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UNDERSTANDING THE EXPERIENCES OF PARENTS USING MENTAL HEALTH SERVICES

Section A

A literature review of what is known about the attitudes of mental healthcare professionals towards parents with mental health problems

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Section B

A qualitative exploration of the experience and meaning of being a mother with a psychosis diagnosis

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Contents

Acknowledgements	3
Summary of MRP Portfolio	7
Section A	8
Abstract	9
Introduction	10
Definitions	13
Previous Reviews	14
Aims.....	16
Methods	17
Literature search	17
Data Extraction, Analysis and Quality Assessment	20
Findings	23
Summary of Key Characteristics and Findings of Each Study	23
Synthesis of Themes from the Studies	32
Favourable and unfavourable evaluations of parenting in the context of mental health problems.	32
MHCPs value the autonomy of clients but experience conflict from other pressures.	33
The therapeutic relationship is highly valued and can conflict with pressures to intervene.	34
MHCPs express a lack of confidence in working with clients who are parents.	35
MHCPs construe clients' parenting roles through their mental health diagnosis.	36
Discussion	37
Implications	40
Strengths and Limitations.....	44
Conclusion	50
References	52
Section B	65
Abstract	66
Introduction	67
Psychosis Diagnosis	67
Psychosis and Motherhood	68
Existing Reviews	69
Rationale for Current Study.....	70
Research Aims.....	71
Method	71
Design.....	71

Ethical Approval.....	72
Participants.....	72
Inclusion and exclusion criteria.	73
Sampling strategy.	73
Participant characteristics.	74
Procedure.....	75
Participant recruitment and consent.....	75
Data collection.....	75
Data analysis.....	76
Quality assurance.	77
Statement of position.....	77
Results	77
Superordinate Theme: Motherhood Provides Meaning.....	78
Subtheme: meaning through the pleasures of parenting.....	78
Subtheme: meaning through the responsibilities of parenting.	79
Superordinate Theme: Making Sense of a Diagnosis	79
Subtheme: diagnostic label as having multiple meanings.	79
Subtheme: making sense of diagnosis with a biopsychosocial model.....	81
Superordinate Theme: Perceived Impact of Psychosis.....	81
Subtheme: perceived impact of diagnosis depends on context,	81
Subtheme: perceived interaction of psychosis and parenting.	82
Subtheme: ambivalent relationship with medication.....	84
Superordinate Theme: Power of Services	85
Subtheme: services as supportive.	86
Subtheme: services as surveillance.	87
Discussion	89
Strengths and Limitations.....	93
Research Implications.....	96
Clinical Implications.....	97
Conclusion	98
References	100
Section C	105
Appendix A: Scoring details of SQAC	106
Appendix B: Interview schedule	107
Appendix C: Health Research Authority approval	110
Appendix D: Local NHS Trust research and development department approval.....	111

Appendix E: Staff information sheet.....	112
Appendix F: Participant information sheet.....	115
Appendix G: Consent Form	120
Appendix H: Abridged reflective diary	122
Appendix I: Extended list of quotations.....	127
Appendix J: Coded transcript example	128
Appendix K: Theme development example for individual participant	129
Appendix L: Theme development from analysis across participants	133
Appendix M: Feedback report for ethics panel and R&D committee	136

Summary of MRP Portfolio

Section A: A systematic review of research that can contribute to knowledge about the attitudes of mental health care professionals (MHCPs) towards the parental role of clients. A search of databases found 15 studies. The findings of these were synthesized to identify five themes relevant to the attitudes of MHCPs. The review suggested that unfavourable attitudes and perceived tensions between the relationship with clients and the need to intervene in child protection issues may affect engagement with clients. MHCP attitudes did not appear to be informed by research into the lived experiences of parents with mental health problems.

Section B: This study explored the experiences and personal meanings of mothers with a psychosis diagnosis. Six semi-structured interviews were conducted and analysed using Interpretive Phenomenological Analysis (IPA). The results indicated that a psychosis diagnosis has multiple meanings. Mothers' experiences of the ways in which a psychosis diagnosis and parenting interact were described as being influenced by symptoms, medication and hospital admissions. Services were experienced as supportive as well as a form of surveillance. This study suggests that neither biomedical nor psychological narratives are sufficient to understanding the personal meanings that mothers attribute to their experiences. This has implications for the way in which practitioners engage with service users to develop individual understandings.

Section A

A literature review of what is known about the attitudes of mental healthcare professionals towards parents with mental health problems

Word Count: 7209

Abstract

Background: Not enough is known about the attitudes of mental health professionals (MHCPs) towards parents with mental health problems. Previous reviews suggest unfavourable attitudes towards mental health problems are prevalent amongst MHCPs more generally but have not focussed on the parental mental health context.

Aim: The aim of this review was to identify peer reviewed research that can contribute to knowledge about the attitudes of MHCPs towards the parental role of clients. This included attitudes towards clients' desire to parent and capacity to parent. It included attitudes towards people with mental health problems beginning either before or after becoming parents.

Method: A systematic search of databases found 15 studies. The findings of these were synthesized to identify five themes relevant to the attitudes of MHCPs. These were: favourable and unfavourable evaluations of parenting in the context of mental health problems; MHCPs value the autonomy of clients but experience conflict from other pressures; the therapeutic relationship is highly valued and can conflict with pressures to intervene; MHCPs express a lack of confidence in working with clients who are parents; MHCPs construe clients' parenting roles through their mental health diagnoses.

Conclusions: Unfavourable attitudes and perceived tensions between the relationship with clients and the need to intervene in child protection issues may reduce engagement with clients which in turn, reduces effective management of risk or support. MHCP attitudes did not appear to be informed by research into the lived experiences of parents with mental health problems.

Key words: parental mental health; attitude; workers; staff; parenting

Introduction

A significant proportion of users of mental health services are parents. It has been estimated that between a fifth and a third of adults engaged with mental health services have dependent children (Maybery & Reupert, 2009). This includes but is not limited to those diagnosed with postnatal depression or psychosis. Parents experiencing mental health problems may have to deal with feelings of inadequacy, fear of passing their problems to their children and stigma associated with mental health conditions (van der Ende, van Busschbach, Nicholson, Korevaar, & van Weeghel, 2016).

Not enough is known about the attitudes of mental health care professionals (MHCPs) towards parents with mental health problems. Attitudes amongst MHCPs are important because they can influence responses and actions towards those using mental health services. Some attitudes, for example, can be based upon stigmatising beliefs with behavioural actions that in turn present obstacles to certain groups accessing support (Schulze & Angermeyer, 2003). The absence of a trusting relationship with MHCPs may make services less accessible to parents. Parents with mental health problems may be assumed to be unfit and required to prove otherwise (Dipple, Smith, Andrews, & Evans, 2002). A risk focussed approach towards parents within clinical practice and the literature ignores the protective role that being a parent may have upon one's mental health (Fox, 2012). This is likely to reduce the extent to which they would trust and confide in MHCPs. Parents with mental health problems often withhold information from professionals when discussing their parenting challenges and needs (Diaz-Caneja & Johnson, 2004). This is despite research indicating parents see the experience of having children as positively contributing to their recovery (van der Ende et al., 2016). Attitudes may have adverse consequences for assessment of risk in terms of influencing the attention of MHCPs. For

example, although professional training encourages rational and evidence based risk assessment this is not always utilised (Grimshaw et al., 2001). Munro (1999) analysed 45 British inquiries on child protection cases finding predictable errors in reasoning like discounting evidence that contradicted workers' attitudes towards the family.

Parental mental health is an important area of mental health policy as well as child protection. Stanley and Cox (2009) reviewed English law, policy and guidance for issues linked to parental mental health needs. They noted that policy was becoming increasingly focussed upon recognising the gaps between children's and adult services with an emphasis on the need for services to consider the needs of the family as a whole. They also found that law, policy and guidance explicitly prioritised the needs of and risks to children in service planning. More recently the Department of Health and Department of Education released a green paper on children and young peoples' mental health (Department of Health & Department of Education, 2017). Although this briefly alluded to the adverse consequences of parental mental health upon children the emphasis was improving child and adolescent mental health services and their integration with schools. In 2019 perinatal mental health was recognised as an area that required investment by the NHS Long Term Plan. The plan aimed to improve access to the quality of perinatal mental health care for mothers, their partners and children (NHS, 2019). These developments in policy and guidance show an increasing focus upon the integration of adult mental health with child protection and children's and young people's mental health services. It is therefore timely to undertake a review to better understand MHCP attitudes since these exist within the institutional structures that manifest from policy.

Parental mental health has an important historical context and intersects with other factors relevant to mental health. Historically 'mentally unwell' women have been subject to segregation within institutional care without respect for reproductive rights or custody over their children (Howard, 2000). Although there has been progress in the rights of those considered to have mental health problems, tensions persist in the area of parental mental health. These tensions may partly be influenced by law, policy and guidance prioritising the needs and risks to children (Stanley & Cox, 2009). Another influence may be related to oppression from multiple compounding factors. It is generally agreed, for example, that social deprivation, lone parenthood and having a family history of mental health problems disproportionately affect black and ethnic minority women (Edge, 2010). The interaction of ethnicity and mental health are well demonstrated. Experiences of racism are strongly linked to mental health problems (Wallace, Nazroo, & Bécaries, 2016) and black clients are overrepresented within in-patient settings and more likely to be subject to restrictions under the mental health act than their white counterparts (Bhui et al., 2003). The formation and manifestation of attitudes of MHCPs towards clients who are parents are likely to intersect with attitudes towards perceived socioeconomic and ethnic groups.

There is, of course, evidence to underpin some aspects of unfavourable attitudes towards parents with mental health problems and this cannot be ignored. There is evidence showing poorer outcomes for the emotional development of children of parents with mental health problems (Leijdesdorff, Van Doesum, Popma, Klaassen, & Van Amelsvoort, 2017; Reupert & Maybery, 2007) and established theory places the child's early experience with parents as vital to their development (Bowlby, 2005). Children of parents with mental health problems have an increased risk of developing mental health problems themselves (Rasic, Hajek, Alda, & Uher, 2014). These children are a common target group for psychiatric nursing practices

because they more frequently suffer from psychological disorders in childhood and adolescence (Wahl, Bruland, Bauer, Okan, & Lenz, 2017). These concerns do not, however, represent the full picture of parental mental health. Seeman (2004) reviewed ethical, clinical and legal topics around parental mental health and argued for the need to consider circumstances on an individual basis. Jones et al. (2016) found that parents with mental health problems believed they have many strengths and should receive more recognition for the periods when they are competent and responsible. A review by van der Ende et al. (2016) found evidence that feeling successful in the parental role correlated with better mental health suggesting that expressing more favourable attitudes toward parents may be therapeutic in itself.

Definitions

MHCPs are defined here as those staff in mental health services whose role involves working with clients. In this review MHCPs are therefore defined by the setting in which they work rather than their discipline. This review did not exclude MHCPs from any particular setting and as such includes child and adolescent mental health services (CAMHS) and adult mental health services. The broad inclusion criteria were used because the review aimed to understand attitudes from a range of MHCPs.

An attitude can be defined as a “psychological tendency that is expressed by evaluating a particular entity with some degree of favour or disfavour” (Eagly & Chaiken, 1993, p.1).

Attitudes, beliefs, affect and behaviour are, however, conceptually very similar. This review takes the position that attitudes represent a tendency or pattern of beliefs and are evaluative towards an entity (Eagly & Chaiken, 2007). The attitude then becomes a pre-requisite for behaviour that occurs in relation to that entity. In other words "attitudes do

not exist at all until an individual perceives an attitude object (on a conscious or unconscious basis) and responds to it on an explicit or implicit basis" (Eagly & Chaiken, 2007, p.584).

The tripartite theory suggests attitudes have three components: affect; behaviour; and cognition (Fabrigar, MacDonald, & Wegener, 2005). The theory labels affect as specific emotional states (Schimmack & Crites, 2005), cognition as the beliefs about an attitude object and behaviour as the overt actions and responses to that object (Rosenberg & Hovland, 1960).

Whilst this review has paid attention to defining attitudes, previous reviews appear to use the word interchangeably with others like 'beliefs', 'feelings', 'views', 'opinions' and 'perspectives' (e.g. Schulze, 2007). This review accepts that attitude is a term used loosely within this area of the literature and therefore takes the position that it is reasonable to use studies with related terms (e.g. 'views') to answer the research question.

Previous Reviews

There have been no previous reviews on the attitudes of MHCPs towards parents with mental health problems but there have been reviews in related areas.

Schulze (2007) reviewed evidence of MHCP's attitudes towards people with mental health problems as a general population. She found evidence that despite MHCPs being well informed about mental health problems some hold unfavourable opinions about the people they work with. Based on her findings she suggested that MHCP attitudes do not differ from unfavourable public conceptions of mental health problems and pointed out the need to include MHCPs as a target group in anti-stigma interventions. The inclusion of large scale surveys allowed for generalisability but the review did not focus upon the specifics of parental mental health. Furthermore, the survey based studies can only show what

respondents express explicitly in response to survey questions. Whilst this is a reasonable methodology it limits how much can be understood about attitudes. Fishbein and Ajzen (2005) argue that information about an attitude can only be inferred from observed actions and words since, like many psychological constructs, there is no direct way to measure it.

Maybery and Reupert (2009) sought to provide an overview of the barriers and issues for the psychiatric workforce in parental mental health. They included qualitative and quantitative studies. Attitudes was found to be one such barrier. They suggested a hierarchy in which organisational support and training was a foundation upon which workers' attitudes, knowledge and skills would be able to support client engagement and consequently address the needs of clients and their families. The inclusion of qualitative studies provides a deeper level of insight than the surveys included by Schulze's review. Similar to Schulze, however, they did not define 'attitude' sufficiently or explore in-depth what the research suggests about these attitudes beyond that they may be a barrier to working with clients. The studies also relied on self-reporting that may limit the validity of the findings.

Dolman, Jones and Howard (2013) featured eight studies reporting views of health professionals specifically on motherhood for women with 'severe mental illness'. The review was more focused on parental mental health and provided insights into the experiences and beliefs of professionals in this area. A synthesis of the views expressed in these studies revealed three themes: discomfort; stigma; and need for integration of services. A limitation of the review is that it did not distinguish MHCPs from general healthcare professionals making it difficult to understand how views are shaped by mental health settings. It also did

not discuss what these findings may mean for MHCP attitudes and, again, relied upon self-report.

This review addresses a gap by drawing upon studies using a range of methodologies and synthesising the findings to advance knowledge on what is known about MHCP's attitudes towards parents with mental health problems. Altmann (2008) suggests that investigating attitudes of healthcare professionals needs to be based upon measurement of a combination of affective, cognitive and behavioural dimensions. This suggests that a range of methodologies, including qualitative and quantitative, would be appropriate to investigate attitudes, especially those that MHCPs may be less likely to state explicitly either due to limited awareness or social desirability.

Aims

The aim of this review was to identify peer reviewed research that can contribute to knowledge about the attitudes of MHCPs towards the parental role of clients.

This includes attitudes towards clients' desire to parent and capacity to parent. It includes attitudes towards people with mental health problems beginning either before or after becoming parents.

Methods

Literature search

The literature was searched for studies using the inclusion and exclusion criteria described in Table 1.

Table 1
<i>Inclusion Criteria for Literature Review</i>
<u>Inclusion Criteria</u>
Published in English in a peer-reviewed journal.
Contained original research.
Included participants who were mental health care professionals working within mental health services.
Researched MHCPs describing attitudes, beliefs, feelings, behaviours or views about and experiences of working with clients who were parents or were planning to be parents.
<u>Exclusion criteria</u>
Researching exclusively attitudes to screening for mental health problems amongst new parents
Contains no information about views, perceptions or experiences of working with clients directly
Researching exclusively evaluation of novel interventions
Researching exclusively perceptions of policy, service design, interagency collaboration or team dynamics
Data from MHCPs cannot be discerned from general healthcare professionals (e.g. midwives, GPs, general nurses and medical doctors).

The databases of ASSIA, PsycInfo and Medline were searched using a combination of the search terms described in Table 2. Database inception took place on 5th April 2019 and the search was conducted on 6th April 2019.

Table 2***Search Terms and Boolean Operators*****Search terms and Boolean Operators**

(Clinician* OR worker* OR staff* OR nurse* OR psychiatrist* OR social worker* OR psychologist* OR occupational therapist*)

AND

(attitude* OR view* OR experience* OR opinion* OR perspective* OR construal OR belief* OR feeling*)

AND

(Parent* OR mother* OR father*) AND (mental health* OR mental disorder* OR mental illness* OR psycho* OR schizo* OR bipolar OR depress* OR anxiet* OR postpartum*)

Titles and abstracts were screened and those not relevant were discarded. The remaining articles were read in full and assessed against the inclusion and exclusion criteria. The reference lists of those meeting the criteria were hand-searched for relevant articles. Reference lists of previous reviews that were related to the research question were also hand-searched (Dolman et al., 2013; Maybery & Reupert, 2009; Schulze, 2007). Google Scholar was searched for any outstanding papers. A diagram of this process is displayed in Figure 1. Overall there were 15 articles that met the criteria for this review.

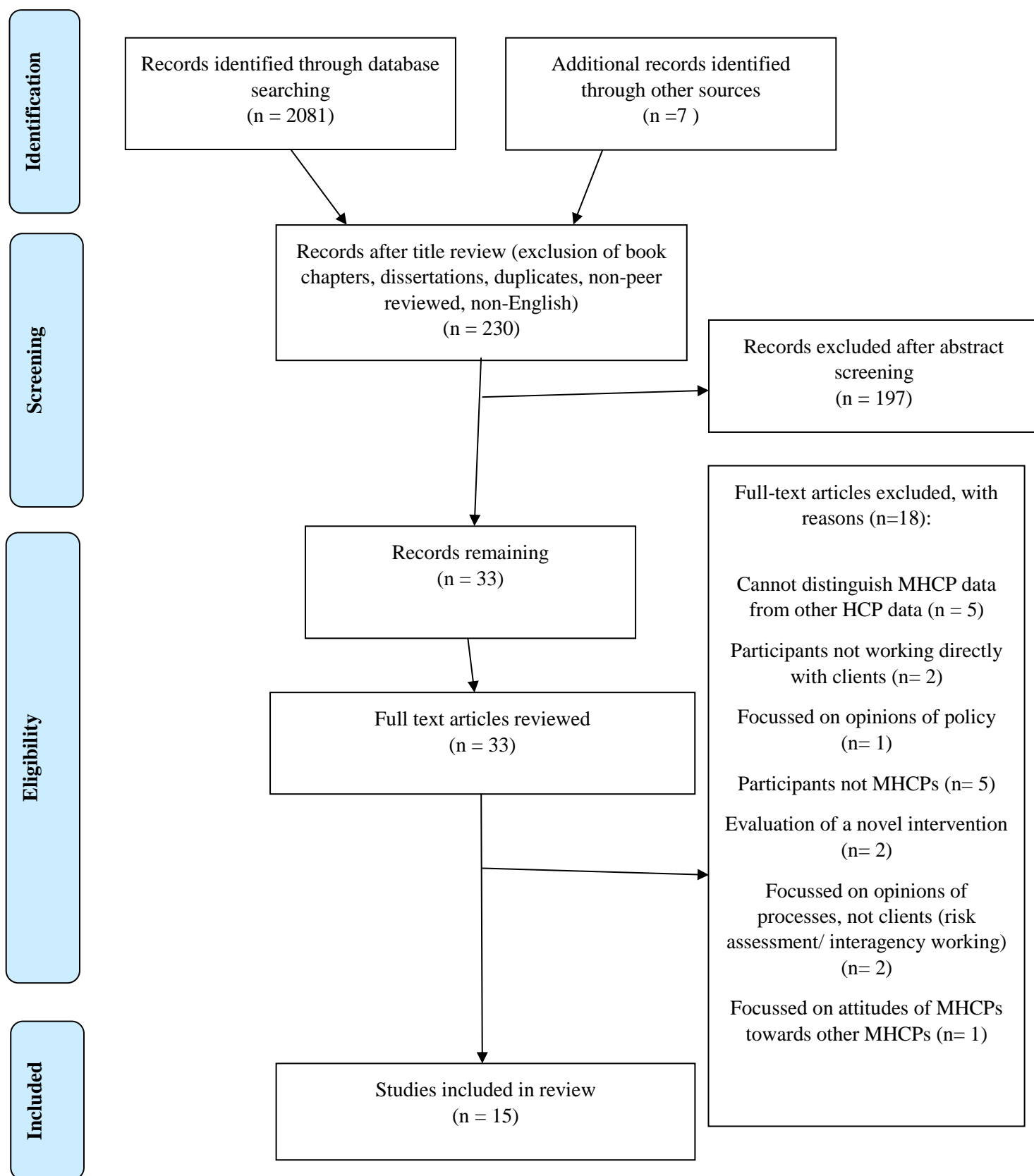


Figure 1. Prisma Diagram. Flow chart showing process of searching for relevant studies.

Data Extraction, Analysis and Quality Assessment

Initial data extraction captured the study characteristics including location, sample size and characteristics, methodology and main findings. The findings from across the studies were then synthesised into themes. To inform this process the studies were searched for findings relevant to MHCP's beliefs, affect or behaviour toward parents with mental health problems. This was consistent with the tripartite theory that positions attitudes as consisting of these three components (Fabrigar et al., 2005). These findings were analysed across studies to identify converging and diverging themes. From this analysis the researcher abstracted five overarching themes that summarised the findings relevant to the research aims.

The quality of each study was assessed according to the Standard Quality Assessment Criteria (SQAC) (Kmet, Lee & Cook, 2004). Qualitative studies are assessed on 10 criteria and quantitative studies on 14 criteria. Each study is given a score depending on the extent it meets each criterion. From this it is possible to give an overall indicator of quality. No disqualifications were made on the grounds of quality.

Tables 3 and 4 present the quality assessment of the studies using the SQAC criteria. See Appendix A for scoring details.

Table 3

SQAC qualitative quality ratings

<u>Criteria</u>	<u>Study ID</u>										
	Darlington, Feeney & Rixon (2005)	(Krumm, Checchia, Badura- Lotter, Kilian, & Becker (2014)	Maddocks, Johnson, Wright & Stickley (2010)	Maybery & Reupert (2006) <i>(Qual Phase)</i>	Rouf, Larkin & Lowe (2012)	Engqvist, Ahlin, Ferszt & Nilsson (2010)	Engqvist, Ferszt & Nilsson (2010)	Engqvist, Nilsson, Nilsson & Sjostrom, (2007)	Engqvist, Ferszt, Hlin & Nilsson (2009)	Engqvist, Åhlin, Ferszt & Nilsson (2011)	McConachie & Whitford (2009)
Question / objective sufficiently described?	1	2	2	2	2	2	2	2	2	2	2
Study design evident and appropriate?	1	2	2	2	2	2	2	2	2	2	2
Context for the study clear?	2	2	2	2	1	1	1	1	1	1	2
Connection to a theoretical framework / wider body of knowledge?	2	2	2	2	2	2	2	2	2	2	2
Sampling strategy described, relevant and justified?	2	1	1	1	1	1	1	1	1	1	1
Data collection methods clearly described and systematic?	2	2	2	2	2	2	2	2	2	2	2
Data analysis clearly described and systematic?	0	2	2	0	2	2	2	2	2	2	1
Use of verification procedure(s) to establish credibility?	0	2	2	2	2	0	0	0	0	2	2
Conclusions supported by the results?	2	2	2	2	2	2	2	2	2	2	2
Reflexivity of the account?	0	1	2	0	2	2	2	2	2	2	0
Total score	60%*	90%*	95%*	75%*	90%*	80%*	80%*	80%*	80%*	90%*	80%*

* Kmet et al. (2004) suggests a score of >55% is a liberal cut-off for inclusion in a review and >75% as a more conservative cut-off. Scoring: 2=yes, 1=partial, 0=no, N/A=not applicable

Table 4

SQAC quantitative quality ratings

<u>Criteria</u>	<u>Study ID</u>				
	Blundell, Wittkowski, Wieck, & Hare (2012)	Howard & Hunt (2008)	(Korhonen, Vehviläinen-Julkunen, & Pietilä (2008)	Maybery & Reupert (2006) (<i>Quant phase</i>)	van der Ende, Korevaar, van Busschbach, & van Weeghel (2017)
Question / objective sufficiently described? Subject (and comparison group, if applicable) characteristics sufficiently described?	2	2	1	1	2
Study design evident and appropriate?	2	2	1	2	2
Method of subject/comparison group selection or source of information/input variables described and appropriate?	2	1	1	0	1
Subject (and comparison group, if applicable) characteristics sufficiently described?	2	2	2	2	2
If interventional and random allocation was possible, was it described?	N/A	N/A	N/A	N/A	N/A
If interventional and blinding of investigators was possible, was it reported?	N/A	N/A	N/A	N/A	N/A
If interventional and blinding of subjects was possible, was it reported?	N/A	N/A	N/A	N/A	N/A
Outcome and (if applicable) exposure measure(s) well defined and robust to measurement misclassification bias? means of assessment reported?	2	1	1	1	1
Sample size appropriate?	0	0	1	0	0
Analytic methods described/justified and appropriate?	2	2	2	2	2
Some estimate of variance is reported for the main results?	1	2	2	2	2
Controlled for confounding	N/A	N/A	N/A	N/A	N/A
Results reported in sufficient detail?	2	2	2	2	2
Conclusions supported by the results?	2	2	2	2	2
Total score	85%	80%	75%	70%	80%

Findings

Summary of Key Characteristics and Findings of Each Study

Table 5 contains a summary of the studies. This includes a description of the MHCP sample, methods and key findings relevant to this review.

Table 5							
<i>Summary of Key Characteristics and Findings of Each Study</i>							
<u>Authors</u>	<u>Year Published</u>	<u>Location</u>	<u>Number of Participants</u>	<u>Sample of MHCPs (and other participants)</u>	<u>Methods</u>	<u>Key Findings</u>	<u>SQAC Score</u>
Darlington, Feeney & Rixon	2005	Australia Various mental health services	36	17 "child protection workers" 15 "adult MH workers" 4 "child & youth MH workers"	"In-depth" individual interviews with "thematic analysis". Each interview focused on one of the worker's cases.	MH workers felt child protection wasn't their area whilst child protection officers lacked confidence in MH assessment. Adult MH workers expressed criticism of child protection workers for removing children unnecessarily. Some of all groups felt the MH needs of parents were incompatible with the needs children.	0.6
Maybery & Reupert	2006	Australia Inpatient Community CAMHS	60 (qual phase) 32 (quant phase)	Breakdown of professions not provided but all were MHCPs	Initial phase of qualitative interviews about barriers to working with parental MH. Analysis method not described.	All survey respondents indicated that parental mental health problems were a problem for children. Those working in adult settings were more likely to report that their	Qual: 0.75 Quant: 0.56

					Second quantitative phase used questionnaire asking for level of agreement to 17 items based on initial phase. Barriers and differences between participants compared statistically.	organisation did not have the time or resources to involve children than those working in more family or child centred settings.	
Engqvist, Nilsson, Nilsson, & Sjostrom	2007	Sweden Inpatient	10	10 psychiatric nurses	Semi-structured individual interviews about subjective experience of caring for mothers with 'post-partum psychosis' ('PPP'). Used content analysis.	Nurses described one of their main strategies as creating a client-nurse relationship. However, when talking to the client about their 'illness' the close connection recedes and the information is relayed in a more formal and clinical way. Nurses imparted information to family about causes, symptoms, treatment and prognosis and that when the client has recovered she will be 'back to normal' again.	0.8

McConachie & Whitford	2009	UK	16	16 MH nurses	Focus groups about experiences and attitudes to women with perinatal 'severe mental illness'. Data analysed thematically.	The 'symptoms' of the 'illness' were seen like any other 'mental illness' but complicated by the presence of a baby. They expressed worry and lacked confidence in their skills to manage a mother and baby which stemmed from lack of experience. Participants actively avoided discussions of suicide and infanticide with researchers.	0.8
Howard & Hunt	2008	UK	34	17 Nursing staff 8 MH Workers 4 Health Visitors 2 Social Workers 1 Psychiatrist 1 Counsellor 1 Psychotherapist (+35 mothers)	Individual interviews with MHCPs and mothers about perceptions of needs using the Camberwell Assessment of Needs – Mothers Versions (CAN-M). Statistical analysis to compare mean number of needs between mothers and MHCPs and agreement between workers.	Mothers report significantly more needs than MHCPs. Agreement particularly low in domains relevant to being a mother and associated risk: pregnancy care; safety to child/others; and practical and emotional aspects of childcare. The low agreement was mostly due to staff not knowing whether a patient had a need rather than stating they didn't have a need.	1.2

Korhonen, Vehviläinen-Julkunen, & Pietilä	2008	Finland	310	222 registered nurses (RN) 88 MH nurses (MHN)	19 Item questionnaire developed by authors about characteristics of nurses and their practice with parents. Associations between characteristics and practice analysed statistically.	For RNs incidences of gathering information and discussing the support network of the family significantly related to the RN's age, gender, professional experience, marital status and further education in family working. For MHNs only, the discussion about children in the family was significantly related to personal characteristics.	0.72
Engqvist, Ferszt, Ahlin, & Nilsson	2009	Sweden	9	9 psychiatric nurses	Semi-structured individual interviews about perceptions of, and responses to caring for a mother with 'post-partum psychosis' ('PPP'). Used content analysis.	MHCPs expressed concern about clients whose behaviour they perceived as chaotic even in the absence of obvious signs of risk. Nurses characterised 'PPP' as delusions and disconnection from one's baby along with aggression, self-absorption, suicidal ideation and personality change. They described strong responses including sadness, sympathy, compassion, discomfort,	0.8

						anger, anxiety and happiness.	
Maddocks, Johnson, Wright, & Stickley	2010	UK	6	6 nurses	Semi-structured individual interviews about lived experience of caring for clients with enduring MH problems who are parents. Thematic analysis.	Nurses supported clients by being present at visits with children, advocating and reassuring. They prioritised person-centred care over family-centred care and tried to remain impartial with regards to the children. Some believed they should not be overly involved with a client's children. They believed that doing so would damage their relationship with the client. Some believed that having children gave clients the motivation to try to maintain their mental state so they could continue to have contact.	0.95
Engqvist, Ahlin, Ferszt, & Nilsson	2010	Sweden	9	9 psychiatrists	Semi-structured individual interviews about psychiatrists' experience of collaboration with other HCPs analysed with content analysis.	They felt responsible for the mother and believed the baby was the responsibility of the paediatrician and family. They expect nurses to prioritise MH clients who are parents.	0.8

Engqvist, Ferszt, & Nilsson	2010	Sweden	10	10 psychiatric nurses	Re-analysis from Enqvist et al. (2007). Content analysis focussed on descriptions of 'presence' when working with mothers with 'PPP'.	Nurses believed that their most important responsibility was to promote and support bonding between mothers and their babies. However, they recognised this may encroach upon the need to defend the client's integrity. Some described great discomfort when restrictive practices were used (e.g. compulsory admissions and medication) but rationalised it as necessary to protect the mother and baby.	0.8
Engqvist, Ferszt, & Nilsson	2011	Sweden	9	9 psychiatrists	Semi-structured individual interviews about perceptions of and responses to caring for a mother with 'post-partum psychosis' ('PPP'). Used content analysis.	They spoke of the necessity of involuntary care but also the importance of a trusting and close worker-client relationship. They felt more emotionally invested in the outcomes of mothers with 'PPP' than those without 'PPP'. Expressed concern that mental health problems result in less time for the mother and infant to bond, with potentially negative consequences later	0.9

						on. Participants described feeling pressure to keep parents and children together as a 'unit' but also that the need to prioritise safety meant separating	
Blundell, Wittkowski, Wieck, & Hare	2012	UK	10	6 MH nurses 4 nursery nurses All from an MBU	Repertory grid completed as part of individual interview with each participant. Grids analysed statistically.	All made critical judgements about some clients. Participants rarely construed clients as being similar to their concept of a 'good mother.'	1.2
Rouf, Larkin, & Lowe	2012	UK	13	3 CPNs 2 psychologists 3 social workers 4 psychiatrists 5 named nurses for child protection	Semi-structured individual interviews about making decisions on parental MH. Named nurses were asked to keep diaries about making decisions. Analysed by IPA.	Workers described the tension of working across systems. They cited the role that client-worker relationships play in understanding and managing risk. They tried to balance a 'felt' sense of problems with more rational decision making whilst recognising the uncertainty inherent in the area. Personal experiences played an important role in decision making though they recognised the pitfalls of this. They were	0.9

						concerned about de-sensitisation to risk and worried that their decisions would lead to harm or destroy their relationship with the client or attract media attention.	
Krumm, Checchia, Badura-Lotter, Kilian, & Becker	2014	Germany	46	8 psychologists 11 social workers 15 nurses 15 psychiatrists	Separate focus groups with each discipline. Semi-structured discussion guide asking views and experiences about patients' desire for children. Analysed by "reconstructive approach of the documentary method".	Workers share a value of client "reproductive autonomy" and professional neutrality but some saw the parenting role as incompatible with having a mental 'disorder'. Positive examples of parenting were often presented as counter to expectations of 'problematic parent-hood'. This may conflict with their value of reproductive autonomy.	0.9
van der Ende, Korevaar, van Busschbach, & van Weeghel	2017	Netherlands	77	37 social workers 19 MH nurses 9 psychologists 6 physicians 6 "other"	Web-based questionnaire addressing support given to parenting and context of discussions relating to parenting role of clients. Of the MHCPs, 41 had	33% Of those without training in parenting support felt competent to address parental MH compared to 49% of those with training. This is lower than workers in general hospitals where 51% felt competent despite having	0.83

	<i>(+51 workers in a general hospital)</i>	received a 4-day training in parenting support whilst 36 had not.	no extra training. All respondents said focus of support is about the emotional connection between client and child including skills like setting boundaries.
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Synthesis of Themes from the Studies

This section describes themes that the researcher identified from reviewing the studies.

These themes must be considered in the context of substantial variation between participants within studies. This variation indicates the range of attitudes that are likely to exist amongst MHCPs. There was also substantial variation between studies that could be attributed to the type of MHCPs recruited, setting and methodological differences. The themes are not based on the frequency with which they were present in the papers and instead reflect the range of findings within and across the studies.

Favourable and unfavourable evaluations of parenting in the context of mental health problems.

Five studies found examples of participants expressing feelings and beliefs about mental health and parenting that could be described as unfavourable (Blundell, Wittkowski, Wieck, & Hare, 2012; Engqvist, Ferszt, Hlin, & Nilsson, 2009; Engqvist et al., 2011; Krumm, Checchia, Badura-Lotter, Kilian, & Becker, 2014; Maybery & Reupert, 2009). Blundell et al. (2012) found participants rarely construed clients as being similar to their concept of a 'good mother'. Krumm et al. (2014) noted that "positive examples were often presented as counter to expectations of 'problematic parent-hood'" which may indicate an expectation that good parenting amongst those with mental health problems is a deviation. Some in the latter study went as far as expressing a belief that the characteristics of mental health problems were opposed to the requirements of parenthood and hoped that clients would decide against having children. Maybery and Reupert (2009) reported all their survey respondents indicated that parental mental health issues were a problem for children. Engqvist et al. (2009) found MHCPs expressed concern about clients whose behaviour they

perceived as chaotic even in the absence of obvious signs of risk. Aside from safety issues, psychiatrists in the study by Engqvist et al. (2011) expressed concern that mental health problems result in less time for the mother and infant to bond, with potentially negative consequences later on.

Three studies featured participants who expressed favourable beliefs about mental health problems and parenting (Engqvist et al., 2010; Engqvist, Nilsson, Nilsson, & Sjostrom, 2007; Maddocks et al., 2010). Participants in these studies believed parenting had a positive impact on mental health. Maddocks et al. (2010) found MHCPs believed that having children gave clients the motivation to try to maintain their mental state so they could continue to have contact.

MHCPs value the autonomy of clients but experience conflict from other pressures.

MHCPs in studies by Krumm et al. (2014) and Maddocks et al. (2010) described how they value the autonomy of their clients and prefer a position of neutrality with respect to decisions about being a parent. These values sometimes conflicted with pressures to intervene. Participants in the study by Krumm et al. (2014) believed that expressing a strong opinion about parenting was contrary to their value of professional neutrality. Krumm et al. (2014) concluded that participants used strategies to manage the tension between values and pressures to intervene. Some may have subordinated child well-being issues and focussed upon those of the adult client. Others held on to their belief that reproduction issues are a private matter and therefore of little relevance to their professional role. Some described how they would offer information in the form of 'rational advice', hoping that clients would make what was perceived to be a rational decision against having children.

The authors also noted that verbalising restrictive attitudes towards clients' reproductive freedom appeared taboo and was avoided in discussions.

Maddocks et al. (2010) found participants believed nurses should not be overly involved with client's children. They believed that doing so would damage their relationship with the client. In the study by Engqvist et al. (2011) participants described feeling pressure to keep parents and children together as a 'unit' but also that the need to prioritise safety meant separating them at times. Similarly, nurses in the study by Engqvist et al. (2010) described great discomfort when restrictive practices were used (e.g. compulsory admissions and medication) but rationalised it as necessary to protect the mother and baby under their care.

The therapeutic relationship is highly valued and can conflict with pressures to intervene.

Participants in two studies described the empathy and compassion they felt towards their clients (Engqvist et al., 2011; Engqvist et al., 2009). For the psychiatrists in the study by Engqvist et al. (2011) this was attributed to the awareness of lost time for the mother to bond with her infant. Some even expressed feeling more empathy towards those clients who were parents than those who were not.

In four studies MHCPs recognised that tensions could arise between the need to maintain the therapeutic relationship and the pressure to intervene in order to manage risk (Darlington et al., 2005; Maddocks et al., 2010; McConachie & Whitford, 2009; Rouf et al., 2012). MHCPs in the study by Darlington et al. (2005) were critical of child protection workers for removing children seemingly unnecessarily with negative consequences for the parent's mental health. However, they expressed the necessity of resorting to child

protection measures when clients refused ongoing monitoring. Those in the study by Rouf et al. (2012) expressed their concerns that if they made the wrong decisions it could destroy the relationship with their client.

There were differences in how the tension between the therapeutic relationship and other pressures was expressed. Maybery and Reupert (2006) found that those working in adult settings were more likely to report that their organisation did not have the time or resources to involve children than those working in more family or child centred settings. A study conducted in a perinatal ward found nurses believed that their most important responsibility was to promote and support bonding between mothers and their babies (Engqvist et al., 2010).

MHCPs express a lack of confidence in working with clients who are parents.

Some MHCPs expressed the belief that they lacked the training, skills or experience to work effectively with clients. For some this led to feelings of anxiety (McConachie & Whitford, 2009). Some studies reported low levels of confidence amongst MHCPs. Darlington et al. (2005) found MHCPs struggled to assess parenting capacity believing that it was not their area of expertise. Of respondents to the survey by van der Ende et al. (2017) only 25% believed their organisation adequately facilitated parental support. Likewise, only 25% believed they had the necessary knowledge for this activity. Howard and Hunt (2008) illustrated how insufficient skills, experience and training may manifest in the cognitions of MHCPs. The study asked MHCPs and clients what they believed were the main unmet needs of parents with mental health problems. There was low agreement between MHCPs and clients in domains relevant to the parenting role including areas like 'risk to others' and 'ability to care for the child practically and emotionally'. The low agreement was due to

MHCPs indicating that they did not know how important this unmet need was rather than having a difference of opinion, suggesting a gap in their knowledge. Nurses in the study by McConachie and Whitford (2009) described feeling fearful of working with parents due to their lack of experience and training. They stated their anxiety about prescribing medication, believing there was insufficient evidence to know it would be safe for those breastfeeding. MHCPs spoke about how decisions were rarely straightforward and referred to their experiences and intuition to guide their behaviours. Participants in two studies rationalised their 'gut reactions' as a guide for further action whilst also acknowledging the limitations of making direct comparisons based on subjective experience (Engqvist et al., 2011; Rouf, Larkin, & Lowe, 2012). Some participants said they wanted to avoid making snap decisions and instead wanted to consider many factors in their assessment of a situation. They spoke about perceiving a 'grey area' where decisions could not be clear cut and it was difficult to decide if children were affected by parental mental health problems. In response to this uncertainty they used personal experience as a benchmark for judging how children were functioning. Participants in two studies were aware of the dangers of making direct comparisons based on subjective experience (Engqvist et al., 2011; Rouf et al., 2012). They did not, however, articulate what they believed these dangers to be.

MHCPs construe clients' parenting roles through their mental health diagnosis.

Engqvist et al. (2009) found MHCPs described the 'disconnection' experienced by mothers who they worked with as a 'symptom' of post-partum psychosis. This meant not wanting to hold, touch or care for their baby. Having confirmed a diagnosis the psychiatrists in another study said they give information about how serious the 'illness' is and try to get the family to see the client in a 'psychotic state' and to understand the 'nature of psychosis' (Engqvist et al., 2011). McConachie and Whitford (2009) found nurses believed that perinatal psychosis

was the same 'condition' as other forms of psychosis and that postnatal depression was the same as other types of depression. They believed the presence of a child merely changed the context but not the 'condition'. Engqvist et al. (2007) found nurses imparted information about causes, symptoms, treatment and prognosis and that when the client has recovered she will be 'back to normal' again. They explained that the intention behind this was to reduce the family's anxiety.

Discussion

This review found that MHCPs may have unfavourable attitudes towards the parenting role in the context of mental health problems. It may be that the evaluations found in this review reflect attitudes towards mental health problems more generally and therefore encompass concerns more specific to parental mental health. For example there is evidence to suggest that MHCPs have pessimistic or ambivalent perceptions about the prognosis of psychosis and depression within the broader mental health context (Caldwell & Jorm, 2000; Magliano, Fiorillo, De Rosa, Malangone, & Maj, 2004; Rettenbacher, Burns, Kemmler, & Fleischhacker, 2004). Attitudes about the ability to parent may be related to the MHCPs' personal assumptions of what 'good' parenting means. It has been argued that professionals may struggle to comprehend what it might be like for children to have a parent with mental health problems because they base their assumptions upon personal beliefs about what a 'proper' childhood is (Hetherington, Smith, & Wilford, 1997; James & Prout, 1990; Olsen, 1996). Whilst three studies described evaluations of how parenting may support one's recovery from mental health problems (Engqvist et al., 2010; Engqvist, Nilsson, Nilsson, & Sjostrom, 2007; Maddocks et al., 2010) it is notable that there were no comments about mental health problems supporting or improving parenting in the short or long-term.

Participants in two studies (Krumm et al., 2014; Maddocks et al., 2010) described how they value the autonomy of their clients but can experience conflict with pressures to intervene. This appeared to be related to the finding that participants in some studies described a tension between maintaining the relationship with individual clients and assessing and intervening in the parental role or needs of children (Darlington et al., 2005; Maddocks et al., 2010; Maybery & Reupert, 2006; McConachie & Whitford, 2009; Rouf, Larkin, & Lowe, 2012). This suggests that some MHCPs have an unfavourable attitude towards the parental role as though it is a barrier to building rapport with the individual client. This varied depending on the service context with MHCPs in adult services more likely to express that they did not have enough time and resources to involve children compared to perinatal or more family centred services. Jessop and de Bondt (2012) attributed the term “dual role” to the tension faced by MHCPs when supporting parents and protecting children. The relative importance given to the therapeutic relationship with the individual client may stem from some of the models of care that have dominated healthcare such as the person centred approach (McMillan, 2004), the recovery model (Kane, 2003) and the stress-vulnerability model (Repper & Perkins, 2003). The principles that have traditionally underpinned therapeutic relationships may also be challenged by the parental context. Rogers (1957) suggested that acceptance was a key feature of a therapeutic relationship. This may, however, conflict with the responsibilities of MHCPs in an era of safeguarding whereby acceptance of some behaviours is impossible. Conversely, it could be argued that person centred care should encompass family needs since this is a crucial aspect of experience (Stewart, 2001). This is consistent with a growing emphasis on family centred practice within mental health and social care nationally (Social Care Institute for Excellence, 2011).

The belief and possible enactment of prioritising the therapeutic relationship may be a strategy to cope with anxiety related to the complexity of working with clients who are parents. This is in the context of pressures to intervene, experiencing a tension in the therapeutic role and believing that they lack sufficient training, skills or experience. A relevant theory to the way in which MHCPs may subjugate the parental role in their work with clients is the 'interactional frame' (M. S. Davis & Goffman, 1975). Davis and Goffman argue that direct conversation between individuals is part of a wider frame of interaction. The breadth of this frame enables and inhibits certain kinds of discussion. Some MHCPs may use an interactional frame that encompasses clients as 'patients' who are 'ill' whilst the concept of them as a parent is excluded. This frame may reflect their training, skills and experience. This may function to enable clients to express their needs to MHCPs without fear that their capacity to parent will be questioned. At the same time it could also function to enable MHCPs to manage their anxiety through avoidance of child-protection issues.

The interactional frame used by MHCPs may have been based upon particular conceptualisations of mental health problems. When describing the nature of their clients' presentation many MHCPs used a narrative akin to that of clinical recovery. Clinical recovery focuses on the elimination of symptoms and is often contrasted with personal recovery that is not specifically concerned with symptom alleviation (Slade, 2009). The concept of clinical recovery relates to the medical model that describes mental health in terms of symptoms, diagnostic categories and biological aetiology and is based upon a positivist position of philosophy (Bentall, 2005). Although none of the participants explicitly stated they construed clients' presentations in this way, the theme emerged from their use of language like 'symptom' (Engqvist et al., 2009), 'illness' (Engqvist et al., 2011), 'condition' (McConachie & Whitford, 2009) and 'back to normal' (Engqvist et al., 2007). It has been

argued that the evidence for such conceptualisations of mental and behavioural problems does not have a conclusive evidence base, fails to appreciate the broader context of a person's experience and does not reliably lead to effective support (Bentall, 2005; Bentall, 2010; Johnstone, 2014; Kinderman, 2014). Attitudes informed by such beliefs may manifest in behaviours that are less helpful to parents. For example, MHCPs may pay less attention and give less support to aspects of experience that are important to parents. In a study of attitudes amongst psychiatrists Kingdon, Sharma and Hart (2004) found less attention was paid to financial matters, accommodation and leisure activities than diagnosis and family relationships. For some parents their distress or the difficulties in the relationship with their child may be understandable given an unstable housing situation rather than being a symptom of some underlying biological or psychological pathology. Alternative terms to describe clients' experiences have been suggested. For example replacing diagnostic and technical labels with terms such as 'difficulty', 'problem' or 'distress' (British Psychological Society, 2015). There are also alternatives to medical and pathologising conceptualisations of distressing experiences. For example, the power threat meaning framework positions low mood, anxiety, hearing voices and other experiences typically labelled as mental health as a response to difficult events in the past or present (Johnstone & Boyle, 2018).

Implications

This review suggested some MHCPs hold unfavourable attitudes towards the parenting ability of their clients. Furthermore, the finding that some MHCPs based their decision making on intuition and personal experience introduces the possibility that MHCPs' behaviour towards these clients may be influenced by stereotypes and stigma. These could affect the quality of the therapeutic relationship even if a MHCP's attitudes are not stated explicitly. Griffith and Griffith (1994) argue that much of the communication within

therapeutic relationships is based on postures and body language and as such is implicitly rather than explicitly stated. MHCPs may inadvertently convey a sense of blame, pessimism or hopelessness to their clients. Power et al. (2016) described how feeling ashamed made it difficult for families to be open about their difficulties when a parent was experiencing mental health problems. They also found that families developed resilience through balancing recognition of difficulties with strengths and maintaining a sense of optimism. MHCPs therefore need to be mindful of how unfavourable attitudes may lead them to behave in ways that are perceived as shaming by parents, focusing instead on highlighting strengths. This approach may be more likely to engage parents and manage risk more effectively as a consequence.

Some attitudes of MHCPs appeared dominated by medical and clinical recovery narratives. Marlowe (1996) argues that such narratives influence presuppositions about mental health problems and limit other possibilities. For example, the interaction of mental health problems and parenting may be a more dynamic process than medical narratives allow (Markova & Berrios, 1992). Hayward and Bright (1997) argue for a more holistic conceptualisation of mental health problems based on a continuum of difficulties that emphasises the role of psychosocial factors. From a systemic perspective medical narratives may limit the potential for talking and thinking differently about a client's situation that could enable more constructive dialogues and behaviours (Anderson & Goolishian, 1988). Formulation could usefully be promoted as a more holistic alternative; a core skill of the clinical psychology profession (British Psychological Society (BPS), 2014). Formulation has been described as an intervention in its own right since it may enable a client to move forward with a richer understanding of their dilemmas (Johnstone, 2014). It can help clients feel understood by professionals, strengthening the therapeutic alliance and reducing a

client's sense of self-blame and shame (BPS, 2011). There is also evidence that women have a preference for psychological support over medicalised interventions like pharmacology during the perinatal period (Buist, O'Mahen, & Rooney, 2014). Greater use of formulation, especially team formulation, may shift MHCP attitudes towards an understanding of parental mental health that is more aligned with the narratives that clients hold. Within perinatal mental health specifically there are policy drivers that advocate for improvements that can be delivered by clinical psychology leadership such as the National Institute for Health and Care Excellence (NICE) guidance on antenatal and postnatal mental health (NICE, 2018). Some of the improvements to perinatal mental health services recommended by the BPS (BPS, 2016) are likely to manifest through the NHS Long Term Plan (NHS, 2019) such as increasing access to evidence-based psychological support.

The increased use of formulation may need to be complemented with organisational shifts towards family centred working. This review found evidence that some MHCPs held attitudes that regard the parental role as a barrier to working with their clients. Some MHCPs described how they attributed the parental role to be of less importance in their work than engaging with the individual client. This occurred for reasons including lack of skills and experience and the service context. The parental role is likely to be one of the most significant aspects of a client's life and so resistance to engaging with it may limit the usefulness of services. MHCP attitudes may be improved through a shift towards family-centred care that acknowledges the strengths and needs of all family members (Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004). This may reduce the tensions between the needs of parent and child by emphasising the family as a system (Brown, 1991). Indeed, Wang and Goldschmidt (1996) found that clients expressed a desire for family-focused interventions rather than focusing solely on themselves. There is also evidence to suggest

that clients appreciate being acknowledged as parents (Gillam, 2013; Savvidou, Bozikas, Hatzigeleki, & Karavatos, 2003).

Participants cited several factors that limit their confidence in working with parents affected by mental health problems. This included role conflict, time and training. This may indicate the necessity for shifts towards family-centred working to be enacted within a broader context. There is evidence that positive attitudes amongst professionals can increase when given sufficient support (Reed & Fitzgerald, 2005). Such change may only be possible within a framework of managerial support and family-centred policies and procedures (Berman & Heru, 2005; Mottaghipour & Bickerton, 2005). There may also be a need for professional training programmes to include more emphasis on family-centred practice. This could feature within continuing professional development opportunities. Programmes have been developed in recent years that aim to promote such practice amongst existing professionals (e.g. Goodyear et al., 2015; Tchernegovski, Reupert, & Maybery, 2015). At an even broader level there may need to be shifts in the emphases within law, policy and guidance that have prioritised the needs and risks to children (Stanley & Cox, 2009) and therefore the context within which MHCP attitudes are developed and maintained. Based on their review of barriers within the psychiatric workforce, Maybery and Reupert (2009) argued that once organisational support and training needs are addressed workers will be in a better position to engage with clients. They predict that this would reduce barriers such as clients being unwilling to discuss their parenting role.

From an academic perspective, this review found that there is little research on the attitudes, beliefs, affects and behaviours of MHCPs in the context of parental mental health. The studies were predominantly descriptive accounts of these phenomena leaving

questions about how they may vary across settings or professional group. Similarly, there is a question of how they vary across the diagnostic and demographic groupings of clients. Intersectionality with gender, ethnicity and social status is also an important topic not adequately addressed in the literature. This raises questions of what is known about the interaction of gender, racial oppression and social status with parenting and mental health. Comparative studies could address these questions and provide insights on how attitudes may develop and impact those affected by parental mental health. Large scale quantitative studies akin to those reviewed by Schulze (2007) would provide valid comparisons of MHCP attitudes within parental mental health compared to mental health care more broadly.

This review found that the attitudes of some MHCPs were informed by medical and clinical models and personal assumptions of what parenting should be like. None of the participants described knowledge or practices rooted in the lived experience of clients. Helpful developments would therefore include studies on the lived experience of clients and the meaning that they make of having mental health problems and being a parent. It may be particularly valuable to focus upon the lived experience of having specific mental health diagnoses. For example, those diagnosed with psychosis are especially subject to professional interpretations and practices dominated by medical and clinical recovery narratives (BPS, 2014).

Strengths and Limitations

The quality of the papers identified for this review was reasonably high according to the SQAC. Using a conservative cut-off (>75% of quality criteria at least partially met) 13 of the 15 studies met the threshold for high quality. Using a liberal cut-off (>55%) all 15 studies met this threshold (see Tables 3 & 4). All the studies involved a small sample size which has

implications for the generalisability of the findings. For the quantitative studies this was a substantial limitation reflected in the low scores for this criterion of the SQAC. Small sample sizes in the qualitative studies were not necessarily a weakness since this is characteristic of the design. All the studies collected self-reported data which risk being biased by individual subjectivity and social desirability. The SQAC deemed that all the studies were reasonably high quality based in part on how well their aims were defined and the suitability of the methodology. The SQAC does not, however, make a valid estimate of quality when studies are taken in aggregate to answer a novel research question. A third of the studies were conducted by the same research group (Engqvist et al., 2010, 2011; Engqvist et al., 2009; Engqvist et al., 2010, 2007) and this could compound the potential for researcher bias since there is inherent subjectivity in qualitative methodology. The conclusions of this review must therefore be considered tentative and exploratory, highlighting areas where further research would be of value.

The variability between participants within studies suggested that individual characteristics of MHCPs play a role in attitudes. In addition, the differences in attitudes between adult services and more family and child centred services as found by Maybery & Reupert (2006) may demonstrate the impact of setting upon MHCP attitudes.

Eight of the 15 studies included participants who worked with mothers in the perinatal period. The remaining studies featured MHCPs discussing their experiences predominantly in the context of mothers (rather than fathers). The findings of this review are therefore mostly rooted in a context of motherhood, particularly the perinatal period and may have limited generalisability to fathers experiencing mental health problems. This also reflects

the lack of research into fathers with mental health problems (Evenson, Rhodes, Feigenbaum, & Solly, 2008).

A consistent limitation amongst the studies was the sampling criteria. Most of the qualitative studies were awarded one (out of a possible three) for the extent to which their sampling strategy was described, relevant and justified. The exception was the study by Darlington et al. (2005) which was awarded three. The sampling criteria of qualitative studies were critical to this review because it is reasonable to expect differences in attitudes between those who do and do not agree to participate in research. For example, those with unfavourable attitudes towards the parental autonomy of people with mental health problems may be less willing to discuss their views due to concerns about how they will be judged. Similarly six of the 11 qualitative studies achieved a score of one (the others scored two) for the extent to which the context of the research was clear. Whilst some studies featured participants who appeared to hold unfavourable attitudes towards their clients it is possible that such attitudes are underreported across the studies when considering the findings of previous research (e.g. Schulze, 2007).

All studies in this review were based upon self-reporting and it is possible that MHCPs may have avoided talking about some of their feelings towards clients out of concern for how they would be perceived by the researchers and other participants. The possibility that some beliefs and feelings are avoided can be understood by considering the broader context of healthcare. Feelings of anger towards clients may be inconsistent with the models of care that inform MHCPs training: for example the theory of caring (Watson, 1997) and of interpersonal relations (Peplau, 1997) as well as the emphasis on compassion described in recent NHS values (Department of Health, 2015). Ogden (1992) argued that processing

experiences in a non-judgemental way depends upon being able to contain emotional responses and that the latter is dependent upon the capacity to reflect in the face of intense interpersonal confrontations. It may, therefore, be inevitable that MHCPs will have unfavourable attitudes towards clients who are parents at least some of the time and this may vary across contexts depending on other demands. However, the expression of such attitudes may be inhibited by perceived social desirability within the cultural expectations of the healthcare context and professional roles. Whilst some MHCPs believe that parental autonomy is preferred, the findings suggest some feel uncomfortable with clients being parents. One study described how some participants believed that clients with mental health problems should avoid becoming parents (Krumm et al., 2014). Other participants within this study seemed reluctant to discuss negative assessments of clients' reproductive decisions indicating a possible taboo around this subject. This could be related to perceptions of what is considered socially acceptable to express and raises a question over what attitudes exist amongst MHCPs that the studies in this review do not reveal. At least three surveys have found that few MHCPs believe in restricting clients' freedoms to have children but a majority support involuntary admission and treatment (Lepping, Steinert, Gebhardt, & Röttgers, 2004; Magliano et al., 2004; Nordt, Rössler, & Lauber, 2006). This suggests that the expression of attitudes in favour of restricting parental autonomy are likely to be in the minority.

The development of the themes was based upon a critical appraisal of the studies that recognised some were of relatively poorer quality. This ensured that themes were not overly weighted by findings from poorer quality studies.

Two studies scored low relative to others and below the conservative cut-off of 75%.

Particular consideration was given to ensure findings were balanced by those from other studies. These were the studies by Darlington et al. (2005), scoring 60% and Maybery and Reupert (2006), scoring 75% for the qualitative phase and 70% for the quantitative phase.

The poorer quality of these studies raised concerns over the robustness of the findings relative to other studies. Findings from these studies were used to inform some of the themes but these were supported by other studies of higher quality to increase robustness.

There were details, however, within these themes that derived only from these studies.

These details were used to add richness to the description of the theme and were given alongside details derived from other studies. For example, within the theme titled 'MHCPs express a lack of confidence in working with clients who are parents' there was a detail from the Darlington et al. (2005) study that 'MHCPs struggled to assess parenting capacity believing it was not their area of expertise'. This was supported by placing it alongside a detail from van der Ende (2017) that 'only 25% believed their organisation adequately facilitated parental support'.

Another issue of integration with the critical appraisal was the presence of five studies conducted by the same research group (Engqvist et al., 2010, 2011; Engqvist et al., 2009; Engqvist et al., 2010, 2007). Some themes were based primarily upon these studies: 'the therapeutic relationship is highly valued and can conflict with pressures to intervene' and 'MHCPs construe clients' parenting roles through their mental health diagnosis'. A major limitation identified by the SQAC for all of these studies was the lack of a description of verification procedures. This limitation was compounded by the studies being of the same research group. On the other hand, these studies did score above the conservative cut-off in the SQAC and their data collection and analysis methods were clearly described, allowing

scrutiny of their approach. To ensure these themes were not too weighted by these studies they include details from other studies that are consistent. For example, a finding from McConachie and Whitford (2009) is used to add weight to the theme describing how 'MHCPs construe clients' parenting roles through their mental health diagnosis'.

The attitudes of MHCPs may be more nuanced than the research reviewed was able to capture. Five of the studies found examples of participants expressing feelings and beliefs that could be described as unfavourable. Unfavourable attitudes towards the parenting role in mental health problems, however, may reflect the service context more than the stable beliefs and feelings of MHCPs. For example, where services place demands to manage large numbers of cases MHCPs may feel overwhelmed by the complexity presented by clients who are parents. The parenting role of clients may then be perceived as an additional complication for MHCPs to manage. The stress created by this context may be informing unfavourable perceptions instead of just the MHCPs direct clinical experience with clients. Similarly, risk averse services may reinforce MHCPs to pay attention to a parent's risks rather than notice and recognise the non-occurrence of problems and strengths. This may result in risks being at the forefront of MHCPs perception of parents and consequently recorded in the studies. All the studies featured single interviews with MHCPs where there was limited opportunity for the nuances to be explored. It was not clear if any of the studies asked participants to reflect on their beliefs or feelings within the interviews to identify what was informing beliefs and feelings. In particular the analysis of the qualitative studies, where such nuances may be expected, appeared limited to a single rather than double hermeneutic of approaches like IPA (Smith, Flowers & Larkin, 2009). In other words the researchers appeared to report MHCPs' feelings, beliefs and behaviours as they were shared

in the interviews rather than a systematic process of interpretation that might have created more nuance in the findings.

Conclusion

This review aimed to advance knowledge about the attitudes of MHCPs towards the parental role of clients based upon a synthesis of findings from studies that investigated the beliefs, affect and behaviours of MHCPs in relation to the parental role of clients. This review addressed a gap in the literature by exploring what studies may say about the attitudes of MHCPs in the parental mental health context. This review identified five themes relevant to the attitudes MHCPs may hold. The studies showed that some MHCPs expressed unfavourable evaluations of parenting whilst having mental health problems with some seeing parenting as having a positive impact upon clients' recovery from mental health problems. MHCPs appeared to value the autonomy of clients but this was challenged by pressures to intervene in the interests of the client's or child's safety. Similarly, it appeared that some MHCPs value their therapeutic relationship with clients but this can conflict when they are under pressure to intervene due to child protection concerns. For all of the MHCPs, their attitudes seemed to be informed by construing parenting through the parent's diagnosis and as such, saw problems in parenting as manifesting from a 'disorder'.

This review discussed the implications of these findings upon the quality of the relationship they establish with parents. Unfavourable attitudes and perceived tensions between the relationship with clients and the need to intervene in child protection issues may reduce engagement with clients which in turn, reduces effective management of risk or support. The review also discusses how MHCPs could be supported to develop attitudes that allow better engagement with parents and deliver more supportive interventions. This could be through training on collaborative formulations and family-centred practice.

From an academic perspective, this review found that MHCP attitudes did not appear to be informed by research into the lived experiences of parents with mental health problems. This raises a question about whether this is an area adequately addressed in the literature.

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Section B

A qualitative exploration of the experience and meaning of being a mother with a psychosis diagnosis

Word Count: 7998

Abstract

Understanding parents' experiences is a key task in recent partnership based approaches to family interventions (e.g. Davis & Day, 2010) but insight into the meaning of psychosis to mothers with this diagnosis is under-developed within the literature. This study explored the experiences and personal meanings of six mothers with a psychosis diagnosis using community mental health services and seeing clinical psychologists. Semi-structured interviews were conducted and analysed using Interpretive Phenomenological Analysis (IPA). The results indicated that psychosis has multiple meanings for mothers but was predominantly understood as biomedical. The interaction of a diagnosis with parenting was perceived to be mediated by the effects of symptoms, medication and hospital admissions. Services were experienced as supportive whilst also providing surveillance of symptoms, medication adherence and parenting. This study suggests that neither biomedical nor psychological narratives are sufficient to understanding the personal meanings that mothers attribute to their experience, in the context of being a parent with a psychosis diagnosis. This has implications for the way in which practitioners engage with service users to develop individual understandings.

Key words: psychosis; motherhood; parental mental health; parenting; bipolar

Introduction

Psychosis Diagnosis

Psychosis is often used to define experiences such as hearing voices ('hallucinations'), believing things that others find odd ('delusions') or periods of confusion where an individual appears to be perceive reality differently ('acute psychosis') (Cooke, 2014). Some people may experience these occasionally and others very frequently (Gelder, Gath, & Mayou, 1983). The diagnoses typically given to people who are distressed by these experiences are schizophrenia, schizoaffective disorder and bipolar disorder. In recent guidelines (National Institute for Health and Care Excellence, 2014) bipolar disorder is referred to as a psychotic disorder.

There is no conclusive evidence for the cause of these experiences (Cooke, 2014) with genetics, stressful life events and trauma all suggested as playing a role (Bentall, 2010; Van Os, Rutten, & Poulton, 2008). The mainstream understanding of these experiences has been shaped by a medical perspective that positions them as symptoms of an illness (Bentall, 2005; Cooke, 2014). Some service users find diagnosis a constructive way to make sense of their distress and access professional support whilst others find them stigmatising and a denial of personal meanings (Cooke, 2014; Perkins et al., 2018). Some have argued that the application of diagnoses takes place within discourses and relationships based upon judgements about 'normal' ways of thinking, feeling and behaving (Johnstone & Boyle, 2018; Pilgrim & Tomasini, 2012). This pre-supposes the meaning of the experiences to which that diagnosis was applied, limiting dialogue and the participants' voices (Friere, 2007) that is essential to develop understanding.

Psychosis and Motherhood

The meaning of motherhood is diverse and intersects with ideologies about what is 'normal' or 'ideal' but appears to be central to how women are defined by themselves and others (Phoenix, Woollett, & Lloyd, 1991). The experience of being a mother may commonly be characterised by socially determined responsibilities for which mothers are assumed to take a primary role (Oyserman, Bybee, Mowbray, & Kahng, 2004).

The Multiple Determinants of Parenting Model (Belsky, 1984) provides a framework of parenting. Akin to the ecological models offered by Bronfenbrenner (1986) it suggests that parenting is an interaction of multiple individual and contextual factors. The most influential factors are those within the child (e.g. temperament), the home environment (e.g. stability), the parents' traits (e.g. personality) and the parents' environment (e.g. relationships, work and social networks). Belsky's model suggests that the interaction between parenting and a psychosis diagnosis is likely to be pervasive, affecting couple relationships, social networks, employment and parent-child interactions. There is evidence that parents with a psychosis diagnosis frequently experience social isolation and poverty placing them at greater need for support from social and health services (Campbell et al., 2012). There is also evidence showing poorer outcomes for the emotional development of children of parents with mental health problems (Leijdesdorff et al., 2017; Reupert & Maybery, 2007). This may place them at an increased risk of developing mental health problems themselves (Rasic et al., 2014).

Belsky's model attempts to dissect parenting into discrete factors, representing it in an abstracted form. This is helpful for strategic consideration of how services may target and support particular aspects of parenting. It does not, however, facilitate understanding of

how it feels to be a parent within a particular context. Seeking to develop a genuine understanding of parents' vulnerabilities is emphasised in more recent evidence-based models of effective family interventions such as the Family Partnership Model (H. Davis & Day, 2010). It is therefore valuable to undertake research that provides insights into the experiences and perspectives of parents.

Existing Reviews

Blegen, Hummelvoll and Severinsson (2010) reviewed literature on the experiences of mothers with mental health diagnoses, synthesising findings from 19 studies. They reported that experiences included feeling vulnerable, fear of being seen as not good enough and concern that their children might develop mental health problems. Blegen et al. described a shift in the research field from an individualistic focus on the mother's mental health problems to the broader socioeconomic factors and interdependence of the mother-child relationship. Socioeconomic factors relate to the intersecting areas of support networks, money, work, education, housing and experiences of misogyny and racism. They identified a gap in the literature concerning the lived experiences and existential concerns of these mothers.

Fox (2012) conducted a narrative review of qualitative studies on mothers with a mental health diagnosis, making connections between the literature and her lived experience. She highlights the value of qualitative research in enabling practitioners to learn about the individual experiences women report rather than relying on more abstract trends from quantitative studies believing that this will facilitate more person-centred practice.

Wittkowski, McGrath and Peters (2014) systematically examined 13 qualitative studies of women's experiences of psychosis and bipolar disorder. They found that women believed it

was impossible to understand experiences related to a mental health diagnosis without considering contextual factors such as culture, religion, socioeconomic status and the need to fulfil role expectations. Across the studies women varied in the extent to which they accepted a diagnosis as part of their experience. This related to whether they believed it was a constructive explanation and facilitated access to services. Some women felt a diagnosis was rendered meaningless where professionals failed to consider contextual factors and spiritual beliefs. Parenting was described as central to their lives and a motivator for strategies they believed facilitated their wellbeing such as engaging with services.

Aside from the small number of studies on the experiences of mothers with mental health problems the existing literature is limited by its epistemological position. The existing studies appear to take a positivist position that sees diagnosis as a valid labelling of a disorder or 'illness' with no exploration into the meaning of that diagnosis from the mothers' perspectives. This limits the understanding that can be learnt from the studies and applied to practice like the Family Partnership Model (H. Davis & Day, 2010).

Rationale for Current Study

Although the review by Wittkowski et al. (2014) included studies with mothers none of these used an IPA methodology. The meaning of a mental health diagnosis to mothers is therefore relatively unexplored despite being an important theme within the literature on women more generally. From an applied clinical perspective understanding parents' experience is a key task in the Family Partnership Model (H. Davis & Day, 2010). This raises questions over what mothers would express about their experiences when the researcher takes a deliberately tentative position towards the meaning of motherhood and a psychosis diagnosis.

Research Aims

The overarching research aim was to develop understanding of the experience of being a mother with a diagnosis of psychosis. There are three particular aspects of this experience that are of interest to the study:

- 1) The meaning mothers attribute to their experience of becoming and being a mother.
- 2) The meaning they attribute to their experience of a psychosis diagnosis.
- 3) The meaning and perceptions they attribute to how the experiences of being a mother and having a psychosis diagnosis interact.

Method

Design

This study used interpretive phenomenological analysis (IPA) based upon the guidance of Smith, Flowers and Larkin (2009). This was selected to enable an in depth exploration of the experience of being a mother with a psychosis diagnosis. IPA assumes a critical realist position, with phenomena existing in relation to the participant's lived experience but interpreted through the relationship with the researcher. In order to situate the researcher's perspective a statement of position is provided below.

Data were collected using one-off semi-structured interviews. Participants were recruited using opportunity sampling from community teams within an urban NHS mental health trust. The interview schedule (Appendix B) was developed under supervision from the research supervisor and with consultation from a clinical psychologist working in parental mental health. It was piloted with a mother with a psychosis diagnosis from the Salomons Advisory Group of Experts by Experience (SAGE) to appraise the appropriateness of the questions. The interview schedule had broad open-ended questions to maximise

opportunity for participants to discuss their experience in their own way (Smith et al., 2009).

The schedule was based upon the research questions to provide focus.

Ethical Approval

Ethical approval was granted from the South Yorkshire Research Ethics Committee (see Appendix C) and the NHS trust research department (see Appendix D).

Participants

Six participants were recruited from one NHS trust over a period of eight months. All were engaged with a psychosis focused community mental health team and having weekly or fortnightly contact with their psychologist for either individual or family therapy sessions.

The number of eligible individuals was unknown since the psychologists involved in recruitment only advised the researcher of the six who went on to participate. All those approached by the researcher therefore agreed to participate. The sample size was based upon recommendations for IPA studies (Maykut & Morehouse, 1994; Smith et al., 2009).

The size was considered sufficient as the emphasis of IPA is on understanding lived experience through in-depth analysis of a small number of participants.

Inclusion and exclusion criteria.

Potential participants were identified using the inclusion and exclusion criteria displayed in Table 6.

Table 6	
<i>Summary of Inclusion and Exclusion Criteria</i>	
<u>Inclusion Criteria</u>	<u>Exclusion Criteria</u>
Be over 18.	Have been exclusively diagnosed with post-partum psychosis (but they could have had this diagnosis at some point as long as they received another diagnosis of psychosis at least 12months post childbirth).
Have given birth to at least one child (currently under 18 years) and continue to have access in some form.	Experiencing a level of distress related to psychosis or other with foreseeable likelihood that the interview would trigger further distress (for example children recently removed to care).
Have had experiences leading to a diagnosis of any kind of psychotic disorder (including bipolar disorder). This could include experiences of psychosis alongside another mental health diagnosis (e.g. depression with psychotic features).	Non-English speakers.
Have capacity to provide informed consent at time of interview.	
Have the ability to be interviewed for 1 hour (possibly up to 2 hours depending on how much they want to share) and talk about what it means to them to be a mother and have a psychosis diagnosis.	

Sampling strategy.

The study aimed to use opportunity sampling to recruit six participants. Ethical approval was sought to recruit up to twelve participants in case some interviews did not provide sufficient depth and breadth of information. Homogeneity of the participants was based upon being a mother with at least one child currently under 18 years and had received a diagnosis of psychosis.

Participant characteristics.

Participant characteristics are displayed in Table 7. All the participants were female (n=6) and ranged in ages from 27 to 37. All the participants described their ethnicity as belonging to a black, asian or minority ethnic group (BAME). The number of children of each participant ranged from one to four. The range in years experienced of motherhood (i.e. the age of each participant's eldest child) was one to 19 years.

Table 7					
<i>Participant Characteristics</i>					
<u>Participant*</u>	<u>Age range</u>	<u>Ethnicity & Religion</u>	<u>Number of children (and age range (years))</u>	<u>Employment status</u>	<u>Given diagnosis**</u>
P1 Alya	25 -30	British-Pakistani	1 (0 - 3)	Full-time mother	"Psychosis"
P2 Amber	31 -35	Muslim British and African Carribean	1 (6 - 10)	Self-employed	"Bipolar"
P3 Khadija	36 - 40	Christian British Asian	2 (11 - 15)	Full-time mother	"Psychosis"
P4 Astur	25 - 30	Muslim British	1 (6 – 10)	Full-time mother	"Psychosis"
P5 Mary	25 - 30	Muslim Black British	3 (0 - 10)	Full-time mother	"Psychosis"
P6 Sheri	36 - 40	Christian Black Carribean	4 (0 - 20)	Full-time mother	"Psychosis" and "Bipolar"
Christian					
*All names are pseudonyms					
**Given diagnosis is that expressed by participant during interview					

Procedure

Participant recruitment and consent.

The researcher contacted psychologists working within psychosis community teams of one NHS trust who approached clients from their caseload who met the recruitment criteria. Psychologists were approached due to pre-existing relationships and were therefore more likely to promote referrals to the study. The researcher explained the study and recruitment criteria using the 'staff information sheet' (Appendix E) and also shared the 'participant information sheet' (Appendix F) for staff to provide to eligible individuals. The researcher contacted eligible individuals who had agreed to participate and an interview was arranged. This was completed either in person or on the phone depending on the participant's preference. Immediately before each interview participants were reminded of the study information detailed on the 'participant information sheet' and given the opportunity to ask questions. The researcher used the opening conversation to judge whether participants had understood what they were consenting to and whether they appeared alert and relaxed enough to take part. Participants were provided with a consent form (Appendix G) and confirmed their intention to take part by completing and signing it. One interview was conducted by telephone and the consent form was read out to the participant who agreed to it verbally. This was audio recorded. A £15 gift voucher was given to each participant to thank them for their time.

Data collection.

Audio-recorded interviews, using the interview schedule (Appendix B), were held with each participant following the consent procedure. These ranged from 60 to 90 minutes duration. Five of the interviews took place at the community team base where participants normally

met their psychologist and one took place over the telephone whilst the participant was at home. The interview schedule was used broadly to focus upon the research aims whilst allowing sufficient flexibility to explore the individual experiences of participants. The order and exact wording of questions therefore differed between participants. The interviewer prompted for elaboration and clarification on expressions that related to the research aims.

As the interview topics were sensitive and the participants potentially vulnerable to high levels of emotional distress, the researcher offered opportunities for breaks, early termination and reminders that they were not obliged to answer any questions. The researcher asked how they were feeling at the end of the interview to check their wellbeing. All of the participants reported that the interview had been a valuable opportunity to express themselves and none were identified as needing further support.

Data analysis.

The researcher transcribed the interviews verbatim and analysed with guidance from Smith et al. (2009) to ensure that the process was systematic and findings could be traced back to the data. This process followed six iterative stages. The researcher analysed each interview before moving on to the next. This consisted of the researcher immersing himself within the data by reading the interview multiple times and noting descriptive, linguistic and conceptual comments. From considering connections and patterns between these comments the researcher developed emergent themes that were grouped to produce further defined themes. The researcher then collated the themes from each participant to identify patterns across participants and produce subthemes. These were then grouped into four superordinate themes.

Quality assurance.

To improve the quality of the study the researcher used guidelines for qualitative research (Elliott, Fischer, & Rennie, 1999). In qualitative studies the researcher needs to be considered as the research instrument, with their ideas and beliefs informing collection and analysis of data (Latimer, 2003). The researcher built awareness of, and 'owned' their position through reflecting on their attitudes towards the project through discussion with their supervisor prior to data collection as well as undertaking a 'bracketing interview' with a colleague. This was supplemented by recording a reflective diary throughout the process (Appendix H). The credibility of findings was maintained through continuous comparison of emerging themes against the verbatim text and reviewing findings with the research supervisor. All themes in this report are grounded in example quotes and an extended list of quotations provided in Appendix I. The researcher has included appendices that document the theme development (Appendices J).

Statement of position.

The researcher identified as a white British man from a middle class background with a mother and father who remained married during his childhood. He also identifies as homosexual, is in a long-term relationship and has no children. He is training to be a clinical psychologist and has worked within a range of adult mental health services where diagnoses of psychosis were common and many of his clients were mothers.

Results

This study aimed to explore the experience of being a mother with a diagnosis of psychosis. Whilst each participant's experience was unique four superordinate themes were identified by the researcher. These and corresponding subthemes are presented in table 8.

Table 8

Superordinate Themes and Subthemes

Superordinate themes	Subthemes
Motherhood provides meaning	Meaning through the pleasures of parenting Meaning through the responsibilities of parenting
Making sense of a diagnosis	Diagnostic label as having multiple meanings Making sense of diagnosis with a biopsychosocial model
Perceived impact of psychosis	Perceived impact of diagnosis depends on context Perceived interaction of psychosis and parenting Ambivalent relationship with medication
Power of services	Services as supportive Services as surveillance

Superordinate Theme: Motherhood Provides Meaning

This superordinate theme consists of two subthemes that describe the way in which meaning is derived from motherhood: meaning through the pleasures of parenting and meaning through the responsibilities of parenting.

Subtheme: meaning through the pleasures of parenting.

All participants described how they derived meaning from motherhood through the love, joy and happiness it brought them or that it fulfilled a long-standing desire to be a mother.

"It just means like everything basically. It was just like....bundle of joy...And it's just like so much happiness all at once... it's a whole life to you basically. It means everything to you" (Alya, 1, p.5)

"Having to look after a little boy or girl. Loving them. Hugging them. Making them laugh." (Khadija, 3, p.4)

Subtheme: meaning through the responsibilities of parenting.

All the participants described how the responsibilities of parenting also gave them meaning.

"I think part of me keeps going for the kids because I think if it was left down to me I probably would have just given up." (Sheri, 6, p.16)

Being a mother was challenging at times but participants found joy in adapting to challenges and derived meaning from this.

"I see children as a blessing, not as a burden. And if it does feel burdensome it's more of a sweet burden." (Amber, 2, p.3)

Superordinate Theme: Making Sense of a Diagnosis

This superordinate theme summarises the experience of being given a diagnosis by professionals and the subsequent process by which participants attributed their own meanings. It contains two subthemes: diagnostic label as having multiple meanings and making sense of diagnosis with a biopsychosocial model.

Subtheme: diagnostic label as having multiple meanings.

Each participant held multiple ideas about what the term psychosis meant to them and this varied between participants. At a descriptive level there was a broad range of experiences attributed to psychosis. Some described behaving in ways they felt were not 'normal' for them such as being very angry, out of control, tearful, disconnected and depressed whilst others described hearing voices or seeing things.

"Like hearing voices, anxiety, OCD, depression. It's most towards depression because I kind of like, kind of like just saying weird things to my parents...cos' mostly I'm quiet. I get really angry, I get angry like with small things, like for example if someone says

something to me I just start to get angry. I just started to cry a lot, I get tearful, I get upset.” (Alya, 1, p.11)

Amber held multiple truths about her experiences, describing them as spiritual and related to her gift of foresight whilst also describing herself as having an illness. This was similar to the account by Astur.

“During my manic episodes I am functioning on a metaphysical or spiritual- I’m on a different complete vibration if you know anything about- ummm, I forgotten the name, something cycles. Anyway there’s a lot- for me there’s a lot of- I understand my illness on many different levels.” (Amber, 2, p.5)

Khadija explained how she considered the meaning of hearing voices could be interpreted in different ways depending on the cultural context, psychosis being the modern day interpretation. Despite this awareness she felt that the term psychosis and a biomedical interpretation made sense as she was benefitting from medication and psychotherapy.

“Olden days God talked to you, ok, then nature talked to you, or some Buddhist say it’s like your third eye open. In Islam it’s like on your right side there is a good angel and on the left side is the bad angel...but if you come to doctor point of view it becomes psychosis!...because its saying you’re hearing voices and you’re not supposed to be like that because your brain is gone...Medication helping me. And all the therapy I’m going is helping me. But if you go to the other people they’re going to have a different point of view.” (Khadija, 3, p.14-15)

Subtheme: making sense of diagnosis with a biopsychosocial model.

This theme summarises how biomedical ideas of psychosis existed alongside psychosocial ideas. Amber, Khadija, Mary and Sheri described how they made sense of psychosis in biomedical terms. Using language such as ‘hormones’, ‘chemical imbalances’, ‘wiring in the brain’ and ‘disorder’.

“It’s a mental health condition and it’s probably something you’ll have to live with for the rest of your life, something that has to be controlled with medication and maybe a form of therapy...Mental health condition is a disorder, to me that’s what it means, it’s also to do with maybe chemical, hormonal imbalances.” (Mary, 5, p.8-9)

Whilst biomedical terms were used by these participants they were also tentatively making sense of their experiences using psychological ideas such as the impact of trauma with major life events like giving birth. For Mary and Sheri the biological understanding seemed to be in opposition to a trauma-informed formulation from their psychotherapy session.

“I could put it down to hormones. But the therapist seems to think that it’s underlying trauma so I’ve got no choice but to try and believe it.” (Sheri, 6, p.23)

Superordinate Theme: Perceived Impact of Psychosis

This theme summarises the way in which participants perceived the impact of psychosis. It consists of three subthemes: perceived impact of diagnosis depends on context; perceived interaction of psychosis and parenting and ambivalent relationship with medication.

Subtheme: perceived impact of diagnosis depends on context,

This theme summarises how participants had varying experiences of dealing with a diagnosis depending on the context surrounding it. Astur, for example, felt comfortable with

professionals using the terms 'psychosis' and 'mental health' because she believed they used it in her best interests whereas she couldn't tolerate family or friends using it because it meant she would be regarded as 'crazy'.

"When professionals use "mental health" I don't have a problem with that because they're professionals, they know what's good for me. But other people will use "mental health" as a different- they might call you 'Oh, she's crazy', they will use a bad word. So I don't tell people that I have mental health." (Astur, 4, p.26)

The stigma of having a mental health diagnosis was also mentioned by participants Amber and Mary. They experienced this through the responses of friends and family as well as how this had been internalised. For Mary this was apparent in the relationship with her husband who she felt did not understand the way in which she made sense of her experiences because of the difference in their cultural backgrounds.

"I think he understand to a certain extent but the part of world where he comes from, he comes from the continent of Africa, mental health is still quite a taboo, there's still stigma about it so it was something quite new to him, he hasn't really had experiences like that before, like hasn't seen his wife going through that." (Mary, 5, p.14)

[Subtheme: perceived interaction of psychosis and parenting.](#)

This theme summarises the way that participants perceived their diagnosis, or the symptoms attributed to psychosis, affected their experience of parenting. One of the study's aims was to understand how they experience motherhood and a psychosis diagnosis interacting. This became a direct question within the interview schedule (Appendix B). The way participants responded was diverse, with some not understanding the question and

others responding in ways that did not seem to answer it directly. This theme emerged instead from expressions throughout the interviews indicating that, though they may not use the term 'interaction', it was an aspect of their experience. Alya spoke about how she perceived the symptoms of psychosis to directly impact how she interacted with her child.

"Oh mixing up is really difficult because it's really frustrating...I sometimes get just so angry so I sometimes shout at my baby." (Alya, 1, p.21)

Mary spoke about how her inpatient admissions took her away from her children and contributed stress to her family.

"It has an effect on the family. I know my husband was very stressed during that time, it was very challenging. You know, he was working and he still had to look after the children." (May, 5, p.13)

Amber expressed her beliefs about what a psychosis diagnosis meant for her identity as a mother, finding it helpful to conceptualise it as a disability affecting her mothering role.

"Just because we have bipolar doesn't mean we're not good mums. We're just mums with a disability. Um. That took a long time for me to realise. And now, with that, I'm more self aware of how I was feeling." (Amber, 2, p.20)

Khadija, Astur, Mary and Sheri expressed how psychosis was something they wanted to conceal from their children. They believed children needed to be mature enough to understand what the diagnosis meant before sharing it. The decision to conceal the diagnosis appeared to be in order to protect their children from a part of themselves that they couldn't explain.

“I didn’t show this to my kids. I’m protecting them. I’m not wanting to show them that I have this problem.” (Khadija, 3, p.21)

Subtheme: ambivalent relationship with medication.

All participants felt that medication was something that benefitted them but they all experienced weight-gain as a side effect. Alya, Mary and Sheri described how they attributed emotional distress, relapses and hospital admissions to trying to stop their medication. It is important to note that these participants believed this was due to symptoms from an illness rather than due to withdrawal from the medication.

“I wanted to be weaned off having to take medicine altogether, so that happened but not long after I had a relapse. So I think if they prescribe you medication to manage your symptoms that you should comply.” (Mary, 5, p.10)

Alya and Astur described the importance of taking medication to feeling more relaxed and maintaining a sense of normality.

“When I’m on medication, especially the medication I’m on now, depot, it really helps. I sleep enough hours, I sleep six to eight hours. I wake up, I do my normal things.” (Astur, 4, p.22)

The ambivalence towards medication was evident in how Alya, Mary and Sheri expressed that they disliked the necessity of medication and wanted to stop using it if they could. This appeared to be related to the meaning of taking medication rather than just disliking the side-effects. For these participants taking medication meant that they had an illness that needed to be managed.

“I didn’t really think anything of it to be quite honest with you. I think the first time round... um... I didn’t really feel that I had Bipolar to be quite honest with you. Like I came off my meds by myself, because I was just hell-bent on not believing that I’ve got Bipolar. Like, I just felt like the tablets were masking over what I truly felt.” (Sheri, 6, p.6)

Alya, Khadija and Sheri expressed frustration at how medication dominated conversations with professionals and family. They felt their distress was being framed in terms of concordance with medication rather than being listened to and understood.

“It was just like, ‘Oh, tablets this, tablets that’, they just wanted to keep me on tablets, tablets tablets tablets, it’s just, just got on my nerves after a period of time because they just want to shove tablets down my throat and that’s it.” (Sheri, 6, p.20)

Alya, Amber and Mary seemed to find it helpful to establish a sense of control over taking their medication, framing it as something they have learnt is beneficial and choose to take rather than being forced to take.

“I don’t refuse medication but what I do is I pick and take because I know what and how it effects me. And um...that’s because I’ve been taking medication religiously since 2013.” (Amber, 2, p.16)

Superordinate Theme: Power of Services

This theme summarises participants’ experiences of managing the power dynamics between them and mental health and social services. It consists of two subthemes: services as supportive and services as surveillance. The researcher produced this superordinate theme from abstraction of the two subthemes.

Subtheme: services as supportive.

Participants expressed ways in which they had benefitted from using mental health services.

Alya described how her psychology sessions helped her to release tension. She also liked to discuss the benefits and drawbacks of medication, helping her to feel in control of her decision to take it.

“When I come for the therapy I feel much relieved when I’m going out of the room cos’ everything’s come out and I’m like feel like more relaxed. Cos’ it’s like a big burden on me.” (Alya, 1, p.16)

Khadija experienced services as meeting her need to be understood in a way that her family and friends could not. This appeared to be related to two factors: the use of therapy sessions to establish a new and constructive understanding of her experience and as a trusted space that she could not find amongst family and friends.

“I don’t know why they’re [friends] so curious that there is something or that I’m hiding something like you know my mental health problem but there is some things that, you know, she don’t want to share and I never share with my husband and my mother-in-law. I share with professionals because like [Psychologist] told me ‘If you don’t talk nobody can understand what’s going on’ but with friends I don’t, I have [Psychologist] there to talk to.” (Khadija, 3, p.28)

Mary seemed to derive support from following the advice of services.

“I’ve learnt for myself or my personal experience is that... you know, I have to acknowledge that I have mental health challenges and that the best way to manage

that is um, listening to the advice of the medical professionals and comply as much as I possibly can but also let my concerns known as well.” (Mary, 5, p.18)

Subtheme: services as surveillance.

This theme summarises the experience of being surveyed for compliance to the requirements of services and sometimes mediated through their family. This was experienced in relation to mental health concerns generally (e.g. taking medication and changes in ‘symptoms’) and potential concerns about how participants were caring for their children. This was produced from the accounts of Alya, Amber, Astur and Sheri who seemed to have an awareness of how their behaviour or compliance with medication was being monitored. For Alya this was experienced through the interactions she had with her parents at home. She felt that her behaviour was being interpreted by her mother as signs of her compliance with medication.

“She [mother] says to me but have you taken your medication or not. It makes me even more angry sometimes because it’s kind of thinking, oh I’ve got this label of being ill.” (Alya, 1, p.19)

Amber described how she had learnt to ‘toe the line’ in terms of accepting the ideas of professionals. She felt it was necessary to accept the diagnosis and frame her experiences as an illness rather than talk about the spiritual significance to her otherwise she would be considered irrational and subject to further conditions. Amber articulated this through sharing the advice she gave to a friend.

“Because in [names NHS mental health trust] you can never go into hospital- like I had a friend, she’s er, schizoaffective disorder. When she went into hospital they said what do you think is wrong with you. She said I’m having a spiritual awakening, right.

They were like, you're sick. She was like, I'm having a spiritual awakening. She knows what she's having. She knows what she's experiencing. You can't see the world through another person's eyes. So the problem is with medicine, modern medicine is all about empirical evidence. So with that being said, I gave her advice, I said stop saying that. Tell them you're sick and you want to get better. Take your medication and get out. And she did then she got out. It's actually that simple." (Amber, 2, p.7)

Amber and Astur had experienced child protection investigations that appeared to have shifted their behaviour. At the time of interview Astur was being assessed by social services and waiting to hear if she could have full custody of her daughter. She did not express anger at this process and instead appeared to find satisfaction in complying with mental health services. This was framed by the belief that complying with mental health services meant she was doing the correct thing and would therefore get to maintain custody of her daughter. It appeared, therefore, that she experienced this surveillance as providing a frame in which she had to do certain things in order to look after her daughter.

Participant: "They [social services] always have contact with the Doctor or Care Coordinator and ask them 'Is she taking her medication? Is she coming to all her appointments? Is she having regular contact with her Care Coordinator?'. So they asked all that questions.

Interviewer: "And how do you feel about that?"

Participant: "Yeah I feel great because even if I can't make the appointment I always call and say I can't make it and come tomorrow or the next day." (Astur, 4, p.11)

In contrast, Amber had been investigated by social services in the past and was clearly angry at how the process was handled. This occurred in the context of her care co-coordinator visiting her at home and building trust that was later betrayed by a referral to social services. She made sense of this as social services being a punitive system and that the care coordinator was incompetent. Her attitude toward the system seemed to have been made more unfavourable by the child protection investigation finding no reason to intervene.

“I was having a manic depressive episode so she was coming to my house to do follow ups with me...And this cow still went and referred me to social services. You know why she did that referral? Because she wasn’t doing her job properly and she had to cover her back. I understand that her caseload may be big, whatever...and it’s all bureaucratic. And because of the system I had to be crucified and publically flogged.” (Amber, 2, p.15)

Discussion

This study found that the responsibility of motherhood gave participants a sense of meaning and endurance in the face of difficulties. This is consistent with previous research on mothers with mental health diagnoses. Sands (1995) reported that mothers described the parenting role as central to their lives whilst Ueno and Kamibeppu (2008) found that it provided a reason to care for oneself. The findings suggest the interaction with a psychosis diagnosis is complex. The responsibilities of motherhood gave the women a sense of meaning that helped them to carry on despite the difficulties presented by a psychosis diagnosis. Behavioural activation theory (Veale, 2008) may explain the parental role as providing impetus for activity that benefits mood. From an existential perspective, the role

may allow mothers to endure their isolation and mortality by providing meaning to their life (Yalom, 1980).

Some participants appeared to hold multiple meanings of the term psychosis. In this study it appeared that participants constructed their own meaning of their problems, making reference to the diagnosis, but only partially. This is consistent with studies suggesting that self-understanding had a stronger influence on how people see themselves in relation to mental health problems than the diagnoses given to them (Estroff, Lachicotte, Illingworth, & Johnston, 2004; Kinderman, Setzu, Lobban, & Salmon, 2006). Other research shows that meanings of mental health diagnoses varied between individuals and interacted with cultural and spiritual beliefs (Chiu, Morrow, Ganesan, & Clark, 2005; Hagen & Nixon, 2011). For some participants the multiple meanings seemed to be held without creating anxiety. However, for two participants their biomedical conceptualisation seemed to be challenged by considering a trauma-informed formulation as though the two were incompatible. This challenge could be attributed to the anxiety of bringing attention to traumatic events, a common feature of psychotherapy for trauma (National Institute for Health and Care Excellence, 2018b). From a cognitive psychology perspective it could be attributed to cognitive dissonance whereby discomfort arises from the perception of information that is incompatible with existing beliefs (Festinger, 1956). This tension may also reflect more general discourses on mental health where there is a lack of alternatives between a biomedical position and a moral one. In other words a dichotomy of 'brain versus blame' (Boyle, 2013). The biomedical position confers a 'sick role' by which difficulties are responded to by others, including institutions like social services and the welfare system, as being something for which the individual is not responsible (Parsons, 1951). Within this context the 'sick role' is essential to access rights and services (Frayne, 2019). This position

may also protect the participants from attributions of shame and guilt by themselves and others despite taking on an identity that positions them as in some way 'defective' (Johnstone & Boyle, 2018). Alongside this it also appeared that for some participants complying with the terms of services was necessary to avoid further surveillance or compulsory admissions, especially since these risk separating them from their children.

This study found that stigma was an important consequence of having a diagnosis but appeared to depend upon the context. The relationship to context may be explained by 'modified labelling theory' in which stigmatised individuals conceal aspects of themselves to manage reactions of others and appear 'normal' because they have learnt how people with mental health problems are commonly treated (Link, Cullen, Struening, Shrout, & Dohrenwend, 2006).

The participants' ambivalent relationship to medication seemed to depend upon their experiences and conceptualisation of psychosis. The participants seemed to hold a 'disease-centred' (Moncrieff, 2009) view of their situation in which they perceive medication as treating an underlying pathology. They therefore saw the medication as something they needed to take despite disliking their dependence upon it and the side-effects they experienced. In contrast, a 'drug-centred' view would see medication as having useful tranquilising or stimulant effects (Bentall, 2010; Moncrieff, 2009).

The study found themes of services being experienced as supportive as well as a source of surveillance. The support described by participants is similar to that found in the review by Wittkowski et al. (2014). Wittkowski et al. found that women saw professional support as an important aspect of coping, especially in the context of poor social support. In the present study services may have reinforced the biomedical meaning of the participants' experience,

facilitating the 'sick role' that may be essential to accessing welfare support and explaining their difficulties to others without being blamed. Some participants also described feeling curious about the trauma-informed meanings introduced by psychologists. Whilst they were sceptical of the value of the meanings presented through psychology they may have benefitted from an alternative to the 'brain vs blame' dichotomy. The use of the biopsychosocial model may reflect that all participants had been prescribed medication and were engaged with psychological therapy. Spiritual and cultural understandings were expressed by some participants but seemed to have been relatively unexplored in professional interactions.

The experience of services as a source of surveillance is reflected in previous studies. Nicholson (2005) noted evidence of parents avoiding discussions about their parenting role for fear that services would file reports with child protection services. The experience of needing to submit to the expectations and instructions of services by some participants in the present study echoes findings by Hagen and Nixon (2011). They found that women were motivated to appear 'normal' to others by fear that they would lose self-determination, especially in relation to custody of their children. Davies and Allen (2007) interviewed mothers using mental health services about their interactions with professionals. They found that surveillance was sometimes resisted by mothers, in choosing what to reveal and conceal. At other times, however, it seemed to have a beneficial aspect in being experienced as professionals validating their identities as mothers. This may explain why some participants in this study expressed satisfaction about complying with the requirements of services.

Strengths and Limitations

IPA methodology, regardless of sample size, does not attempt to generalise to the population (Smith et al., 2009). The findings from this study contribute insights into the experience of mothers with a diagnosis of psychosis but are not intended to be reliable predictions of experiences in the broader population.

Participants were all engaged with a psychologist and doing some form of family or individual psychotherapy. As well as increasing the homogeneity of the sample, participants may have been more trusting of the interviewer (identifying as a trainee clinical psychologist) by association. The study may have been able to develop insights into the participants' experiences that they wouldn't have chosen to express had they not already been engaged in psychology. A caveat of this is that some participants explicitly stated how psychology sessions had changed their meanings of psychosis. Engagement in psychology is likely to intersect with other factors important to the experience of psychosis and motherhood such as service provision, homelessness or extreme distress. Whilst this study explored experiences within a certain context, further research is needed to draw conclusions about how experiences may differ in other contexts (e.g. inpatient settings or more severe emotional distress).

The interviews were all conducted by a man, whose profession (clinical psychology) was made clear to participants, as was the possibility it may be necessary to share some disclosures with the mental health team. All but one of the participants was interviewed in their typical community team base. These factors could have influenced responses as participants may have intentionally withheld aspects of their experience for fear that the interviewer would not understand or would report them. Additionally, the interviewer and

location of the interviews may have set an interactional frame (Goffman, 1981) typical of professional interactions such as using biomedical concepts or not disclosing some of their difficulties with parenting. On the other hand it is difficult to predict what the setting and interviewer's gender meant to each participant. It would not be possible to remove the effects of the interviewer since this study, like IPA generally, was based upon a position of critical realism. It was anticipated that characteristics of the interviewer would affect how insights are developed from the encounter with participants (Latimer, 2003; Smith et al., 2009). Whilst generalisations cannot be made on the basis of individual experiences, it is noteworthy that the one participant who clearly expressed criticism of services and the biomedical conceptualisations of her experience was interviewed at home via the telephone.

The participants in this study all identified their ethnicities as belonging to a minority group. Recruiting only ethnic minorities was not an aim of the study and instead reflects the demographics of the population where the research took place. There were not enough explicit comments from participants to create a theme related to ethnic or cultural identity. Identifying a theme based on the white researcher's perception of difference, rather than explicit comments from participants would have been inappropriate. Historically, 'white' clinical psychology researchers have studied the 'other' (Kitzinger and Wilkinson, 1996) from a normative position. Instead, the interviewer needed to have given more consideration to how participants may have voiced experiences in relation to their ethnicity and cultural background. It is possible that the interviewer's whiteness intersected with his professional status to limit the interactional frame and reduce opportunities to voice an important aspect of participants' experience. Widening the interactional frame could have been done through the interviewer offering that their own whiteness may have brought particular

understandings of psychosis and motherhood and being curious about the participants' own experiences of race (Nolte, 2007).

Previous research suggests it is possible that participants in this study may have been inhibited from talking openly about the challenges they experience when parenting. There is evidence from studies in the context of health visiting and psychiatric nursing that clients conceal some behaviours from professionals because of fear of moral judgements or being reported to child protection services and to construct a more positive identity (Bloor & McIntosh, 1990; Davies & Allen, 2007). Hagan and Nixon (2011) also found that some women with a psychosis diagnosis felt invalidated and unheard by mental health services. There is evidence from research on the use of peer interviewers in other mental health contexts that participants felt more comfortable with peer researchers compared to research staff (Croft et al., 2016; Elliott et al., 2002). Before interviewing participants in this study the researcher was clear about his professional role and that confidentiality would need to be broken should participants share information that constituted a safeguarding issue. It is reasonable to expect participants perceived the researcher with similar expectations and concerns that they would have towards other professionals. It is therefore possible that participants actively withheld some of the challenges they experience when parenting. Issues may have included expectations that a white, male researcher would not understand the nuances of challenging experiences and fears that he may judge them as unfit to care for their children and report them to other professionals.

There are limitations to the generalisability of the findings due to the nature of the sample and recruitment process. All participants were recruited through clinical psychologists seeing them for psychological therapy. It was clear from discussions with the clinical

psychologists that they referred clients who they felt would be sufficiently stable, in terms of emotional distress and current social circumstances, to participate in an interview. They also referred those they perceived would be able to narrate their experiences with a level of depth that would be meaningful to the project. This context had implications for how participants interpreted their experiences and therefore limits the findings. For example, participants were interpreting their experiences from a current emotional and social context that was different from when they were in the midst of severe distress. The interpretation of their experiences may therefore be very different from women who were in the midst of severe emotional distress or, for example, feeling acutely threatened by the prospect of their child being removed. The participants in this review may also have had more supportive experiences of mental health services that led to them agreeing to participate. The experiences of women who were less engaged with services are therefore absent from this study.

Research Implications

Further research is needed to draw wider conclusions from the findings in this study. This could be achieved by using IPA with different groups of mothers with a range of mental health diagnoses to develop a richer picture of experiences that seems relevant in different contexts.

Studies should also include mothers who have never used services or reject the need for services, as they are likely to have a very different experience of the interaction between psychosis and parenting, for example benign voices being experienced as benevolent spiritual guides.

A peer-researcher approach in which mothers with a psychosis diagnosis are recruited to conduct the interviews could support participants to talk more openly (e.g. Croft, Ostrow, Italia, Camp-Bernard, & Jacobs, 2016; Elliott, Watson, & Harries, 2002). This could allow a broader interactional frame and reveal important insights that would not be identified by a professional researcher. The researcher's background and status, however, will bias all stages of the study including what questions are deemed important to research, what findings are considered salient and what they mean when applied to a clinical context. It may be essential that researchers of a particular ethnicity, gender and background do not have superficial involvement or consultancy but lead the research process. Writers on feminism, racial oppression and liberation psychology have argued that this is essential to develop understanding that is rooted in the interests and voices of the oppressed group rather than a more privileged researcher (e.g. Friere, 2007; Lorde, 1984; Martín-Baró, Aron, & Corne, 1996).

Clinical Implications

The results of this study reinforce the centrality of the parenting role to the experience of people using mental health services and the value of professionals allowing the parenting role to be a significant aspect of assessment and plans. This needs to be balanced against the tendency for the surveillance of services to be experienced as intrusive. This balance may depend upon mothers feeling they have enough control over their lives and parenting role and perceiving their strengths as recognised. The finding that mothers had multiple meanings of psychosis and benefitted from feeling in control of how it was managed (even if this was to closely follow the advice of professionals) suggests that a collaborative approach with services is important. The importance of professionals developing and conveying a genuine understanding of parents and their strengths is emphasised in The Family

Partnership Model (H. Davis & Day, 2010). A strengths based approach is also emphasised in models that are more specific to parental mental health than the Family Partnership Model such as Falkov's (2012) Family Model. The findings from this study could support the work of clinical psychologists using these models when working with families where the mother has a diagnosis of psychosis. The findings could enrich clinical psychologists' understanding of how mothers may make sense of their experiences. Where clinical psychologists may be working individually with mothers the findings of this study could be helpful for promoting a collaborative formulation rooted in a whole person approach rather than focussing on the mental health diagnosis (Johnstone, 2014).

Conclusion

This study found that mothers with a psychosis diagnosis experience their parenting role as having a central meaning to their lives. The mothers held multiple meanings about their diagnosis in which a biopsychosocial understanding was dominant. Biomedical understanding was the most dominant with psychological meanings, specifically the role of trauma, tentatively expressed. The impact of a diagnosis depended upon the participant's social context. Diagnosis was seen as helpful to explain difficulties and reduce personal blame when used by professionals but could be experienced as stigmatising by family and friends. The interaction of a psychosis diagnosis and parenting was experienced in terms of how perceived symptoms reduced energy and hospital admissions interrupted relationships with family. Side effects of medication impacted energy for parenting but continued adherence was regarded as essential to manage what was perceived as an illness. Services were seen as supportive by providing a confidential, professional relationship and advice on

what should be done to manage their diagnosis. Services were also seen as a form of surveillance both in terms of checking adherence to medication and capacity to parent.

This study provided insights into the personal meanings of motherhood and a psychosis diagnosis. This showed the complexity of these meanings as an interaction of biopsychosocial, spiritual and cultural understandings. This suggests neither biomedical nor psychological narratives are sufficient to understand experiences of mothers with a psychosis diagnosis. If services are to follow strengths based and partnership models of support for parental mental health (e.g Davis and Day, 2010) then practitioners will need to develop individual understandings of their clients' experiences.

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Section C

Appendices and supporting information

Appendix A: Scoring details of SQAC

Quality Scoring of Quantitative Studies

“Total sum = (number of “yes” * 2) + (number of “partials” * 1) Total possible sum = 28 – (number of “N/A” * 2) Summary score: total sum / total possible sum”

(p14; Kmet et al., 2004).

Quality Scoring of Qualitative Studies

“Total sum = (number of “yes” * 2) + (number of “partials” * 1) Total possible sum = 20 Summary score: total sum / total possible sum”

(p20; Kmet et al., 2004).

Appendix B: Interview schedule

Interview date _____ Participant identification number _____

Study title: The experience of being a mother with a diagnosis of psychosis

Document title: Interview schedule. Face-to-face version. V3.2 – 01.02.2018

First meeting

After greeting participant they are to be given a gift voucher to thank them for giving up their time for the interview.

Consent

Participant to be given 'participant information sheet' should they not already have one and interviewer to explain aims and procedures of the study as described.

Participant to be asked if they have any questions about the 'participant information sheet', aims and procedures of the study. Confidentiality to be reiterated, as well as the limits to this. Offer that participant can use pretend names for their family members if they prefer.

If participant wishes to continue with the study they must sign the consent form.

If participant declines to continue with the study they are to be thanked for their involvement so far. The interview to then be terminated and debrief procedure followed. They are to keep the voucher.

If consent has been obtained, inform participant that audio recording will begin.

Begin audio recording

Introduction

Interviewer to say: *I am going to ask you some questions about what it is like to be a mother with a diagnosis of psychosis. You'll probably notice that I'll say very little. This is because I'll be listening to what you have to say and ensure I understand as best I can. I'll apologise in advance if I interrupt you. This would only be to check I understand or to ask a question. Some of the questions might seem quite vague. This is because there are no right or wrong answers and the main focus of the interview is on your ideas and experiences and what you feel is important to share. If at any point I ask a question you don't want to answer please just say something like "I'd prefer not to answer that". Before we begin do you have any questions?*

Section 1. Warm up questions to settle in to the interview – current family

i) As a way to start, can you tell me a bit about your family?

ii) Who lives at home with you?

iii) Who else is in your family?

Section 2. Experiences of being a mother

i) We've spoken a bit about your family so far. I was wondering if you could tell me about your experience of being a mother?

Possible prompts: When did you first become a mother? What are the main differences between before and after you became a mother? Can you tell me about any positive aspects of being a mother? Can you tell me about any challenges of being a mother? What does being a mother mean to you?

Section 3. Experiences related to a diagnosis of psychosis

i) I understand that you received a diagnosis of psychosis, can you tell me more about that?

Possible prompts: When did you receive the diagnosis of psychosis? What did psychosis mean to you at that point? What does psychosis mean to you now?

ii) What words do you use to describe your experiences that the mental health team called psychosis?

NOTE: From this point on use participants own words (e.g. "stress", "problems", "hearing voices" etc) rather than "psychosis" unless they use this word themselves. Use these in the spaces indicated by (.....).

iii) In what ways do you think (.....) affected your life in the past?

Possible prompts: If there were difficult aspects, what were they? If there were positive aspects, what were they?

iv) In what ways do you think (.....) affect your life now?

Possible prompts: If there are currently difficult aspects, what are they? If there are currently positive aspects what are they?

Section 4. The interaction of being a mother and having experiences related to a diagnosis of psychosis.

NOTE: Due to the context of this interview, there may already be sufficient responses to this area during sections 2 and 3. Therefore do not repeat questioning where it is clear the subject has been covered.

i) You've shared some of your experiences of being a mother and also your experiences of a psychosis diagnosis and of (.....). I'd like to understand a bit more about how you see your experiences as interacting.

I'll just explain what I mean by interacting. For example, I wondered how you see your experience of being a mother as having made a difference to your experiences of a psychosis diagnosis and of (.....). Perhaps you also see your experiences of a psychosis diagnosis and of (.....) as making a difference to your experience of being a mother?

Possible prompts: In what ways, if any, have the experiences interacted in the past? In what ways, if any, do experiences interact in your life now? Are there any positive aspects in the way that these experiences interact? Are there any difficult aspects to the way that these experiences interact?

Section 5. Concluding the interview

Interviewer to say: *Thank you for talking with me. I found it really interesting to hear about your experience and it's given me lots to think about for my research. How has the interview felt for you? Do you have any questions for me?*

Interviewer to ask participant to answer questions necessary for demographics capture form if this information not already captured during interview.

Interviewer to check participant still consents to have their interview included in the study. If they decline, audio recording is to be deleted.

Cease recording

End of interview

Appendix C: Health Research Authority approval

This has been removed from the electronic copy.

Appendix D: Local NHS Trust research and development department approval

This has been removed from the electronic copy.

Appendix E: Staff information sheet



Researcher: Laurence Palfreyman, Trainee Clinical Psychologist (Laurence.palfreyman@XXXX.nhs.uk)

Supervisor: Dr Maria Griffiths, Consultant Clinical Psychologist (Maria.Griffiths@XXXX.nhs.uk)

The experience of being a mother with a diagnosis of psychosis

Staff information sheet – v2.1 – 06.03.2018. IRAS ID 239602.

Who is running this study?

This study is run by me, Laurence Palfreyman, a trainee clinical psychologist at The Salomons Centre for Applied Psychology and supervised by Dr Maria Griffiths, Consultant Clinical Psychologist at XXXXX NHS and clinical and academic tutor at The Salomons Centre for Applied Psychology.

The study has had approval from an NHS ethics panel, XXXX R&D and XXXXXXXXX R&D. It has also had approval from The Salomons Centre for Applied Psychology to ensure it has academic and clinical relevance.

What is this study about?

There has not been enough research that seeks to understand the experience of being a mother with a diagnosis of psychosis. In particular, there's little research on how they make sense of this experience, both the negative and positive aspects. This study will involve interviewing mothers to understand their experience of being a parent, the experiences they see as related to a diagnosis of psychosis and how they make sense of the interaction between these experiences.

This could include any mothers who have had experiences leading to a psychosis diagnosis e.g. schizophrenia. It could also include those with other sorts of difficulties, such as low mood, or bipolar disorder, where this occurs alongside experiences described as psychosis.

This study is not planning to involve those diagnosed with post-partum psychosis.

What will these interviews involve?

I'm planning to interview 8-12 mothers. The interviews will be very open ended in order for the mothers to share what they feel is important. Each interview will last about one hour,

possibly longer, depending on how much they want to share, and can take place either in the participant's usual clinic or via the phone or video call e.g. Skype, WhatsApp (whichever they feel most comfortable with). I will use a semi-structured interview schedule. If you'd like to see a copy of this please let me know. The interviews will be transcribed and analysed using Interpretive Phenomenological Analysis (IPA).

All interviews will be treated as confidential with the exception of events that constitute a safeguarding issue.

Participants will receive a £15 Love2shop gift card that can be used in over 120 well known high-street stores including Boots, Argos, Primark and T.K.Maxx amongst others.

What would recruitment involve?

If you were interested in helping with recruitment I would provide you with copies of the participant information sheet. You would be able to use this to consider any mothers on your caseload who might meet the inclusion criteria. You could then provide them with the participant information sheet and ask them if they'd be happy for me to contact them to see if they're interested in being interviewed.

If they agree then I'd need the minimum information necessary to make contact with them (e.g. first name and phone number or an email address). This could be emailed to me using myXXXX address (Laurence.palfreyman@XXXX.nhs.uk).

I would use this to make contact after 7 days, to give them a chance to consider their decision. If they then agreed to be interviewed I would arrange a time with them. If they decline then I will not contact them again.

If they prefer to be interviewed at the clinic where they normally see you then I may need to contact you asking how I would book a room.

You would not need to do anything else.

What next?

If you have any clients who may meet the inclusion criteria and may wish to participate then please email me at: Laurence.Palfreyman@XXXX.nhs.uk.

You can also use this address to ask me any questions.

Inclusion and exclusion criteria

Inclusion criteria

To take part, participants must:

- Be over 18.
- Have given birth to at least one biological child (currently aged 18 years or younger) and continue to have access in some form.
- Have had experiences leading to a diagnosis of any kind of psychotic disorder before or during being a parent. This could include experiences of psychosis alongside another mental health diagnosis e.g. depression with psychotic features.
- Have capacity to provide informed consent at time of interview.
- Have the ability to be interviewed for 1 hour (possibly up to 2 hours depending on how much they want to share) and talk about what it means to them to be a mother and have a psychosis diagnosis.

Exclusion criteria

- Have been exclusively diagnosed with post-partum psychosis (but they could have had this diagnosis at some point as long as they received another diagnosis of psychosis at least 12months post childbirth).
- Experiencing a level of distress related to psychosis or other with foreseeable likelihood that the interview would trigger further distress (for example children recently removed to care).
- Non-English speakers.

If you have any clients who may meet the inclusion criteria and may wish to participate then please email me at: Laurence.Palfreyman@XXXX.nhs.uk

Appendix F: Participant information sheet

Participant Information Sheet

IRAS ID: 239602

I invite you to take part in a research study

The experience of being a mother with a diagnosis of psychosis

- Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve.
- Please take time to read the following information. Discuss it with friends and relatives if you wish.
- You are free to decide whether or not to take part. If you choose not to take part this will not affect your

Important things that you need to know

care in anyway.

- Ask me if there is anything that is not clear or if you would like more information.
- I want to contribute to understanding of the experiences of mothers who have had a diagnosis of psychosis. This may help professionals to better understand the needs of mothers and support them more effectively.
- If you take part I would interview you for up to 2 hours about your experiences of being a mother and having a diagnosis of psychosis.
- The interview can take place either in person at your usual care team location or on the phone or video-call.
- The interview is anonymous and you can share as much or as little as you feel comfortable.
- As a token of appreciation you will receive a £15 Love2shop gift card for participating.



Contents

1. Why is this study being done?
2. Why am I being asked to take part?
3. Do I have to take part?
4. What will I need to do if I take part?
5. What are the possible benefits of taking part?
6. What are the possible risks or disadvantages of taking part?
7. Further information
8. Next steps and full contact details

How to contact me

If you have any questions about this study please contact me:

Laurence Palfreyman
Trainee Clinical Psychologist

Tel: XXXXXXXXXX

Laurence.palfreyman@XXXXX.nhs.uk

1. Why is this study being done?

There has not been enough research on how mothers with a diagnosis of psychosis make sense of their experiences and what they feel is important for people to know. This study aims to understand how they make sense of their experiences of being a mother and having a diagnosis of psychosis. I hope that the findings will suggest ways that services can improve the support they offer to mothers with a diagnosis of psychosis. This study is being done as part of my clinical psychology training at Canterbury Christ Church University.

2. Why am I being asked to take part?

You've been approached about this study because a member of your routine care team is aware that you are a mother with children under 18 years of age and have a diagnosis of psychosis. You therefore may be eligible for the study and may be interested in finding out more.

3. Do I have to take part?

No, the decision to participate is solely up to you.

If you choose not to take part this will not affect your care in anyway.

You can withdraw from the study at any time.

4. What will I need to do if I take part?

All the results will be anonymous so it won't be possible to identify you or link you to the results in any way.

If you decide to take part in this study I will interview you for up to 2 hours and ask some questions about being a mother and having experiences related to a diagnosis of psychosis. The interview will be a bit like a conversation where I ask you what you'd like to say about your experiences. I'm really interested in your own individual experience, what you think is important and how you have made sense of things.

I will not ask you to talk about anything which you do not feel comfortable talking about.

If possible I'd like to meet you in person. We can do this where you normally meet those involved in your care. Alternatively you may feel more comfortable to be interviewed over the phone, Skype or a video call on WhatsApp. It is entirely up to you how we conduct the interview. However, it's important that you can be interviewed alone so that you feel free to share your experiences. This means that I won't be able to interview you with any children present.

I'll audio record the interview so that I can listen back later and make sure I've heard everything properly.

After the interviews I will type up the recordings, removing any names or information that could identify you. You can choose whether the recordings will be typed up by me or a professional typing service. I'll then think about them in a lot of detail so I can write up a report for my university and later publish it in an academic journal. I'll also present the findings to mental health services that want to learn more about the needs of mothers.

5. What are the possible benefits of taking part?

I hope that this study will lead to a better understanding of the experiences and views of mothers who have had a diagnosis of psychosis. This may help professionals to better understand the needs of mothers and support them more effectively.

The interview will be an opportunity for you to share your experiences with a researcher without judgement. Many people who take part in research like this find the experience of telling their story in detail to be a helpful experience.

As a token of appreciation you will receive a £15 Love2shop gift card for participating. This can be used at over 120 high street shops.

6. What are the possible risks or disadvantages of taking part?

Sometimes people find it difficult to share their experiences with someone they have not met before. This can also bring up difficult experiences that they'd rather not think or talk about. I will make sure that your wellbeing takes priority. It is fine to stop the interview at any time if you don't wish to continue.

7. Further information

Notifying your GP

With your permission I will write a short letter to your GP and mental health care team stating that you've chosen to participate in an interview about being a mother and experiencing a diagnosis of psychosis. I will not share what you talked about in your interview in this letter.

Limits to confidentiality

Although I may have met you through staff in the NHS, I will not share what you have talked about with them. One exception is if you tell me that you or a vulnerable adult or child is at risk of harm. In this case I have a duty that if you raise concerns regarding safeguarding of adults and children, then this will be raised via the local policies and procedures. The other exception is if we conduct the interview via telephone, Skype or WhatsApp and you terminate the interview abruptly, whether deliberately or due to a poor connection. If I cannot contact you again to see if you are OK then I may need to contact your care team so they follow up to see if you need further support.

Collection and storage of names

Your name will only be required for the declaration of consent but this will not be attached to your interview. Your declaration of consent will be securely stored at Canterbury Christ Church University for 5 years. These will only be looked at if the project needs to be reviewed to check that people consented to take part. They'll then be destroyed.

Quality and ethical assurance of this study

This study will be supervised by Dr Maria Griffiths who is a clinical psychologist and works at Canterbury Christ Church University and the XXXXXXXXXXXX NHS.

This study has received approval from an NHS ethics committee meaning it's been carefully checked to make sure that the well-being of anyone who takes part is given priority.

Support available following the interview

Following the interview I will ask you how you are feeling. If you feel you need further support following the interview you can find anonymous and free telephone support by calling *Samaritans* on 116 123. You can also contact your usual care team and GP. There's also a 24 hour crisis support line provided by XXXXXXXXXXXX. If you have any questions regarding the study please do not hesitate to call me on XXXXXXXX.

8. Next steps and full contact details

If you have any more questions about this study or you have decided that you would like to take part, please email me (Laurence.Palfreyman@XXXX.nhs.uk) or call or text me on XXXXXXXX. If I do not hear from you after 7 days, I'll contact you using the preferred details you provided.

If you're interested in taking part we will discuss how you would like to be interviewed and the date and time most convenient for you.

If you're not interested in taking part you do not have to do anything and your care will not be affected in any way.

If I've tried to contact you and you've said you're not interested in taking part, or have not responded to my attempts to contact you, I will not contact you again.

My full contact details are:

Laurence Palfreyman
Trainee Clinical Psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road
TN1 2YG

Tel:XXXXXXXXXX

Email: Laurence.palfreyman@XXXXXXX.nhs.uk

Appendix G: Consent Form



Consent Form

Study title: The experience of being a mother with a diagnosis of psychosis

IRAS ID: 239602

Date: Participant ID:

Please read the statements below and **tick each one**:

1. I confirm that I have read and understand the participant information sheet and that I have had an opportunity to ask questions. [☐]

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. [☐]

3. I consent to an audio recording of the interview being made and typed up [☐]

4. I consent to anonymous quotes from my interview being used in the write up, publication and presentation of this study. [☐]

5. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. [☐]

6. I consent to my interview being typed up by someone other than Laurence and understand they are bound by a confidentiality agreement to not share information from my interview outside the research team:

Yes, I'm happy for someone else to type up my interview [☐]

No, I'd prefer that only Laurence types up my interview [☐]

Participant Name:

Participant Signature:

Researcher Name:Laurence Palfreyman.....

Researcher Signature:

Appendix H: Abridged reflective diary

Initial research question development

August 2017

I met with my internal supervisor for the first time to discuss broadly the ideas for a project. I didn't have a particular area of in mind so was interested in being guided by a supervisor whom I felt I could work well with. My supervisor discussed the idea of researching the experience of mothers with psychosis as this, as an area of focus, seemed to be under-researched. I had absolutely no idea about this area but I was attracted by how little I knew and what I could learn from undertaking it. A few weeks later we met with a potential external supervisor to discuss the ideas further. We settled on a broad question of the experience of mothers with psychosis. I then worked alone to develop the ideas further independently.

Developing the research proposal

September - November 2017

I've been working on the proposal. I've had detailed and constructive feedback from both my internal supervisor and potential external supervisor. The underlying theory and research gap are clear, as is the research question. There was a significant difference of opinion between me and the potential external supervisor regarding the sample size. They wanted to use a sample size of 16-20. This did not seem justified by IPA methodology and was unfeasible considering my timeline. I had a few email conversations and telephone calls with other staff at Salomons and came to the conclusion that I would pursue a small sample size of about 6. As the potential external supervisor wanted a larger study we agreed for them to no longer be involved as a supervisor and instead act on a consultative basis.

Ethics application

December 2017 – June 2018

Having had the proposal signed off I was ready to start the ethics application. I felt very daunted by it, having heard from other trainees about how slow and awful it is. To keep me motivated I started networking with psychologists in the Trust where I'm hoping to recruit. We had a meeting where I presented my proposal. The response was really positive and the project felt realistic and valuable. This was helpful as writing the ethics application made me feel anxious about whether I would be able to recruit enough people and if the project would be a disaster – the process required me to think through how I'd manage all sorts of terrible scenarios from distressed participants to losing my laptop. The process was fiddly and a laborious but I do believe it's made me think in a more detailed way about what I'm trying to achieve and ensuring I've got everything in order. During the preparation I had a couple of telephone consultations with a woman who had a diagnosis of psychosis. I contacted her via the Salomons Advisory Group of Experts by Experience. She pointed out that some of the wording in my interview schedule and participation information sheet didn't make sense. She also talked to me about the importance of being open and honest about how information will be used as she believed a lot of mothers may feel uneasy about talking to me. I eventually submitted my application in January 2018 and had a review date for February. It was quite scary knowing that my project was being scrutinised by a panel somewhere. However, the queries that came back were entirely manageable and I was able to address them in a day or so. There were some things about it that I felt were a bit unreasonable. For example, I had made lots of effort to get my participant information sheet down to two pages but they wanted a lot more information included. The finished product ended up being extremely long and I needed to spend a lot of time tweaking the format to make it easier to read. There was then quite a delay in getting the final sign off. I found out that this was because the HRA assessor had been off-sick! The delay was ok, however, as it gave me space and

time to think about my Part A. Once I had the HRA approval the NHS Trust R&D came through fairly easily.

Bracketing

June 2018

In preparation for interviewing I've been having a lot of conversations with colleagues and friends, including those who are mothers, about the project. We talked about how I expected participants to be reticent about talking to me because I was a man and a professional. I was also expecting them to be critical of the psychosis diagnosis, perhaps from my exposure to people with such a diagnosis.

Recruiting and interviewing

June 2018 – January 2019

This has been easily the most anxiety provoking aspect of the whole research process so far. Once I had ethical approval I was very worried that I wouldn't actually be able to recruit anyone. The whole process felt completely outside my control. Having never done an MRP before I have no idea how long it will take me to analyse and type up – a lot of unknowns. Whilst I met several psychologists who have been interested in my project it was rarer to find one that would put action to words and actually speak to their clients. A colleague of my supervisor has been really helpful and it was through them that I made contact with my first participant. This was daunting because I felt like I was asking a lot of the participants and thought I'd need to persuade them to take part. I was pleasantly surprised by the first participant who said she thought what I was doing was valuable and of interest to her. When it came to interviewing her I was really surprised by what she said as it made me think about aspects of her experience I could never have imagined – I was particularly fascinated by how she seemed to hold multiple truths about the experience. My fears about whether she would want to talk to a professional and a man about her experience were somewhat relieved as at the end of the interview she spoke about how good it felt to talk openly about her experience. Doing an actual interview made all the effort of the design and ethics application completely worth it. I felt inspired and more confident about discussing the project with other psychologists and prompting them to talk to their clients. I started to quite enjoy the process of regularly emailing psychologists who had expressed interest in the project. It's been satisfying recruiting participants and it's made me appreciate how 'hard-to-reach' this population is. Psychologists told me that the mothers they see are either too busy or too distressed to take part in an interview so I've needed to exercise lots of patience.

Emailing subsequent participants has been equally fascinating because the experiences seem to diverge so much. I've been trying to not get too anxious about identifying commonalities between the experiences and trust that the analysis process will give me space and time to think about themes in more depth. It's fascinating to explore with people with their meaning of their experience is. I've been really surprised by how important the psychosis diagnosis is to some of the participants and how they're not critical of it.

To help with my upcoming analysis I recorded my initial impressions following each interview.

I started noting down my initial impressions after analysing each interview.

Participant 1 (Alya)

My experience of being with her in the room. I found her to be very engaging and charming. She laughed easily and was eager to talk, almost to the point where I had to interrupt her. At times I was struck by the way she would share what sounded like very distressing experiences (e.g. thoughts of harming her baby) but would run past these quickly. She also frequently describe herself in the third-person, often talking about her past behaviours rather than her thoughts or feelings at that time. I was aware that she had a very different cultural context from my own and so I struggled sometimes to

contextualise what she was saying. For example, I wondered how typical it is for a mother and her husband to live in the grandmother's home or whether this was necessary due to the difficulties that she was experiencing.

Participant 2 (Amber)

During the interview she seemed articulate but at times I wondered why she was telling me about her various successes and if this functioned to signal to me to take her seriously. At points during the interview she kept drifting in and out seeming to get distracted by tasks on the phone.

Participant 3 (Khadija)

There is a commonality between the first three interviews in that children give the participants meaning. It's not about the joy or status so much as the meaning of being responsible for someone else. I started thinking about the parallel of finding meaning from children, which seems quite clear and strong, and the search for meaning in the diagnosis, which has more multiplicity and at times conflicts in ways that are difficult. In other words, the responsibility and challenge of motherhood doesn't conflict with the sense of meaning it provides. Psychosis diagnosis, on the other hand, does seem to conflict and feels like the meaning is rarely owned by the participant. It's something they tolerate, accept, push away or hold in opposition. Analysing this interview felt sometimes challenged by a language barrier. It was difficult to ascertain whether her narrative, or recollection, of events was confused or whether it was the result of her intonation. She was someone who had grown up in an English speaking country (Canada) but referenced specific cultural aspects of muslim and Asian heritage. I was struck by how she was living in a stressful home environment and that it seemed impossible to disentangle it from her experiences of phenomena labelled as psychosis. The psychosis diagnosis seemed to hinge upon that she heard voices shortly after the birth of her daughter. During the interview I found it hard to follow her account and I think there were moments where I didn't ask for clarification when that may have been useful. I was struck by how this woman wanted to establish a role and identify that transcended the meanings of womanhood and motherhood that she attributed to her cultural background and that were being reinforced by her husband and mother-in-law. I was struck by how she didn't articulate the experiences of motherhood and psychosis diagnosis as two interacting aspects of her life. It made me wonder if that's a dichotomy that I'm bringing.

Participant 4 (Astur)

I was struck by how young this person was. I was also struck by how distant she seemed at times. I wondered if this was the meds or something else – she just seemed to drift away at moments. I was struck that she wasn't currently able to see her daughter and wondered how this must have felt for her. She seemed remarkably flat at the same time – though she was on a depot.

Participant 5 (Mary)

She spoke about the difficulty her family face by a lack of space. Her and her husband's room can't be closed off from the children as there's nowhere else for them to go. She spoke about the importance of the mental health team in writing letters to try and change her banding but this was fairly limited. The medication seemed to have quite a significant effect on her such as making her very sleepy and unable to care for her children to the same extent. She feels that psychosis has had a big impact on her family with her husband and mother having to help out more.

Participant 6 (Sheri)

The interview was difficult – Sheri was feeling very despondent and expressed many times how she would rather be dead than carry on like this. It was difficult to retain my position as a researcher and not take on a feeling of responsibility for helping her to feel better. She repeatedly spoke about how desperate she was and I wondered if this function to try and elicit more care for me. That said, she shared how others express hope for her and yet she feels nothing. I was struck by how little interest she seemed to have in diagnostic labels. She didn't seem to make much meaning from them beyond that they related to her 'illness'. This illness was something that she desperately wanted to be rid of.

Data analysis

January 2019 – April 2019

I've now completed six interviews! In some ways it feels like a small number but when I think about the time it took to recruit it feels quite substantial. I'm also revisiting IPA theory repeatedly and appreciating that I'll be analysing each of these interviews in a lot of depth.

I've transcribed some of the interviews and commissioned another person to transcribe the rest. Before plunging into the analysis I felt it was important to do another bracketing interview. A very patient friend and colleague sat with me for an evening and pushed me to think about what had stood out for me, what I had learnt from the process. Again, it seemed to come back to my increased respect for how the diagnosis is important to some of the participants and that they have such a different understanding of it than my own academic and critical understanding of it.

I've gone through each interview in turn and come up with a bunch of themes that tell a story about that individual's experience. It felt fairly straightforward to go through each interview in turn but the prospect of trying to produce themes for the interviews overall is quite daunting. I've revisited each individual interview and picked out the themes that were most clearly evidenced by the transcripts. Those that were less rooted in the transcript got put to the side. I think this has helped me clarify which are most important. I've written all these on post-it notes. Each participant gets their own colour of post-it note. I've then been laying them all out on my table and exploring different ways they group together. I keep looking at my research questions to make sure the themes I produce are relevant.

Write up of first draft

April 2019 – May 2019

According to the Smith et al. (2009) book the write up is a continuation of the analysis process. I now understand what they mean. I've been trying to write up my themes into a coherent story. I've been surprised at how I keep needing to revisit and refine the themes. When I tried to put them into a narrative I was surprised how some made less coherence than when I was thinking about them as groups of post-it notes. The write up process has made me review what themes feel justified by the data and what no longer seem relevant when I put them into a narrative.

Write up of second draft

May 2019 – June 2019

I've had my supervisors comments back. There's a lot to think about in terms of the themes. One of the subthemes was produced based on only three of the participants' accounts. Whilst I was following the suggestions by Smith et al., I think there are other themes that are better supported by the data and answer the research aims more sufficiently. She pointed out that some of the quotes I gave seem to talk about the interaction of parenting and psychosis. I've reviewed this and considered it against one of the study aims being about this very topic. I've created a new theme that I think summarises that data around this interaction. I've also noted a limitation of the research in the way that participants didn't answer my question about interaction very directly. I've removed some more themes that felt like they repeated the same ideas. I'm aware I need to be more concise as my

supervisor thinks I need to write about more elsewhere. I've gone back to the individual participant themes and transcripts to ensure that my themes trace back to the data. To strengthen the quality even further I've pulled out more quotes to lengthen the extended table of quotes.

I had a phone call with my supervisor. We talked through my revised themes and to her, as someone less immersed in the data they are clearer and make more sense. We talked about the importance of writing a coherent story that reflects the data and has a clear rationale. We discussed how ethnicity seems to be neglected within my write up which is important since all the participants were BAME. Whilst I don't think there's enough in the participants' accounts to make it as a theme I do need to discuss it.

Write up of final version June – July 2019

I've had the second round of comments back from my supervisor. She feels that the revised write up of my themes is more coherent. We discussed the way in which spiritual and cultural understandings seemed to feature but were marginalised by biomedical and psychological understandings so I've written more about this.

Appendix I: Extended list of quotations

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Appendix J: Coded transcript example

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Appendix K: Theme development example for individual participant

Shading = Themes most strongly rooted in data and used to inform analysis across participants

Link to research aims	Themes from individual participant (Participant 5)	Emergent themes
Experiences of motherhood	Context of motherhood	Three children
		Lives with husband and children
	Motherhood as responsibility, caring and boundaries	Motherhood means responsibility
		Motherhood means caring
		Motherhood means establishing boundaries
		Housing and need for boundaries within motherhood
	Difficult to communicate experience of being a mother	Difficult to communicate experience of being a mother
		Motherhood as complex
	Always wanted to be a mother	Expected motherhood to be easier
		Expectations of motherhood based on looking after children
		Always wanted to be a mother
		Desire for children as being naturally maternal
	Motherhood as feeling best not good enough	Motherhood as feeling best not good enough
		Doubting self as mother due to financial limitations
		Children demand material things that cannot be provided
Experience of psychosis diagnosis	Descriptions of phenomena diagnosed as psychosis	Episode as fanatical about religion
		Episode as being out of character
		Episode as spending money extravagantly
		Episode as not eating
		Phenomena labelled as an episode of psychosis
	Recalling episodes of psychosis	Vague recollection of first diagnosis

	Recollecting behaviours rather than thoughts and feelings
Meaning of diagnosis given by professionals	Diagnosis as given
	Professionals introduced her to meaning of psychosis
Value of following advice of professionals	Psychosis as something to be controlled through services
	Belief in using therapy
	Learning to comply with professionals
	Learning to acknowledge mental health
	Needing some collaboration with professionals
	Value of complying with professionals
Diagnosis as meaningful	Diagnosis made sense of her behaviour
	Diagnosis as new and bizarre
Psychosis as a biomedical phenomenon but open to other conceptualisations	Psychosis means a mental health condition
	Mental health as a biological disorder
	Mental health as a disability
	Mental health as internal and manifests physically
	Biomedical conceptualisation reinforced by professionals
	Attributes psychosis to hormones in childbirth
	Mental health as a biological vulnerability
	Attributes psychosis to weaning off meds
	Biomedical conceptualisations dominant
	Biomedical conceptualisations dominant amongst professionals
	Limited power of professionals to address social factors of distress
	Anyone can get mental health condition
	Used psychotherapy three times
	Limited belief in idea that psychosis relates to trauma
	Significance of traumatic memories for healing
	Open to exploring alternative meanings of psychosis

	Stigma of mental health conditions	Husband worries about children inheriting mental health
		Where husband is from mental illness is a taboo and there is stigma
	Biomedical dominant but also attributes to psychosocial factors	Psychosis attributed to psychosocial factors
		Biomedical conceptualisations dominant
		Biomedical conceptualisations dominant amongst professionals
		Housing impacts mental health
		Limited power of professionals to address social factors of distress
	Value of spirituality	Value of spirituality
	Benefits of family history of mental health	Family history means she can talk to relatives
		Values talking about experiences
	Some of community understanding	Some of community understanding
Interaction of experience of being a mother and of psychosis		
	Diagnosed with psychosis before being a mother	Diagnosed with psychosis before being a mother
	Impact of admissions on family	Admissions restrict contact with family
		Admissions stress husband
		Familial support during admissions
		Admissions as missing out on children's development
		Five admissions in past 13 years
		Children as a motivating influence
		Adjustments made by extended family
		Seeking balance to prevent admissions
	Ambivalent relationship to meds as a mother (abstraction)	Motherhood motivates her to comply with meds
		Complying with meds means she can be better mother
		Meds affect capacity to parent
		Some meds make her too drowsy
		Adapting to meds

		Management means taking medication
		Desire to cease medication
		Belief in necessity of complying with medication
		Motivated to take meds by threat of relapse
		Tried many types of meds
		Complying with meds means she can be better mother
		Meds as affecting energy and sleep
	Limited contact with other mothers with psychosis diagnosis	No contact with other mothers with psychosis diagnosis
		Similarity to others with psychosis diagnosis who are not mothers
	Believes children too young to understand	Believes children too young to understand mental health
		Children aware of her being more or less present
	Limited recognition of parental role amongst professionals	Professionals can lack understanding
		Professionals should see motherhood as paramount
		Professionals should consider impact on family
		Overall professional take into account motherhood
	First episode of psychosis 3 months after first child	First episode of psychosis 3 months after first child
		Birth seen as contributing to first episode of psychosis

Appendix L: Theme development from analysis across participants

Sub-theme	Participant	Themes from individual participant analysis used to develop the sub-theme
Meaning through the pleasures of parenting	Alya (1)	Motherhood as meaning everything
	Amber (2)	Always wanted to be a mother
		Motherhood as enjoyment and meaning
	Khadija (3)	Joys of motherhood
	Astur (4)	Joys in challenges of motherhood
	Mary (5)	Always wanted to be a mother
	Sheri (6)	Motherhood means everything
		Co-existence of joy and suffering in motherhood
Meaning through the responsibilities of parenting	Alya (1)	Beliefs about the role of a mother based on marriage and gender roles
		Motherhood as a process of adaptation
	Amber (2)	Responsibility of motherhood is challenging but enjoyable
	Khadija (3)	Motherhood means love and responsibility for children
	Astur (4)	Responsibilities of motherhood feels good
	Mary (5)	Motherhood as responsibility, caring and boundaries
	Sheri (6)	Motherhood means everything
Diagnostic label as having multiple meanings	Alya (1)	Psychosis as a collection of symptoms
		Diagnosis as received and adapted to
		Making sense of experiences in relation to beliefs about normality
	Amber (2)	Multiplicity in experiences labelled as psychosis and mania
		Spirituality gives meaning to episodes
	Khadija (3)	Multiplicity in meaning of psychosis
	Astur (4)	Multiplicity of meaning of psychosis influenced by context and culture
		Experience of phenomena labelled psychosis
	Mary (5)	Descriptions of phenomena diagnosed as psychosis

		Diagnosis as meaningful
	Sheri (6)	Multiple meanings of psychosis
Making sense of diagnosis with a biopsychosocial model	Alya (1)	<i>There was no data in this interview that led to the development of the subtheme</i>
	Amber (2)	Psychosis as triggered by stress
	Khadija (3)	Overcoming difficulties through working on self
		Experiences in context of stressful home environment
	Astur (4)	<i>There was no data in this interview that led to the development of the subtheme</i>
	Mary (5)	Psychosis as a biomedical phenomenon but open to other conceptualisations
		Biomedical dominant but also attributes to psychosocial factors
	Sheri (6)	Ambivalent relationship with psychotherapy
		Hormones as meaningful cause
Perceived impact of diagnosis depends on context	Alya (1)	Diagnosis features within interactions with family
		Having psychosis is isolating
	Amber (2)	Stigma of diagnostic labels
	Khadija (3)	Making sense of interaction of birth and journey to diagnosis
	Astur (4)	Stigma as being called crazy
	Mary (5)	Stigma of mental health conditions
	Sheri (6)	Diagnosis as unhelpful and unwanted
Perceived interaction of psychosis and parenting	Alya (1)	Beliefs about how behaviour referred to as psychosis impacts child
	Amber (2)	Diagnosis means she has a disability not a bad mum
		Values reciprocity of care in parent-child relationship
	Khadija (3)	Interaction believed to be mediated by gender
		Making sense of interaction of birth and journey to diagnosis
		Wanting to protect children from aspects of self
	Astur (4)	Perceived interaction of motherhood and psychosis
		Needing to conceal experience from daughter
	Mary (5)	Impact of admissions on family

		Believes children too young to understand
		Children as a motivating influence
		Limited recognition of parental role amongst professionals
	Sheri (6)	Age of children determines decision to reveal experience
		Children motivate her to keep going
Ambivalent relationship with medication	Alya (1)	Ambivalent relationship with medication
	Amber (2)	Side-effects of medication
		Asserting choice over medication
		Medication as a chemical restraint
	Khadija (3)	Ambivalent relationship with medication
	Astur (4)	Side-effects of meds
		Importance of meds to maintaining normality
	Mary (5)	Ambivalent relationship to meds as a mother
	Sheri (6)	Ambivalent relationship with meds
Services as supportive	Alya (1)	Psychology as releasing
	Amber (2)	Needs to feel understood and encouraged by professionals
	Khadija (3)	Overcoming difficulties through working on self
	Astur (4)	Value of services
	Mary (5)	Value of following advice of professionals
	Sheri (6)	Ambivalent relationship with psychotherapy
Services as surveillance	Alya (1)	Sense of surveillance mediated by family
	Amber (2)	Social services experienced as powerful and punitive
	Khadija (3)	<i>There was no data in this interview that led to the development of the subtheme</i>
	Astur (4)	Surveillance as benevolent
	Mary (5)	<i>There was no data in this interview that led to the development of the subtheme</i>
	Sheri (6)	Frustrated by absence of collaboration with professionals

Appendix M: Feedback report for ethics panel and R&D committee

Background: The meaning of a mental health diagnosis to mothers is relatively unexplored in the literature despite being an important theme within research on women with mental health diagnoses more generally. From an applied clinical perspective understanding parents' experience is a key task in the Family Partnership Model (Davis & Day, 2010). This raises questions over what mothers would express about their experiences when the researcher takes a deliberately tentative position towards the meaning of motherhood and a psychosis diagnosis.

Aim: The overarching research aim was to develop understanding of the experience of being a mother with a diagnosis of psychosis. There are three particular aspects of this experience that are of interest to the study:

- 1) The meaning mothers attribute to their experience of becoming and being a mother.
- 2) The meaning they attribute to their experience of a psychosis diagnosis.
- 3) The meaning and perceptions they attribute to how the experiences of being a mother and having a psychosis diagnosis interact.

Method: This qualitative study used an interpretive phenomenological analysis (IPA) design based on Smith, Flowers and Larkin's (2009) methodology. The design was selected to facilitate an in-depth exploration of the participants' experiences and meanings of motherhood and a psychosis diagnosis. Six participants were recruited from community mental health teams in one NHS mental health trust in London. Participants provided written and audio recorded consent. Data was collected using one-off semi structured interviews. The interviews focused on the experience of being a mother, the experience of a psychosis diagnosis and perceptions of how these experiences interacted. Interviews were transcribed verbatim and analysed using IPA.

Results: This study found that mothers with a psychosis diagnosis experience their parenting role as having a central meaning to their lives. The mothers held multiple meanings about their diagnosis in which a biopsychosocial understanding was dominant. Biomedical understanding was the most dominant with psychological meanings, specifically the role of trauma, tentatively expressed. The impact of a diagnosis depended upon the participant's social context. Diagnosis was seen as helpful to explain difficulties and reduce personal blame when used by professionals but could be experienced as stigmatising by family and friends. The interaction of a psychosis diagnosis and parenting was experienced in terms of how perceived symptoms reduced energy and hospital admissions interrupted relationships with family. Side effects of medication impacted energy for parenting but continued adherence was regarded as essential to manage what was perceived as an illness. Services were seen as supportive by providing a confidential, professional relationship and advice on what should be done to manage their diagnosis. Services were also seen as a form of surveillance both in terms of checking adherence to medication and capacity to parent.

Conclusions: This study provided insights into the personal meanings of motherhood and a psychosis diagnosis. This showed the complexity of these meanings as an interaction of biopsychosocial, spiritual and cultural understandings. This suggests neither biomedical nor psychological narratives are sufficient to understand experiences of mothers with a psychosis diagnosis. If services are to follow strengths based and partnership models of support for parental mental health (e.g Davis and Day, 2010) then practitioners will need to develop individual understandings of their clients' experiences.