised as puerperal psychosis. These include hormonal imbalances resulting from childbirth and genetic vulnerabilities (Boyce, 2010). However, psychosocial factors have also been implicated in the occurrence of postpartum psychotic experiences (Song, 2003). Additionally, anecdotal evidence from women who have lived through such an experience often highlight difficult circumstances surrounding the birth as contributing to their experiences, rather than focusing exclusively on biological causes. For example, one lady spoke about the anxiety she felt after the birth of her child and seeking comfort in imagining her mother speaking to her to combat the loneliness of being alone in a side ward (NCCMH, 2007).

Motherhood is often socially constructed as a period of harmony and fulfilment, however many women experience a very different reality (Phoenix, 1991). This appears to play a role in difficult puerperal experiences. For example, one theme which emerged from a meta-synthesis looking at the experience of women living with postnatal depression was an “*incongruity between expectations and reality of motherhood*” (Beck, 2002). This incongruity included relationships with partners and the support received from family and friends. Moreover, many women portray this period of time as one of lost relationships with infants, older children, partners, family and friends (Mauthner, 1998). Similarly, women who have received a diagnosis of puerperal psychosis have described the strain placed on close relationships by their unusual experiences after childbirth (Robertson, 2003). However, women in the same study also acknowledged the positive effects of these experiences, for example a new appreciation of their close relationships. Furthermore, the positive role of relationships is demonstrated in women’s preferences for receiving emotional and practical support from their informal networks of family and friends (Doucet, 2012). In line with this, a recent report commissioned by the National Society for the Prevention of Cruelty to Children emphasises the need for services to “engage, support and work with partners and carers” of women experiencing postnatal mental distress (Hogg, 2013). The report includes a section entitled “The Whole-Family Approach”, and advocates that services also consider the impact of postnatal mental distress on the family.

Another relationship of principal importance during the postnatal period is between mother and baby. The development of an emotional connection with the baby is a key psychological objective during this time, one which research suggests can be disrupted by the mother’s mental distress. Mothers who report feeling low in mood ten days after giving birth have been shown to experience their relationship with their infant as less positive than mothers who report lower levels of depressed mood (Lilja, 2012). This experience persists at least over the first year of their infant’s life. Previous observational research has found that women who have experiences categorised as schizophrenia show greater impairments in their interactions with their infant than women experiencing mood-related distress (Riordan, 1999). However, a more recent study has identified that mothers experiencing mental distress in the form of psychosis report a better bond with their infant than mothers suffering from low mood (Hornstein, 2006). Despite this, observations of mother-infant interactions revealed a similar level of difficulty for both groups of mothers, in terms of their responsiveness, patience and levels of appropriate stimulation. This evidence suggests that any form of mental distress in the postnatal period has some impact on the mother’s bond and interactions with their infant, although it is less clear as to how this occurs or in what way the process is affected.

The NSPCC has recently emphasised the responsibility of service providers to address the impact of maternal mental distress on infants and to support mothers in developing healthy relationships with their baby (Hogg, 2013). In the United Kingdom, it is recommended that women who require inpatient care during the year after childbirth be admitted to a mother and baby unit (MBU), unless specific circumstances dictate that this is not appropriate (NCCMH, 2007). MBUs provide women with access to specialist care in a safe environment which supports the development of a bond with their baby. Women tend to stay within the MBU for a number of weeks and upon discharge receive outpatient care for up to twelve months. National guidelines highlight the need to involve women’s wider support systems in both inpatient and outpatient care, including the need to consider the impact of this experience on family relationships (NCCMH, 2007). In addition,

published quality standards for MBU's state that they must be 'family-friendly' and encourage family participation in their relative's care (Royal College of Psychiatrists, 2008). Furthermore, perinatal psychiatrists have described family as a vital resource, and recognise that involving family members within the mother's care allows them to develop a deeper understanding of her experience and consequently assists her healing (Engqvist, 2013). However, of the approximately 20 MBUs in the UK, only one has facilities for fathers to stay with the mother and baby, and just five offer support groups for partners (Hogg, 2013). This discrepancy is clearly on the agenda of many mental health professionals working in the perinatal community, as evidenced by a recent Special Interest Group which focused on involving significant others in perinatal mental health care.

It is clear that women who experience extreme mental distress in the postnatal period may note changes within their personal relationships, which may be positive or detrimental. It is possible that the role of relationship is two-fold; with relationships being affected by the experience of puerperal psychosis, and the experience of puerperal psychosis being affected by relationships. A lack of social support has been cited as a risk factor for reoccurrence of difficulties in people living with a diagnosis of bipolar disorder (Johnson, 2003), postnatal depression (Dennis, 2006) and puerperal psychosis (Terp, 1999). However, little is known about how women and their significant others experience their relationships after a period of postnatal mental distress where a diagnosis of puerperal psychosis is given. The aim of this research, therefore, is to explore the role of relationships in women's experiences of puerperal psychosis. This may include insights into additional stressors during this period, such as managing shifts in close relationships, as well as elucidating whether aspects of these relationships can act as supportive and protective mechanisms. It is hoped that the results from this study will inform the development of implications for clinical practice, which can then be disseminated through presentations and publications to commissioners and staff who work with women during this distressing period. This will allow MBU professionals to develop an awareness of the context into which they discharge women and their infants, perhaps providing support for them to work with the family prior to discharge or to consider how they can utilise the supportive nature of close relationships within their clinical care.

PARTICIPANTS

Inclusion criteria:

Each pair of participants will fit the following inclusion criteria:

<i>Age:</i>	18 +
<i>Identifying characteristics:</i>	A woman who has had experiences which meet the diagnostic criteria for puerperal psychosis and have consequently received such a diagnosis. This may either have been their first experience of psychosis, or within the context of a long-term psychological difficulty.
	<i>and</i>
	A significant other who has been chosen to participate by the mother. This person should have had a relationship with the

mother throughout the postnatal period (for example, but not restricted to: mother, friend, partner or sibling).

Time limits:

Initial recruitment will be mothers who have left a Mother-and-Baby Unit within the previous 12 months (if they have spent time within a Mother-and-Baby Unit). If further recruitment is required, this will be expanded and no time limit since the experience will be stipulated. For mothers who have not spent time in a Mother-and-Baby Unit, no time limit since the experience will be stipulated. However, mothers who have been through the experience within the last 15 years will be prioritised if there are a large numbers of women interested in participating.

Place of residence:

Women and their significant others must live within the United Kingdom.

Potential participants who do not wish to participate with a significant other may still potentially be eligible to be interviewed. However, the researcher will prioritise dyads of participants. This will be made explicit within the participant information sheet.

Exclusion criteria:

Time since onset:

There will be no upper limit on length of time since the participant experienced puerperal psychosis. However, if large numbers of women express an interest in participating, those who have received a diagnosis within the last 15 years will be prioritised over women who experienced this over 15 years ago.

Participants will not be interviewed whilst they are staying within an inpatient Mother and Baby Unit.

Current level of mental distress: Women who are currently experiencing levels of mental distress which may mean that participation in an interview is unadvisable will be excluded from the study. This will be achieved through the following methods:

- Staff at mother-and-baby units will use their clinical judgement and liaise with care co-ordinators to evaluate on an individual basis whether it is appropriate for the woman to be invited to participate in research.
- Women who respond to advertisements will be asked to provide consent for the chief investigator to contact their GP and/or care co-ordinator before arranging an interview. The GP and/or care co-ordinator will be asked to provide their opinion as to whether this would be an appropriate time for the mother to participate in research.

The current study will aim to interview up to ten dyads. Small sample sizes are widely accepted within qualitative research and allow the researcher to conduct in-depth “analytic, inductive, exploratory studies” (Crouch, 2006). If more than ten potential dyads register their interest in this study a purposive sampling approach will be taken based on the demographic data collected. Those participants who have had experiences in line with a diagnosis of puerperal psychosis within the last 24 months will be prioritised, as will participants who have indicated that a significant other would also like to take part in the research. If the majority of respondents offer to participate with a particular significant other (e.g. partner or mother) women who have also indicated this significant other will be selected, in an effort to increase homogeneity. This is in accordance with the intended form of analysis (Interpretative Phenomenological Analysis). The possibility that an individual may not be selected for participation will be made explicit within the participant information sheet.

DESIGN

The current study will adopt semi-structured interviews as an exploratory, qualitative design. No hypotheses will be generated prior to the study to allow the data to lead the inductive formation of themes. However, the following research questions have been developed based on clinical experience and previous research:

- How do women and their significant others experience their relationships after living through the post-birth period during which the mother received a diagnosis of puerperal psychosis?
 - Do women and their significant others experience qualitative changes in their relationships?
 - Do women and their significant others believe that their relationships have an impact on their postnatal experiences?
- How do women and their significant others make sense of their experiences within the context of their relationships?

Interpretative phenomenological analysis (IPA) will be adopted to analyse the research data, which allows exploration of participants’ personal experiences and the meanings that they have attributed to these (Smith, 2004). IPA calls for the researcher to identify any assumptions and bracket these whilst interviewing and working with the data. To aid this process of research reflexivity, a reflective diary will be kept throughout each stage of the study.

MATERIALS

The following materials will be required for the current study:

- Initial letter to potential participants
 - Recruited from mother-and-baby units
 - Recruited from advertising materials
- Letter introducing research to GPs and/or care co-ordinators
- Opt-in form
- Sample of wording for adverts to be provided to Lancaster University Press Office and placed on internet forums, for example:
 - www.app-network.org

- www.puerperalpsychosis.org.uk
- Participant information sheet
- Consent form
- Interview schedule
- Debrief sheet detailing sources of additional support

PROCEDURE

Service User Involvement

Service user involvement was sought at various stages of the planning of this research. Service-users from a local service-user involvement group sat on the panel during a University research review to ask questions and provide feedback on the research. A woman who has experienced puerperal psychosis heard about the research by word of mouth. She offered to review the recruitment materials and protocol and provide feedback, particularly on the level of reader-friendliness of recruitment materials. Her feedback was incorporated into the present documents prior to ethical permission being sought.

Recruitment

Participants will be recruited using two methods. The first stage of recruitment will follow procedure one, as outlined below. If, after a period of one month, not enough participants have been recruited, the second recruitment procedure will be followed.

Recruitment procedure one

Participants will be recruited through Mother-and-Baby Units, identified as Participant Identification Centres (PIC). At each PIC, a member of the staff team will be designated to identify potential participants who fit the inclusion criteria. They will be asked to use their clinical judgement (or that of the client's care co-ordinator if they do not have clinical contact with the client) as to whether the potential participant would be safe to take part in the interview. An information sheet detailing the research process will be posted to the potential participants' home address, along with a covering letter. This will be undertaken by a named staff member or administrative staff. Included within this information will be the telephone number, postal address and email address of the chief investigator, which can be used to request further information. An opt-in slip and stamped addressed envelope will also be provided for both the mother and significant other, which potential participants can return to register their interest in the study.

Recruitment procedure two

Participants will also be recruited via online support groups, internet forums and websites. Some of these online recruitment sources are specific to puerperal psychosis whilst others provide support for mothers who have experienced a range of difficulties during the puerperal period. A message will be posted on forums and websites which outlines the research and asks people to contact the researcher for further information. This will be done after seeking consent from forum or website administrators. The researcher will also create a research profile on the website Facebook and post a message about the research on the pages of groups created for people affected by postnatal mental health difficulties. The profile will not contain any identifying details of the researcher other than those already provided to participants (name and university email address). Advertising materials will be publicised through the Lancaster University Press Office. Snowball

sampling will also be used, with potential participants asked to “spread the word” about the study and circulate the researcher’s details if they feel that this is appropriate. If the researcher is contacted by potential participants they will be screened according to the inclusion/exclusion criteria and, if appropriate, they will be provided with a participant information sheet and covering letter (either by post or email depending on their preference). They will then be asked to opt-in to the study if they are interested in doing so.

Participants who are recruited through this method will be asked to provide consent for the researcher to contact their GP or care co-ordinator, if they have one, during the initial telephone conversation. They will be informed that this is to think about whether now is the best time for them to participate in this research. Details of the care co-ordinator or GP will be stored electronically, subject to the same protections as other personal information. These details will be destroyed after data collection finishes. Care co-ordinators and GPs will be sent a letter which advises them that their client has agreed to take part in the study. The researcher will also contact the care co-ordinator or GP by telephone to discuss whether participating in the research will pose any risks for the potential participant or the researcher. If any risks are raised the researcher will contact the potential participant to advise them that their GP / care co-ordinator has raised concerns and discuss this with the participant. The final decision as to whether the participant may be interviewed will be taken by the chief investigator after liaison with both their field and research tutor at Lancaster University. If the potential participant does not give consent for their GP or care co-ordinator to be contacted, they will be unable to take part in the research.

Aspects common to both recruitment procedures

If, after receiving the information pack, women are interested in taking part in the study they will be asked to return an opt-in form or contact the researcher directly. The researcher will then contact them by telephone to answer any questions and arrange an initial date and time to conduct the interview. The fact that this research is to be conducted with both the mother and a significant other will be made explicit within the participant information sheet. The term ‘person important to you’ will be used within participant information as this allows the person to define who they feel was significant during this time period, rather than the researchers imposing their preconceptions. It is expected that this definition will recruit significant others who have some involvement in the life of the mother and child. This will be explored during the initial telephone conversation and the researcher will ask whether the participant has discussed the information sheet with a significant other. If they have not, the researcher will request that they do so and arrange a further opportunity to discuss the research after this time.

The interviews will take place either at the participant’s home address or in a local community building (e.g. children’s centre or GP practice). This will not be a Mother-and-Baby Unit, to protect the anonymity of participants. The location of the interview will depend on the preference of the participants and the availability of a community building in their local area. Participants will also be given the option of a telephone interview.

At the beginning of the interview, the researcher will discuss the information sheet with the participants and ensure that they have sufficient time to ask any questions. Participants will then be briefed and reminded that the interview will be recorded, at which point written informed consent will be gained from both the mother and their significant other. Interviews are anticipated to last approximately 60 minutes. Following the interview, participants will be debriefed and allowed time to ask any further questions. A debrief sheet will be provided which will signpost participants to appropriate support. Participants will also be asked whether they would like to receive a copy of

the final report. If so, they will be asked to provide consent for their home address to be recorded by the researcher so that the report can be posted to them.

After participants have consented to take part in the study, basic demographic details will be recorded, for example:

- Gender (of significant other)
- Age (of mother and significant other)
- Relationship between mother and significant other
- Approximate time elapsed since the onset of difficulties in the postnatal period
- Whether the mother was deemed to have experienced 'first-onset' psychosis, or whether these experiences were in the context of pre-existing emotional difficulties
- Whether the mother has had any further unusual experiences, labelled as psychosis
- Whether the mother has had previous and/or subsequent pregnancies / deliveries and if she experienced difficult emotions and experiences after these

To ensure informed consent, participants will be able to ask questions at any point during the study, and will be given information in both written and verbal form. They will be made aware that participation or non-participation in the study will not affect clinical care in any way, and they will be informed that they are able to withdraw from the study at any point, without providing a reason. However, after the data has been made anonymous and analysed it may not be possible for individual participants' data to be withdrawn, although every effort will be made to remove their data prior to publication. Participants will be required to complete a consent form. Participants will also be made aware that any safeguarding concerns, both in relation to their own or others' safety, will have to be discussed with the researcher's supervisors and acted upon accordingly.

Interviews will be digitally recorded and the resulting audio files will be stored on a password protected computer using TrueCrypt encryption software. Recordings will be destroyed following transcription and analysis, within 3 months of the interview taking place. During the transcription process any names or identifying information will be altered to ensure anonymity. Transcripts will be stored on a password protected computer using TrueCrypt encryption software. At the end of the study, electronic copies of transcripts and consent forms will be stored on an encrypted memory stick in a secure location at Lancaster University for 10 years.

Following analysis, the findings of the study will be disseminated in a variety of ways, including:

- A report to all participants (who have consented to receive this)
- A report to the Participant Identification Centres
- Submission for publication in a journal (appropriate journal to be decided at a later date)
- Presentation at a thesis presentation day, attended by clinical psychology trainees, staff members and members of the LUPIN service-user involvement group
- Submission to relevant conference(s) or CPD day(s)

ANALYSIS

This study aims to explore how participants understand their experience of difficulties in the postnatal period, which have been labelled as puerperal psychosis. In particular, the research team are interested in how this understanding is constructed within the relationships between the mother and her significant others, and whether these relationships have a role within the experience. Thus,

ETHICAL CONSIDERATIONS

Potential emotional distress to participants during or after the interview

- It is acknowledged that talking about experiences related to puerperal psychosis may bring up some difficult emotions for participants. The following points explore how this potential risk will be managed:
 - Whilst completing the consent form, participants will be asked to provide consent for the researcher to contact their GP or care co-ordinator. It will be explained that this contact will only be made if the researcher is concerned about the well-being of the participant or others. The researcher would discuss this with the participant before making contact.
 - As women will be participating with a significant other, it is likely that they will receive mutual support from each other both during and after the interview. However, significant others will also be asked to provide consent for their GP to be contacted in the event that they become significantly distressed during the interview.
 - During the briefing, the researcher will inform the participants that they can withdraw or take a break from the interview at any point. They will also offer a time to discuss any difficult feelings that the interview has brought up during the debriefing stage, and can signpost the participant to other services if this is felt necessary.

Confidentiality

- Each interview will be audio-recorded and the files stored on a password-protected computer using TrueCrypt encryption software. Each audio-recording will be transcribed by the chief investigator and the audio recording will then be destroyed. Some recordings may also be listened to by the chief investigator's field supervisor to provide feedback prior to transcription. Any personal information contained within the audio-recording will be made anonymous at the point of transcription.
- Electronic transcripts will be stored on a password-protected computer and will be identified by a participant code. This code will take the form of a pseudonym, which participants will be asked to generate during the consent procedure. This pseudonym will only be accepted if the researcher believes that it is suitably different from the participant's real name. Full transcripts will be seen by the chief investigator. They may also be seen in part by the academic and field supervisors, and other clinical psychology trainees (members of a small peer supervision group).
- Data containing identifying details of participants will be stored electronically on a password protected computer. These will be stored separately from the anonymous transcripts.

Lone working

- The researcher may carry out interviews at either the participant's home or a local community building.

- If participants opt for the interview to take place at home, the researcher must consult Lancashire Care NHS Foundation Trust's Procedure for the Risk Assessment of Lone Workers document and work in accordance with this. This includes designating a 'safe person' to contact before and after the visit.
- If participants opt for the interview to take place in a community building, the researcher must ensure that the room has been booked and is sufficiently sound-proofed to ensure confidentiality.

Mental capacity

- Mental capacity will be assumed by the act of giving consent to participate in the research, as suggested by the Department of Health's guidance for social scientists. However, the researcher will use their judgement to determine whether the individual has made a free decision and has been able to base this on the information provided.
- If the researcher judges that an individual may not have capacity to consent, this will be discussed with their supervisors and, if necessary, the individual will not be interviewed for the research.
- If an individual gives informed consent but then loses capacity to consent during the research, data already collected will be retained, but no further data will be collected.

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Appendix 4-B. Example wording of recruitment advert

Lancaster University

Doctoral Programme in Clinical Psychology



The role of relationships in puerperal psychosis (unusual experiences during the postpartum period)

- **Have you been given a diagnosis of puerperal psychosis?**
- **Would you be willing to talk about your relationships with important people in your life in relation to these experiences?**

I am a trainee clinical psychologist at Lancaster University and I am currently carrying out research into the experiences of women who have lived through a period of mental distress after childbirth, and their significant others. I want to learn about the role of relationships during and after this experience. I hope that my findings will help staff in Mother-and-Baby units to work with the families and friends of women and continue to improve the services that women receive.

I would like to talk to women who have experienced puerperal psychosis and someone important to them (you can choose who this is – perhaps it could be a partner, mother, sibling or friend?) Both of you would need to be 18 years old or over. If you fit the above criteria and are interested in sharing your experiences, please contact me to find out more.

Caroline Wyatt

Tel: 0785 251 6566

Email: c.wyatt@lancaster.ac.uk

Thanks!

Appendix 4-C. Letters to participants.***Letters to mothers – recruited through mother-and-baby unit***

Lancaster University

Doctoral Programme in Clinical Psychology



Hello

I am writing to invite you to be interviewed as part of a research study. My name is Caroline and I am a trainee clinical psychologist at Lancaster University. As part of my training I have chosen to research the experiences of women and their significant others, when the woman has had experiences after the birth of their baby which were diagnosed as puerperal psychosis. I am hoping to interview women who have received a diagnosis of puerperal psychosis alongside a significant other (who could be a friend, family member or partner).

I have asked a member of staff at [*insert name of mother-and-baby unit*] to send this information to any women who they believe may be interested in taking part in this study. I have enclosed a participant information sheet which explains the study in more detail. I would be grateful if you could read this to decide whether you are interested in taking part in the study. I have provided my contact details and I would be more than happy to answer any questions that you may have regarding this research. I have also provided an information sheet and covering letter which you can provide to somebody close to you, if you would like to invite them to take part with you.

If you are interested in taking part, please call me on 0785 251 6566 or return the opt-in slip in the stamped-addressed envelope provided. I will then contact you to discuss the information sheet, answer any questions and, if you are still interested, arrange a convenient time for an interview. Please be aware that, due to time constraints, only a limited number of interviews will take place.

If a significant other is not available to be interviewed with you, it may still be possible for you to take part. Please contact me either by telephone or by completing the opt-in slip and we can discuss this further.

If you are not interested or cannot take part for any other reason, this will not affect your care at [*Insert name of mother-and-baby unit*]. I would like to take this opportunity to thank you for reading about the study.

Yours sincerely,

Caroline Wyatt

Trainee clinical psychologist, Lancaster University

Enc. Participant information sheets / SAE / Opt-in slip

*To mothers – recruited online**Lancaster University**Doctoral Programme in Clinical Psychology*

Dear _____

I am writing to invite you to be interviewed as part of a research study. My name is Caroline and I am a trainee clinical psychologist at Lancaster University. As part of my training I have chosen to research the experiences of women and their significant others, when the woman has had experiences after the birth of their baby which were diagnosed as puerperal psychosis. I am hoping to interview women who have received a diagnosis of puerperal psychosis alongside a significant other (who could be a friend, family member or partner).

I am sending you this letter because you have seen information about this study online and have contacted me to request further information. Thank you very much for expressing an interest in the research at this stage. I have enclosed a participant information sheet which explains the study in more detail. I would be grateful if you could read this to decide whether you are interested in taking part in the study. My contact details are at the bottom of the information sheet, and I would be more than happy to answer any questions that you may have regarding this research. I have also provided an information sheet and covering letter which you can provide to somebody close to you, if you would like to invite them to take part with you.

If you are interested in taking part, please call me on 0785 251 6566 or return the opt-in slip in the stamped-addressed envelope provided. I will then contact you to discuss the information sheet, answer any questions and, if you are still interested, arrange a convenient time for an interview. Please be aware that, due to time constraints, only a limited number of interviews will take place.

If a significant other is not available to be interviewed with you, it may still be possible for you to take part. Please contact me either by telephone or by completing the opt-in slip and we can discuss this further.

If you are not interested or cannot take part for any other reason, please do not feel as though you need to get back in touch with me. I would like to take this opportunity to thank you for reading about the study.

Yours sincerely,

Caroline Wyatt

Trainee clinical psychologist, Lancaster University

Enc. Participant information sheet / SAE / Opt-in slip

*To significant others**Lancaster University**Doctoral Programme in Clinical Psychology*

Hello

I am writing to invite you to be interviewed as part of a research study. My name is Caroline and I am a trainee clinical psychologist at Lancaster University. As part of my training I have chosen to research the experiences of women and their significant others, when the woman has had experiences after the birth of their baby which were diagnosed as puerperal psychosis. I am hoping to interview women who have received a diagnosis of puerperal psychosis alongside a significant other (who could be a friend, family member or partner).

I have sent information about this study to somebody who you are close to, who has experienced puerperal psychosis. I have asked them to provide this letter and information sheet to somebody who they would like to be included in the interview. This is because they feel that you had a close relationship with them during the time at which they experienced puerperal psychosis.

The information sheet provided explains the study in more detail. I would be grateful if you could read this document and decide whether you are interested in taking part in the study. I have provided my contact details and I would be more than happy to answer any questions that you may have regarding this research.

If you are interested in taking part, please let the person who gave you this letter know, and they will in turn contact me. I will then contact this person to discuss the research and arrange an interview which is convenient for both of you. Please be aware that, due to time constraints, only a limited number of interviews will take place.

If you are not interested or cannot take part for any other reason, this will not have any impact on the care which the person who gave you this information receives. I would like to take this opportunity to thank you for reading about the study.

Yours sincerely,

Caroline Wyatt

Trainee clinical psychologist, Lancaster University

Enc. Participant information sheets

Appendix 4-D. Letter to GP

Lancaster University

Doctoral Programme in Clinical Psychology



Dear (GP)

RE: **patient name & address**

I am writing to inform you that one of your patients, (name), has expressed an interest in being interviewed as part of a research study. The title of the research is:

‘The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships’

Each participant will be interviewed, together with a significant other, either in their own home or at a community building. The definition of ‘significant other’ has been left open so that participants can choose who they would like to be interviewed with. The interviews will focus on the role of relationships within their experiences of puerperal psychosis.

[This section will be inserted if the participant has been recruited online]

_____ heard about this research through an online forum. I would therefore find it very helpful to speak to you before I include them within my research, to discuss whether now is an appropriate time for them to take part, in your opinion. I hope to ring you within the next few days to discuss this, if this is convenient.

If you have any questions about the research, please feel free to contact me on 0785 251 6566.

Yours sincerely

Caroline Wyatt

Trainee clinical psychologist

Lancaster University

Appendix 4-E. Participant information sheets***For mothers***

Lancaster University

Doctoral Programme in Clinical Psychology

**Participant Information Sheet**

The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships

Thank you for taking the time to look at this information sheet, which I have sent to you because I would like to invite you to take part in my study. Before you decide, I will explain why I am doing the research and what your involvement would be. If you are interested in finding out more, I will be happy to telephone you to discuss the information sheet and answer any questions that you may have. Please feel free to discuss the study with others if you wish.

The information sheet is divided into two sections:

- Part one tells you about the purpose of the study and explains what you will be asked to do, if you wish to take part
- Part two tells you more detailed information about how the study will be carried out.

I will use the term puerperal psychosis throughout this information sheet, although I am aware that some of you may think of this in other ways (for example postnatal psychosis).

PART ONE**What is the purpose of the study?**

This study aims to explore the experience of women who have experienced mental distress after the birth of their baby and have received a diagnosis of puerperal psychosis, and people important to them. We are particularly interested in the role of relationships during and after this time. It is hoped that the study will allow services to understand what it is like for the mother experiencing puerperal psychosis, as well as her family and friends. This is important because services often involve family and friends in supporting mothers, particularly after discharge from a mother-and-baby unit. This research is being undertaken as part completion of the lead researcher's Doctorate in Clinical Psychology.

Why have I been invited to take part?

You have been invited to take part because you have experienced emotional distress after the birth of your baby which was diagnosed as an episode of puerperal psychosis. This information sheet has been sent to you either because medical staff at the mother-and-baby

unit where you stayed thought you may be interested or because you have got in touch in response to an advert. I am hoping to interview up to ten pairs of people (a mother and someone close to her) for this study.

Do I have to take part?

No – taking part in the study is entirely voluntary, and if you do not want to be involved, this will not affect your care in any way. If you are interested in taking part, you will be asked to complete a consent form before participating, a copy of which you will keep. If you wish to withdraw your consent at any point, you are free to do so without giving a reason.

What will happen to me if I take part?

If you agree to take part in the study, I will contact you to discuss the information on this sheet. I will try to answer any questions that you may have and will then arrange a convenient time to interview you. This interview would be with both you and somebody close to you, who also wishes to take part in the research. The interview is likely to last for about an hour. It can take place either in your own home or at a local NHS building, depending on your preference. The interview would be audio-recorded and later typed up in full. If you are currently receiving medical or psychological care, this will not need to be altered in any way.

Expenses and payments

You will be reimbursed for any travel expenses up to £10. As I plan to interview you either at your home, in a local community building, I hope to reimburse all of your expenses. Travel expenses will be at public transport rates or 25 pence per mile if travelling by car. Any parking costs will also be reimbursed.

What will the interview involve?

During the interview you will be asked questions related to your experiences of the postnatal period, during which time you were given a diagnosis of puerperal psychosis. The questions will mostly focus on the role which you feel your relationships with significant others played during this time. For example, I may ask about whether these have been affected by the experience. You will not be expected to answer any questions that you do not wish to.

What are the possible risks of taking part?

Whilst we do not anticipate that you will experience any distress, you will be aware that speaking about your experiences of puerperal psychosis can be an emotional process. You will be encouraged to take a break whenever necessary during the interview, and you can decide to stop the interview at any point. When the interview finishes, you will be given a list of resources which you can access, should you feel that this is necessary. I will also provide time at the end of the interview to discuss any concerns.

What are the possible benefits of taking part?

Although this study does not intend to provide any specific benefits to individuals taking part, it is hoped that the information we gain could help improve awareness of puerperal psychosis and a wider understanding of the impact of this experience on mothers and those close to them.

What if there is a problem?

If you experience any problems due to taking part in the study, I would be happy to discuss these with you. However, contact details for other people involved in the research are available in Section two, and they can also help with any problems or complaints.

Will my participation in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details of these procedures are available in Part Two.

Thank you for reading this far. If you are still interested in taking part in the study, please continue to read Part Two.

PART TWO

What will happen if I don't want to carry on with the study?

You are able to withdraw from the study at any point and you will not be expected to provide a reason. You can contact the lead researcher to discuss withdrawing from the study, at which point any data and personal information relating to you will be destroyed. If your data has already been made anonymous and analysed, it may not be possible for this to be withdrawn. However, the researcher will discuss any concerns with you and will make every effort to withdraw your data

Will my taking part in the study be kept confidential?

Yes. All information about your participation in this study will be kept in accordance with the Data Protection Act (1998).

- Your interview will be audio-recorded and I will later type this up, with all identifying information removed. The audio-recording may be listened to by my clinical research tutor.
- Transcripts (typed copies of your interview) will be kept electronically on a password protected and encrypted computer.
- Your anonymised transcript will be seen by members of the research team, employed by Lancaster University.
- Once the research is completed (this is anticipated to be by May 2014), electronic copies of the transcript will be stored securely on the university network until the point of secure disposal.
- If, during the interview, I am concerned that you or somebody else is at risk of harm, I will have to break confidentiality to inform my supervisors and seek advice. However, I would discuss this fully with you at the time.

What will happen to the results of the research study?

As the study is part of my doctoral course in Clinical Psychology, it will be submitted to the University for marking. I also hope to publish the findings of this study in a relevant journal and perhaps present this at a conference. A brief report of the findings will be sent to interested participants. Participants will not be identified within any of these publications, but anonymous quotes will be included, if you provide your consent for this.

Who is organising and funding the research?

I have organised the research as part of my studies, alongside staff at Lancaster University. Expenses are covered by Lancaster University.

Who has reviewed the study?

All research in the NHS is looked at by a group of people, called a Research Ethics Committee (REC). This study has been reviewed and approved by the [REDACTED] Research

and Ethics Committee. It has also been approved by various NHS Foundation Trust Research and Development Committees.

What if there is a problem?

If you have a concern about any aspect of this study, I am happy to discuss this with you and do my best to answer your questions (my contact details are provided at the end of this information sheet). If you remain unhappy and wish to complain formally, you can do so by contacting:

Professor Susan Cartwright (Head of the Division of Health Research)

Email: s.cartwright@lancaster.ac.uk Tel: 01524 592430

Lancaster University, Lancaster

LA1 4YT

Contact details

For further information about the following areas, please consult below:

- General information about research – www.nimh.nih.gov – search for ‘participants’ guide to clinical research’
- Specific information about this study:

Caroline Wyatt (trainee psychologist)

Email: c.wyatt@lancaster.ac.uk

Post: Doctorate in Clinical Psychology

C12 Furness College

Lancaster University

LA1 4YG

Tel: 0785 251 6566 or 01524 492730

Dr. Jenny Davies (clinical research supervisor)

Email: j.davies1@lancaster.ac.uk

Post: Doctorate in Clinical Psychology

C12 Furness College

Lancaster University

LA1 4YG

Dr Craig Murray (academic supervisor)

Email: c.murray@lancaster.ac.uk

Post: Doctorate in Clinical Psychology

C12 Furness College

Lancaster University

LA1 4YG

Tel: 01524 492730

Tel: 01524 492730

Thank you for taking the time to read this information sheet.

For significant others

Lancaster University

Doctoral Programme in Clinical Psychology



Participant Information Sheet

The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships

Thank you for taking the time to look at this information sheet, which I have sent to you because I would like to invite you to take part in my study. Before you decide, I will explain why I am doing the research and what your involvement would be. If you are interested in finding out more, I will be happy to telephone you to discuss the information sheet and answer any questions that you may have. Please feel free to discuss the study with others if you wish.

The information sheet is divided into two sections:

- Part one tells you about the purpose of the study and explains what you will be asked to do, if you wish to take part.
- Part two tells you more detailed information about how the study will be carried out.

I will use the term puerperal psychosis throughout this information sheet, although I am aware that some of you may think of this in other ways (for example postnatal psychosis).

PART ONE

What is the purpose of the study?

This study aims to explore the experience of women who have experienced mental distress after the birth of their baby and have received a diagnosis of puerperal psychosis, and people important to them. We are particularly interested in the role of relationships during and after this time. It is hoped that the study will allow services to understand what it is like for the family and friends of women who experience puerperal psychosis, as well as the mother herself. This is important because services often involve family and friends in supporting mothers, particularly after discharge from a mother-and-baby unit. This research is being undertaken as part completion of the lead researcher's Doctorate in Clinical Psychology.

Why have I been invited to take part?

You have been invited to take part because somebody you are close to experienced emotional distress after the birth of their baby and received a diagnosis of puerperal psychosis (I will refer to this person as 'the mother' throughout this information sheet'. I have invited them to take part in this study and asked them to select a person important to them to be interviewed

alongside them. I am hoping to interview up to ten pairs of people (a mother and someone close to her) for this study.

Do I have to take part?

No – taking part in the study is entirely voluntary, and if you do not want to be involved, this will not affect the care of the person who has asked you to be involved in the study with them. If you are interested in taking part, you will be asked to complete a consent form before participating, a copy of which you will keep. If you wish to withdraw your consent at any point, you are free to do so without giving a reason.

What will happen to me if I take part?

If you agree to take part in the study, please ask the mother that you will be participating with to put your name on the opt-in slip which she will return to me, or to tell me your name when she speaks to me. I would be happy to contact you to discuss the information on this sheet further, if you would find this helpful. I would then arrange a time to interview you and the mother who has experienced puerperal psychosis. The interview is likely to last for about an hour. It can take place either in the mother's home or at a local NHS building, depending on your preference. The interview would be audio-recorded and later typed up in full.

Expenses and payments

You will be reimbursed for any travel expenses up to £10, which I hope will cover all of your travel expenses. Travel expenses will be at public transport rates or 25 pence per mile if travelling by car. Any parking costs will also be reimbursed.

What will the interview involve?

During the interview you will be asked questions related to your experiences of the postnatal period, during which time the mother received a diagnosis of puerperal psychosis. The questions will mostly focus on the role which you feel your relationship with the mother played during this time. For example, I may ask about whether these have been affected by the experience. You will not be expected to answer any questions that you do not wish to.

What are the possible risks of taking part?

Whilst we do not anticipate that you will experience any distress, you will be aware that speaking about your experiences of a loved-one experiencing puerperal psychosis can be an emotional process. You will be encouraged to take a break whenever necessary during the interview, and you can decide to stop the interview at any point. When the interview finishes, you will be given a list of resources which you can access, should you feel that this is necessary. I will also provide time at the end of the interview to discuss any concerns.

What are the possible benefits of taking part?

Although this study does not intend to provide any specific benefits to individuals taking part, it is hoped that the information we gain could help improve awareness of puerperal psychosis and a wider understanding of the impact of this experience on mothers and those close to them.

What if there is a problem?

If you experience any problems due to taking part in the study, I would be happy to discuss these with you. However, contact details for other people involved in the research are available in Section Two, and they can also help with any problems or complaints.

Will my participation in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details of these procedures are available in Part Two.

Thank you for reading this far. If you are still interested in taking part in the study, please continue to read Part Two.

PART TWO

What will happen if I don't want to carry on with the study?

You are able to withdraw from the study at any point and you will not be expected to provide a reason. You can contact the lead researcher to discuss withdrawing from the study, at which point any data and personal information relating to you will be destroyed. If your data has already been made anonymous and analysed, it may not be possible for this to be withdrawn. However, the researcher will discuss any concerns with you and will make every effort to withdraw your data.

Will my taking part in the study be kept confidential?

Yes. All information about your participation in this study will be kept in accordance with the Data Protection Act (1998).

- Your interview will be audio-recorded and I will later type this up, with all identifying information removed. The audio recording may be listened to by my clinical research tutor.
- Transcripts (typed copies of your interview) will be kept electronically on a password protected and encrypted computer.
- Your anonymised transcript will be seen by members of the research team, employed by Lancaster University.
- Once the research is completed (this is anticipated to be by May 2014), electronic copies of the transcript will be stored securely on the university network until the point of secure disposal.
- If, during the interview, I am concerned that you or somebody else is at risk of harm, I will have to break confidentiality to inform my supervisors and seek advice. However, I would discuss this fully with you at the time.

What will happen to the results of the research study?

As the study is part of my doctoral course in Clinical Psychology, it will be submitted to the University for marking. I also hope to publish the findings of this study in a relevant journal and perhaps present this at a conference. A brief report of the findings will be sent to interested participants. Participants will not be identified within any of these publications, but anonymous quotes will be included, if you provide your consent for this.

Who is organising and funding the research?

I have organised the research as part of my studies, alongside staff at Lancaster University. Expenses are covered by Lancaster University.

Who has reviewed the study?

All research in the NHS is looked at by a group of people, called a Research Ethics Committee (REC). This study has been reviewed and approved by the [REDACTED]

Research and Ethics Committee. It has also been approved by various NHS Foundation Trust Research and Development Committees.

What if there is a problem?

If you have a concern about any aspect of this study, I am happy to discuss this with you and do my best to answer your questions (my contact details are provided at the end of this information sheet). If you remain unhappy and wish to complain formally, you can do so by contacting:

Professor Susan Cartwright (Head of the Division of Health Research)

Email: s.cartwright@lancaster.ac.uk Tel: 01524 592430

Lancaster University, Lancaster

LA1 4YT

Contact details

For further information about the following areas, please consult below:

- General information about research – www.nimh.nih.gov – search for ‘participants guide to clinical research’
- Specific information about this study:

Caroline Wyatt (trainee psychologist)

Email: c.wyatt@lancaster.ac.uk

Post: Doctorate in Clinical Psychology

C12 Furness College

Lancaster University

LA1 4YG

Tel: 0785 251 6566 or 01524 492730

Dr. Jenny Davies (clinical research supervisor)

Email: j.davies1@lancaster.ac.uk

Post: Doctorate in Clinical Psychology

C12 Furness College

Lancaster University

LA1 4YG

Dr Craig Murray (academic supervisor)

Email: c.murray@lancaster.ac.uk

Post: Doctorate in Clinical Psychology

C12 Furness College

Lancaster University

LA1 4YG

Tel: 01524 492730

Tel: 01524 492730

Thank you for taking the time to read this information sheet.

Appendix 4-F. Opt-in form**OPT-IN**

I would like to register my interest in taking part in your research study.

Name:

Name of significant other (if applicable):

Relationship to significant other:

CONTACT DETAILS (PLEASE TICK TO INDICATE YOUR PREFERENCE)☐

Email:

☐

Home address *(Please provide the name of the county you live in if you would rather not provide your whole address):*

☐

Home Phone:

☐

Mobile:

When would be the most convenient time to contact you?

Thank you for registering your interest in this study – I will contact you as soon as possible.

Appendix 4-G. Consent form*Lancaster University**Doctoral Programme in Clinical Psychology***Consent Form**

Title of project: The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships

Name of researcher: Caroline Wyatt

Please initial boxes

1. I confirm that I have read and understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.
2. I understand that participation is voluntary and that I am free to withdraw before, during, or after my interview.
3. I understand that transcripts of my interview may be seen by staff at Lancaster University. The audio-recording may also be heard by the clinical research supervisor. I give permission for these individuals to access these records.
4. I agree for my interview to be audiotaped, and transcriptions to be kept by Lancaster University for 10 years after the study has finished.
5. I consent to anonymised quotations from my interview being used in reports, publications and conferences.
6. I consent to provide my GP contact details and am aware that they may be contacted should the researcher be concerned about mine, or others, wellbeing
7. I agree to take part in the above study.
8. I would like to receive a copy of the final report, and have agreed to provide my contact details for this purpose.

☐☐☐☐☐☐☐☐_____
Name of participant_____
Date_____
Signature_____
Researcher taking consent_____
Date_____
Signature

Appendix 4-H. Semi-structured interview schedule

Interview Schedule

The following semi-structured interview schedule has been developed to provide a flexible structure for the interviews. Participants will be encouraged to discuss any topics that they feel are pertinent to the research question even if these are not explicitly focused on within this schedule.

The schedule outlines particular areas of interest and suggests example questions which may be asked, although these will be refined in collaboration with the research team and during the interviews themselves. The schedule will be reviewed after the first interview to ensure that it is eliciting information of importance to the research questions.

Significant others will be encouraged to give their opinion on each question.

Introduction

Introduction of the research and the researcher to the participant

Discussion of the participant information sheet

Time for any queries to be answered

Consent processes

Background Information

This section provides the researcher with an understanding of the participants' life situation and aids in the development of a rapport between participants and researcher. The questions will be directed both at the mother and significant other.

- Can you tell me a bit about yourself and the person you have brought with you today?
- Can you tell me a bit about you and your family?

Experience of postnatal distress

This section is aimed at briefly exploring the experiences of both the mother and significant other during the postnatal period.

- Can you tell me a bit about your experience of pregnancy?
- Can you tell me about your experience of the birth?
- Can you tell me about what it was like after the baby was born?
- What was it like to spend time in a mother-and-baby unit? [prompt significant other with 'what was that like for you?' if they do not discuss this]

Relationships

This section aims to gain an understanding of how participants experienced their relationships at the time and now.

- How would you describe your relationship with each other during the postnatal period?
- Was this a change from before the postnatal period?
- Do you think your relationships changed in any way during your experiences, or did they stay the same?
 - Can you tell me more about that?
 - Why do you think they (changed / haven't changed depending on their answer)
- Have any of your other relationships changed since the postnatal period or have these stayed the same?
 - Can you tell me more about that?
 - Why do you think they (changed / haven't changed depending on their answer)
- Do you think your relationship with each other affected your experiences of the postnatal period?
 - If yes – 'how do you think they affected it?'
- Do you think that your relationship with each other affect your experience of being in a mother-and-baby unit?
 - If yes – 'how do you think they affected your experience?'
- Can you tell me about your relationship with [name of child]?
- Do you think your experiences affected your relationship with [child] or not?
 - If yes – 'how do to think they affected it?' If no 'what do you think helped you to not let these experiences affect your relationship?'
- Do you think your relationship with [child] affected your experience or not?
 - Can you tell me a bit more about that?
- Is there anything else about relationships and this time around the pregnancy, birth and afterwards that you would like to tell me about?

Debrief

Thank participants

Time for questions / queries

Provide debrief sheet

Appendix 4-I. Debrief sheet

Lancaster University

Doctoral Programme in Clinical Psychology

**Debrief Sheet**

The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships

Thank you for taking the time to participate in the above research. Your generosity and willingness to be interviewed is greatly appreciated by all of the research team.

The purpose of this study was to explore the personal experiences of people who had experienced puerperal psychosis, along with somebody close to them. I am aware that this can be a difficult topic to talk about and I hope that you have felt that we had enough time at the end of the interview to discuss any feelings that this may have brought up for you. If you would like to talk to somebody further about how you are feeling, please contact your GP. For an independent source of support, please consider calling the Samaritans on 08457 90 90 90. I have also listed some online support communities that may be of some help:

www.app-network.org

www.puerperalpsychosis.org.uk

If you have any concerns or questions about this research, please do not hesitate to contact me on 0785 251 6566. Please remember that you are free to withdraw your information from this research at any point until I have submitted it as part of my thesis. This may be more difficult after your data has been made anonymous, but if you contact me about this I will discuss our options with you and do my best to find a solution.

Thank you for taking part!

Caroline Wyatt

Trainee clinical psychologist

Appendix 4-J : REC provisional opinion letter

Telephone: [REDACTED]
Facsimile: [REDACTED]

12 September 2013

Miss C Wyatt
Trainee Clinical Psychologist
Lancashire Care NHS Foundation Trust
C12 Furness College
Lancaster University
Lancaster
LA1 4YG

Dear Miss Wyatt

Study Title: The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships

The Research Ethics Committee reviewed the above application at the meeting held on 09 September 2013. Thank you for attending to discuss the application.

Documents reviewed

The documents reviewed at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Advertisement	1	12 August 2013
Covering Letter		14 August 2013
Evidence of insurance or indemnity		13 August 2013
GP/Consultant Information Sheets	1	12 August 2013
Interview Schedules/Topic Guides	1	12 August 2013
Investigator CV	Caroline Wyatt	12 August 2013
Letter from Sponsor		13 August 2013
Other: Summary CV for supervisor	Dr Craig Murray	08 August 2013

A Research Ethics Committee established by the Health Research Authority

Other: Letter of invitation to participant (recruited through mother-and-baby unit)	1	12 August 2013
Other: Letter of invitation to participant (recruited through advertisement)	1	12 August 2013
Other: Opt-in form to register interest in participating	1	12 August 2013
Other: Debrief sheet	1	12 August 2013
Participant Consent Form	1	12 August 2013
Participant Information Sheet	1	12 August 2013
Protocol	1	12 August 2013
REC application	131222	16 August 2013

After the Committee's initial discussions, you were invited to join the meeting to clarify the following issues:-

1. Reference was made to the sample size of 10 and members considered the method of IPA to be a very detailed thematic analysis which is considered to work well with a homogenous sample. The REC asked if it was found that the sample is less homogenous than expected would there be a concern on whether the sample size would be big enough.

You considered this to be a valid point and recognised that some of the variants make it questionable whether you would be able to do IPA. You added that you have been told that thematic analysis can be undertaken on that number.

The Committee considered that it would be beneficial to be aware and increase if necessary.

You replied that you would be happy within the time limits to increase the sample size should this prove necessary.

2. Members asked what strategy would be used for recruiting.

You stated that five mother and baby units or other perinatal services have offered to help you to recruit which are nationwide. You had also considered recruiting on-line.

The Committee asked whether you are able to travel to meet people.

You confirmed that the University will fund any mileage further than from your home to base.

3. The REC made reference to the telephone interviews in that there may be a need to have a three-way conversation.

You replied that in previous research people have said they would prefer to speak over the telephone, but accepted that it could be difficult.

Members were of the opinion that if there is no protocol for this, it may be better not to offer in the first place. The practicalities of a three-way telephone call for this purpose

would be difficult. If it was decided to speak to people over the telephone the committee would need to know how this would be facilitated and how the potential upset for participants would be dealt with.

The Committee asked whether you had any questions, to which you replied no and left the meeting.

Provisional opinion

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

Authority to consider your response and to confirm the Committee's final opinion has been delegated to the Chair.

Further information or clarification required

1. Information Sheet

- (i) The information should be proof-read for typographical and grammatical errors.
- (ii) The area telephone code for Lancaster should be amended.
- (iii) The information should include that this study is being undertaken as part of a PhD.

2. Consent Form

- (i) Point 5 should refer to anonymised quotations.
- 3. An information sheet and letter of invitation is required for the partner.
- 4. The GP letter should be amended, first line patient's should read patients.

If you would find it helpful to discuss any of the matters raised above or seek further clarification from a member of the Committee, you are welcome to contact [REDACTED], telephone number [REDACTED].

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 12 October 2013.

Membership of the Committee

A Research Ethics Committee established by the Health Research Authority

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

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

13/NW/0625	Please quote this number on all correspondence
------------	--

Yours sincerely



Signed on behalf of



Chair

Email: 

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to: Debbie Knight, Lancaster University

Appendix 4-K : Response to REC provisional opinion

Lancaster University
Doctoral Programme in Clinical Psychology



16th September 2013

Dear [REDACTED]

Thank you for informing me of the provisional opinion of the NRES Committee [REDACTED]. It was a pleasure to meet you all during the meeting and to receive your constructive and valuable feedback. Please find below a response to each of the points that required further clarification or amendments. Any amendments which I have made are highlighted within the appropriate document (please find attached).

1. Information Sheet (version 2)

- i. I have proof-read the information and corrected several errors.
- ii. I have amended the telephone code for Lancaster.
- iii. I had included a line which informed participants that the write-up of the research would be submitted as part of my Doctorate in Clinical Psychology. I have reworded this slightly so that it is more explicit that the study is being undertaken as part of this Doctorate.

2. Consent Form (version 2)

- i. I have amended point 5 to refer to anonymised quotations

3. Information Sheet and Letter of Invitation for significant other

- i. I have used the original Information Sheet (v.2) as a basis for an Information Sheet to be provided to significant others. I have highlighted within this where this document differs from the Information Sheet for mothers.
- ii. I have written a letter of invitation to significant others.

- iii. I have also amended the letter of invitation to mothers. It now includes a line which informs mothers that I have included a letter and information sheet for them to give to their significant others. This addition is highlighted within the Letter to Participants – from MBUS (v.2) and Letter to Participants – from advertisement (v.2).

4. GP letter

- i. I have corrected the grammatical error within this letter.

5. Telephone interviews

- i. I appreciate the inquiry related to the use of telephone interviews, as I think that this was something which did require further consideration. I have consulted my supervisors and have also done some further reading around this to inform my thinking. I would like to raise the following points:
 - i. It has been recognised in the literature that telephone interviews can be useful in mental health research, where the participant may wish to remain as anonymous as possible. It has also been suggested that telephone interviews can feel less emotionally intense or intrusive.
 - ii. On a practical level, I believe that it would be possible for participants to meet at a determined time and place, and then take part in the interview via the loudspeaker function available on the majority of mobile phones and landlines.
- ii. In relation to the safety protocol, I do not believe that this would be largely different for phone interviews than for face-to-face interviews:
 - i. At the beginning of the conversation, I would read out the consent form and request that both participants verbally consent to each aspect of this. I would also offer to send them a copy of the consent form.
 - ii. I would emphasise at the beginning of the interview that participants can take a break as and when needed, and we could agree a way in which participants could communicate that they require a break from the interview.
 - iii. If any issues of concern are raised, the protocol developed in relation to face-to-face interviews would be followed i.e. I would discuss this with participants, before contacting their GP.
- iii. Bearing the above in mind, I would appreciate it if you would consider whether conducting phone interviews would be ethically viable. I wonder whether this could be something that I do not advertise within the Participant Information, but which I could offer to participants as a 'last resort'. For example, if a

participant is very keen to participate but we cannot find a mutually convenient time for me to visit for an interview; or if weather disrupts travel plans and the interview would otherwise need to be cancelled at the last minute. I envisage that the option of a telephone interview would be helpful in both of these situations, but perhaps could be kept as a 'back-up' plan, rather than as an initial suggestion.

I hope that I have addressed all of your queries sufficiently. Please let me know if you require any further information. I look forward to hearing from you.

Yours sincerely



Caroline Wyatt

Trainee clinical psychologist, Lancaster University

Enclosures: Participant Information Sheet (v.2)
Consent Form (v.2)
Participant Information Sheet for significant others (v.1)
Letters of invitation

- From MBUs (v.2)
- From advertisement (v.2)
- To significant others (v.1)

GP letter

Appendix 4-L: REC approval letter

Telephone: [REDACTED]
Facsimile: [REDACTED]

23 September 2013

Miss C Wyatt
Trainee Clinical Psychologist
Lancashire Care NHS Foundation Trust
C12 Furness College
Lancaster University
Lancaster
LA1 4YG

Dear Miss Wyatt

Study title: The experience of women who have received a diagnosis
of puerperal psychosis and their significant others:
Exploring the role of relationships

[REDACTED]
[REDACTED]

Thank you for your letter of 16 September 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

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

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager [REDACTED], via [REDACTED]

Confirmation of ethical opinion

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

Ethical review of research sites

NHS sites

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

Non-NHS sites

Conditions of the favourable opinion

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

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

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

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

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

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

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

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

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Advertisement	1	12 August 2013
Covering Letter		14 August 2013
Evidence of insurance or indemnity		13 August 2013
GP/Consultant Information Sheets	2	16 September 2013
Interview Schedules/Topic Guides	1	12 August 2013

Investigator CV	Caroline Wyatt	12 August 2013
Letter from Sponsor		13 August 2013
Other: Summary CV for supervisor	Dr Craig Murray	08 August 2013
Other: Letter of invitation to participant (recruited through mother-and-baby unit)	1	12 August 2013
Other: Letter of invitation to participant (recruited through advertisement)	1	12 August 2013
Other: Opt-in form to register interest in participating	1	12 August 2013
Other: Debrief sheet	1	12 August 2013
Other: Information Sheet and letter of invitation to significant other	1	16 September 2013
Participant Consent Form	2	16 September 2013
Participant Information Sheet	1	12 August 2013
Participant Information Sheet	2	16 September 2013
Protocol	1	12 August 2013
REC application	131222	16 August 2013
Response to Request for Further Information	Cover letter	16 September 2013

Statement of compliance

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

After ethical review

Reporting requirements

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

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

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

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/NW/0625**Please quote this number on all correspondence**

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

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

Yours sincerely



Signed on behalf of

[Redacted]

Chair

Email: [Redacted]

Enclosures: "After ethical review – guidance for researchers"

Copy to: Ms D Knight - Lancaster University

Appendix 4-M. R&D approval letters***Trust A***

[REDACTED]

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
Tel: (External) [REDACTED]
(Internal) [REDACTED]
Fax: [REDACTED]

09/10/13

[REDACTED]

Caroline Wyatt
Trainee Clinical Psychologist
Lancaster University
Lancaster
LA1 4YG

Dear Caroline

Re: The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships

I write to confirm that [REDACTED] are happy to support and approve the above study. Please accept this letter as verification of Trust approval.

Approval is granted with the condition that the R&D Department are notified of:

- Commencement and completion of the study
- Any significant changes to the study design
- Suspension or abandonment of the study
- Copy of annual REC report and end of project REC report
- All publications and/or conference presentation of the study findings

The Department of Health's minimum standards for research governance state that at least 10% of projects should be routinely audited. It is a condition of our approval that the researchers accept the Trust's right to include this project in the auditing and monitoring process.

Best wishes

Yours sincerely

A black rectangular box redacting the signature of the sender.A black rectangular box redacting the name of the sender.

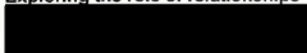

Senior Manager for Research, Innovation and Clinical Effectiveness


Trust B

14 October 2013

Miss Caroline Wyatt
 C12 Furness College
 Lancaster University
 Lancaster
 LA1 4YG


Dear Miss Caroline Wyatt

Study Title: The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships 		
This NHS PIC Permission is based on the REC favourable opinion given on 23 September 2013 . The potential participants will be referred to the PI/LC stated below who is based in Lancaster University.		
Name of the trust	Name of current PI/LC at research site	Date of permission issue(d)
	Miss Caroline Wyatt	14 October 2013
If any information on this document is altered after the date of issue, this document will be deemed INVALID		

Specific Conditions of Permission (if applicable) To recruit patients only from: 
If any information on this document is altered after the date of issue, this document will be deemed INVALID

I am pleased to confirm that any site within **the trusts identified above** can act as a PIC for the above study subject to the following conditions:

- Any site within **the trusts identified above** that is acting as a PIC **MUST** indicate their willingness to participate by completing the second page of this letter and returning it to our office.
- Please note that it is the responsibility of the Chief Investigator/Principal Investigator for the research study to ensure that this PIC agreement confirmation slip is completed for each participating PIC site and returned to the R&D office. Audits will be conducted on randomly selected PIC sites to ensure this requirement of R&D approval is adhered to.
- The role of the relevant sites will be restricted to identifying potential patients. No research procedures will be conducted in these PICs and these sites **will not** take on the duty of care for patients in relation to the research study; this responsibility will be retained by the external research site.

- 
- The ethically approved details and relevant guidelines, including data protection, are adhered to.
 - The Trust accepts no responsibility, and provides no indemnity, for any patient-related research procedures, including recruitment and informed consent. Please ensure that all members of the research team are aware of their responsibilities as researchers. For more details on these responsibilities, please check the NoCLoR website: <http://www.noclor.nhs.uk>.

We would like to wish you every success with your project.

Yours sincerely,



Research Management & Governance Manager

Cc: Debbie Knight, Research Ethics Officer, Lancaster University (Sponsor Contact)

Trust C

Wednesday, 16 October 2013

Miss Caroline Wyatt
Trainee Clinical Psychologist
C12 Furness College
Lancaster University
Lancaster
LA1 4YG

Dear Miss Caroline Wyatt

Re:

The experience of women who have received a diagnosis of puerperal psychosis and their significant others: Exploring the role of relationships

I am please to notify you formally that NHS permission for research has been granted for this study by

Date of commencement of NHS permission for research: 16.10.2013

Permission has been granted for you to approach relevant and named clinicians for the purposes of recruiting subjects to the named study. Permission is not given for you to conduct research at any

-

NHS permission for the above research has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

DOCUMENT TITLE	Version	Date
Confirmation of Indemnity		17/07/2013
Confirmation of Sponsorship		13/08/2013
Ethics Approval		23/09/2013
Protocol	1	12/08/2013
Participant Information Sheet	2	16/09/2013
Letter to – Significant Other	1	16/09/2013
Participant Consent Form	2	16/09/2013
Letter of Invitation to participant (Mother and baby unit)	1	12/08/2013
Letter of Invitation to participant (Advertisement)	1	12/08/2013
Opt-in form to register interest in participating	1	12/08/2013
Debrief Sheet	1	12/08/2013
GP/Consultant Information Sheets	2	16/09/2013
Advertisement	1	12/08/2013
CV – Caroline Wyatt (CI)		12/08/2013
CV – Dr Craig Murray (Academic Supervisor)		08/08/2013

Indemnity for this study is provided by Lancaster University.

_____ conducts all research in accordance with the requirements of the Research Governance Framework, and the NHS Intellectual Property Guidance. In undertaking this study you agree to comply with all reporting requirements, systems and duties of action put in place by the trust to deliver research governance, and you must comply with the Trust information management and data protection policies. In addition, you agree to accept the responsibilities associated with your role that are outlined within the Research Governance Framework as follows:

- That satisfactory honorary contracts/letters of access are obtained and copied to _____ Research Governance team prior to the commencement of any research activity (including those required by new researchers joining the study post-approval).
- The study follows the agreed protocol
- All amendments (including changes to the local research team) need to be submitted in accordance with guidance in IRAS.
- All changes in the status of the project should be reported to the _____ Research Governance team.
- That the PI co-operates with appropriate monitoring activity carried out by the _____ Research Governance team.
- Participants should receive appropriate care while involved in the study
- The integrity and confidentiality of clinical, other records and data generated by the study will be maintained.
- All adverse events must be reported using the Trust's Adverse Incidents Policy.
- The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety.
 - The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action.
 - The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies.
- Any suspected misconduct by anyone involved in the study must be reported
- Permission is only granted for the activities for which a favourable opinion has been given by the REC [and which have been authorised by the MHRA if applicable]

Please note - you must ensure that the protocol is followed at all times. Should you need to amend the protocol, please follow the national research ethics service procedures. You should forward a copy of all amended versions of the protocol and/or documentation together with written confirmation that a favourable opinion has been given by the REC, to the R&D office at the trust, and confirmation that there has been no change in the NHS permission status should be obtained prior to further research activity commencing.

You will be required to complete electronic progress reports and a final monitoring form on completion . As part of this requirement, please ensure that you are able to supply an accurate breakdown of research participant numbers for this trust (recruitment target, actual numbers recruited). To reduce bureaucracy, progress reporting is kept to a minimum, however, if you fail to supply the information requested, the trust may withdraw approval.

Please note that the NHS organisation is required to monitor research to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit of research.

I would like to wish you every success with this project

Yours sincerely
