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‘Can I still be a Mum’?’

An Exploration of the Experience of Women with Formerly Diagnosed Severe Mental Health Issues in Relation to Motherhood During the Postnatal Period.

O.T. Ojiako

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An Exploration of the Experience of Women with Formerly Diagnosed Severe Mental Health Issues in Relation to Motherhood During the Postnatal Period.

Onyinyechi, Theodora. Ojiako

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Abstract

Severe mental health issues are a substantial contributor to the global disease burden, and a significant cause of maternal morbidity and mortality in the perinatal period, with a prevalence of 1 in every 1,000 births. Women with a diagnosis of severe mental health issues (SMHI) are at higher risk of suicide or being admitted to hospital in the postnatal period. In addition, having a SMHI diagnosis influences the mother's relationship with their infant which can have further implications for both. While maternity services in the UK have gradually adopted more responsibility for women with SMHI, there are several factors such as stigma, discrimination and isolation, social, economic and physical environment inequalities that challenges the care for them. Currently, there is a lack of understanding for SMHI mother's postnatal experiences. Thus, there is lack of evidence on how to best address these challenges for them and improve their postnatal experiences and ultimately help with reducing the risk of hospital readmissions or suicide.

The goal of this research was to understand, explore and develop a theory-based model on the experiences of women with SMHI in relation to motherhood during the postnatal period. A constructive grounded theory was employed, which was underpinned by the theoretical perspective of symbolic interactionism.

Ten women with SMHI were interviewed with the focus on their postnatal experiences in relation to motherhood. The semi structured interviews were conducted online, and participants were recruited from mental health hospitals in accordance with ethical approval standards. The age of participants were from 18 to 49 years with different social backgrounds. Data analysis was according to grounded theory method utilising a constant comparison approach, and theoretical sampling was facilitated by Mind genius software and Nvivo.

The generated Resilience-Led Behavioural Model (RLBM) for supporting SMHI mothers in the postnatal period had three categories. 1. personal resilience associated with coping mechanisms, hopes and sleep deprivation; 2. social context, such as family support cultural and religious issues, and stigma affecting access to services and 3. childbirth experiences, including met and unmet needs, anxiety, fear, bonding and attachment.

The core category was personal resilience, which seemed to have the greatest influence on participants experiences. They strived towards coping and adopting positive changes with effective support from families concerning their motherhood role. Accepting the reality of a situation, although it is unpleasant and uncomfortable, is a crucial component of cognitive flexibility. The RLBM highlights the behavioural changes and resilience adopted by women during their transition into motherhood. The RLBM, therefore, creates awareness and introduces new ways and ideas on coping for women with SMHI in relation to motherhood during the postnatal period.

Contents

List of Figures

List of Tables

Acronyms

GT	Grounded Theory.
PA	Proposal Approval.
MHI	Mental Health Issues
MHD	Mental Health Disorder
PPP	Postpartum Psychosis
PMH	Perinatal Mental Health
PP	Postpartum Period
R&D	Research and Development
HRA	Health Research Authority
SMI	Severe Mental Illness
SI	Symbolic Interactionalism
SMHI	Severe Mental Health Issues
WHO	World Health Organisation
EXMEPP	Experience of women with severe mental health issues in relation to motherhood during the postnatal period.

Acknowledgments

I simply wanted to express my appreciation to everyone who has assisted me throughout my PhD journey. Thank you for your patience and encouragement, which began with my family, my children, and my amazing husband, and continued throughout my life.

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The data collection would not have been possible without the assistance of Dr Cairn. Even though the journey was not without its difficulties, his assistance would be remembered fondly. Thank you so much to all the women who contributed to the EXMEPP study by sharing their own experiences as mothers. Your participation was appreciated. You are not going to be forgotten.

My mother (prestige), a distinguished lady, I wish to express my appreciation to you and daddy for instilling courage and hope in me even before I had completed this course of study by bestowing this title on me. You are doing a fantastic job, thank you for all the prayers.

Thank you to all my co-workers who have opened up about their personal lives and shared them with me; you are all incredible in your way, and I admire you all. Dr Catherine McParlin deserves thanks for her confidence in my abilities and potential. Her encouraging words lent their support to these endeavours.

It takes one step to travel a thousand miles, and you were there to help, so thank you very much. I cannot express my gratitude to you all enough; you are all incredible.

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that this is all my own work.

Ethical approval has been sought and granted by the Faculty Ethics Committee on 24th and 28th April 2020.

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Signed:

Date: May 2023

“I have always admired roses
But not for their color
There is something about them
That l haven’t yet discovered
Yet everyone tells me
That l’m looking into deep
That it is just a flower
Just a little prize you can keep
But yet there is something special
About the roses that you see
And it’s not about the petals
It’s about the thorns to me
It puzzles me how something
So beautiful and rare
Can cut you so deep
And you wouldn’t even care”.
(Nadia McGhee, Roses, 2018)

A rhyming poem by Nadia McGhee.

To illustrate the importance of the study, the above poem could be understood as signifying women's experiences of becoming mothers, taking on the role of motherhood, and caring for their families, the significance of which cannot be overemphasised.

To elaborate, it may be said that the rose represents the reward most women receive for deciding to become mothers; nonetheless, the thorns of the rose relate to the agony and obstacles women face in motherhood, which can wound them deeply, though they may not notice or care once they have children. Thus, despite the high price the journey through motherhood and its challenges generally considered to be worth it in the end. In the case of this study, that price may include mental health.

Thesis arrangement

This thesis is divided in eight sections, each of which will build on the previous chapter to demonstrate a progressive approach. Feedback received from assessors advised me to include more of me. Therefore, l have begun with a personal description uncovering the originality. There will be a combination of relevant supporting literature, women's views, experiences, and personal reflection. A brief summary of each chapter provides an introduction and conclusion that will help to set the concept for this thesis.

Chapter one (Introduction):

This section provides a general introduction to the study by offering underlying knowledge about the writer, the scope and relevance of the research to the study, and the research aim and objectives, supported by a brief introduction to the rest of the chapter's structure.

Chapter two (Literature review):

This section details a primary review of the research process, including how the literature was searched for particular concepts and subject areas; a comprehensive examination of literature from a philosophical viewpoints; and an analysis of the study literature, concentrating on women diagnosed with severe mental health issues. This section starts with an acknowledgment pertaining to the claims for and against literature reviews in grounded theory enquiry, as well as the viewpoint of the researcher on the matter. Mental health issues fall under the purview of mental health nursing, and in this field, psychosis is an umbrella term for severe mental health issues (SMHI), the history of which is examined in this study. Following that, the effects, assessment, and management of SMHI are discussed. This chapter also explores formulation and feminism in the available literature, considering women's experiences of SMHI and motherhood. The research into these areas resulted in the identification of gaps in the literature and the formulation of research objectives. Furthermore, care navigation was deemed necessary for women to access support and direction, and this was therefore explored in chapter three.

Chapter three - Navigating care for women with diagnosed severe mental health issues for an effective motherhood transition during the postnatal period.

This chapter describes how women with SMHI are assisted in identifying and utilising appropriate health care services and other resources, as services are delivered by several agencies and individuals, which can lead to confusion. The chapter begins with an introduction to and exploration of care navigation as well as why care navigation is necessary for women with SMHI during their transition to motherhood in the postnatal period. More research is needed to fully understand the experiences and perspectives of women diagnosed with severe mental health issues in navigating the care system during the transition to motherhood. It is important that all aspects of working collaboratively within a multidisciplinary team, such as obstetrics with mental health care, are taken into consideration.

Chapter four (Philosophical and methodological position)

This chapter introduces and concisely reviews the research methodology employed in this research, as well as its theoretical underpinnings and rationale. A grounded theory technique was used in consistency with relativism and social constructionism. Thus, this research process and its philosophical perspective are explored in this chapter, allowing deeper understanding of the experiences of women with a diagnosis of SMHI during the postnatal period and how these experiences relate to motherhood. A history of grounded theory is also discussed, as well as its strengths and limitations.

Chapter five (Research design and methods)

This chapter details the activities and actions that occurred throughout the data collection procedure, which was based on a qualitative grounded theory approach. The initial activities discussed are the preparations for data collection, which involved ethical considerations and governance, study site access, recruitment and sample methodologies. Theoretical and purposive sampling are therefore discussed in this section, as well as the criteria for inclusion and exclusion.

Thereafter, this chapter highlights the data collection process, obtaining consent, an overview of the research site and the reflective narrative of the research journey.

Then, there is a discussion of the renegotiation of access to the research site, before the chapter continues with a description of the data evaluation procedure, illustrating the iterative procedure used during coding, as well as axial and focused coding leading to the study's findings and discussion.

Chapter six (Research findings)

This chapter presents the study's findings, which are organised into three major categories; the first is social context which discusses various social contexts such as culture and religion, stigma, access, perception, and attitude as these contribute to a reduced level of functioning and can affect mothers' decisions concerning their mental health issues. The second theme is personal resilience, which includes coping mechanisms, hopes and sleep deprivation all of which play a role, whether positive or negative, in an individual's ability to cope with the transition to motherhood. Childbirth experience is the third and comprises anxiety and fear, met and unmet needs, bonding and service user experience. These findings resulted in the development of the Resilience-Led Behavioural Model', (RLBM).

Chapter Seven (Discussion)

This chapter begins with a comprehensive analysis of the study's outcome and a detailed evaluation of the data generated. Each theme is discussed in relation to the purpose of the study. For example, individuals discuss their strengths as mothers, as well as how they manage and control themselves while coping with SMHI. These views, which might be positive or negative, were expressed by the participants as a result of their lived experiences.

Chapter eight (Reflection and recommendation)

The final chapter summarises the research study's findings and recommendations and discusses the study's shortcomings. The study's contributions are presented, and the effect of the methodological limitations on the findings are evaluated using qualitative credibility criteria along with a discussion of the study's limitations.

Each chapter serves as a link to the preceding chapter. The appendices that follow contain detailed information about the research materials. These resources include a research timeline/Gantt chart, the protocols for collecting the sample data, participant information leaflets, a presentation, and informed consent forms. A discussion of the sample methods, data gathering, analysis in addition with interpretations are also presented in this chapter.

Chapter 1

Chapter 1 – Introduction

1.1 Introduction

This chapter highlights a general overview of the study its context and philosophical ideology. It starts by explaining the researcher’s inspiration and motivation for the topic in the field of mental health nursing. This thesis presents the culmination of three years of continuous study and research effort. It demonstrates a broad view of the background of the research study, discusses perinatal mental health initiatives and then concludes with the study's aims and objectives.

1.2 Researcher’s inspiration and motivation for the study

The following section describes the reasons for my initial consideration of postnatal women who have been diagnosed with severe mental health issues (SMHI). As a healthcare professional and a researcher, the purpose of participating in individual and professional reflection remains being transparent about decisions made throughout the research study as suggested by Devlieghere and Gillingham, (2021). I am a registered midwife currently working in a hospital setting, providing care to women and their families during the perinatal period. The perinatal period is the period from pregnancy up until the first year of the postnatal period in women’s lives (Knight et al., 2018).

As a midwife, I have a range of roles and responsibilities, with a professional commitment to “caring for and monitoring the progress of the mother during the perinatal period” (NMC 2018, pp 17). I ensure that the student midwives, newly qualified midwives, and new-to-post midwives are supported to gain the skills necessary for assessing, planning, and evaluating care during the perinatal period. The experience of becoming a new mother is typically joyful and filled with aspirations and opportunities that should be cherished (Howard et al., 2014). When I was growing up in the eastern part of Nigeria, every childbirth resulted in children being handed a baby powder to massage into their faces. The baby will be brought to the children by an adult while they are singing and partying (happy memories from my childhood).

In 1981, when I was five years old, my mother gave birth to my brother, and the smell of a newborn baby in the house was a source of great delight for me. We had many people come over to our house to rejoice and celebrate the birth. Having a baby has been a source of happiness for the family. I also recall my family's grief when my brother died of an illness at the age of eight months. Due to this, I witnessed first-hand, the agony of losing a child, as well as the psychological toll it can take on a family. My mother's loneliness and depression were alleviated because she was surrounded by her sisters, who were able to empathise with her and share her pain and grief. I recall having a similar experience a few years back, I felt so depressed and alone because none of my family were living close to give me that support, as was experienced by my mother.

While living in Eastern Nigeria between 1982 and 1984, I recall an encounter where a woman who was holding a baby, was not wearing clothes. She was consuming the contents of the rubbish at the end of the street. She was occasionally breastfeeding the child and sleeping rough with her baby, she was referred to as a ‘mad woman'. I noticed that no one approaches her, she was considered a danger, especially when nursing a child. I could not understand why mentally ill women were wandering the streets naked and not cared for by any health professional or group. In Nigeria during the 1980s and 1990s, upon further inquiry, l discovered that the woman has a postnatal SMHI. There were no mother and baby units, there was no social welfare system, and there was no insurance coverage; everyone had to pay for their medical treatment and care. It was common practice for people to lock their loved ones with SMHI away or chain them to a bed to keep them safe from harming others and themselves, or to protect the family from shame and stigma. Caring for their loved ones who are suffering from SMHI in Nigeria, is very difficult for families. Their families were subjected to societal stigma as a result of the belief that they had suffered. The majority of them were not permitted to interact with other people or with society. I discovered that most women suffering from postnatal SMHI were homeless, having either fled their homes or had no one to care for them. Watching women suffering from SMHI chained by both their hands and feet and locked away because their families could not afford to place them in a psychiatric facility, was not the most pleasant experience. In contrast to developed countries, there are mother and baby units for women with SMHI during the postnatal period. As a result of the mother and baby unit’s attentiveness, these women are not left in the dark as they would be in developing countries like Nigeria.

In 2002, my family and I moved to England. Upon completion of my midwifery conversion course, I began working as a registered midwife in the Northeast region of England. Throughout my career, I have worked with and cared for women who have faced a variety of health challenges, including those who had been diagnosed with SMHI and, among other conditions. Reading midwifery journals and participating in seminars as required has helped me to stay up to date with the latest developments and contemporary literature in this field of study. Professional experience has been known to generate research topics (Strauss and Corbin, 1990), which is exactly what happened in this study. Since 2019, I have been assigned to a research position in a hospital setting, which has given me a better understanding of the impact of research on healthcare quality improvement. Following my time (17 years now) working as a midwife in England, I was left with a slew of questions about women who have SMHI, including their pregnancy experiences, conceptions, and transitions into motherhood. For instance,

I witnessed an encounter at the postnatal wards sometime in 2008/2009 in which a woman who had given birth the previous night came out of her room completely naked, confused, and convinced that the baby wanted to harm her. She was hallucinating and in a delusional state. The woman had previously been diagnosed with bipolar disorder, and she had also suffered from postpartum psychosis. An intervention or summoning of a mental health crisis team is initiated or requested as soon as a mental health crisis occurs in the maternity department. This was the case, and she was subsequently transferred to the mother and baby unit for additional care and observation. This was a traumatic experience that happened so unexpectedly (Meltzer-Brody et al., 2018). Due to my work shift patterns, l had little chance or time of caring for these women, and they must be cared for by other midwives instead when l am not working. A more defined path was established, and staff training was put in place because of the incident. I also worked in the maternity assessment unit, which is a resource for women who are concerned about themselves or their babies. For some time in 2015/2016, while on shift, I received a phone call around 3 a.m. from a partner who was screaming, saying, and claiming that his wife was going insane. I could hear a baby crying sound in the background. I hurriedly instructed him to dial 999, and the phone line went silent at that moment. As a result, I confided in my colleagues and my manager, who assured me that I had done everything in my power and that my advice to them was the right action.

I informed one of the midwives' supervisors, who worked as a risk management midwife and a member of the perinatal mental health team, about the incident. She advised me and we agreed that l should join the perinatal mental health team.

Later, in 2015/2016, I joined the team and shared my experience with them, I was reassured that I had done my best in the situation. My recollections of these events are still fresh in my mind, and many questions remain unanswered as a result. Thus, the purpose and objectives of this study is to attempt to answer some of these questions. I was motivated to conduct a review of existing research on the experience of women with severe mental health issues in relation to motherhood during the postpartum period (EXMEPP). This is a result of the experiences and observations I had in midwifery practice and settings, which are detailed in the study. Most relapses occur within a few days or weeks of birth (González-Rodrguez and Seeman, 2019), or when they are no longer under the care of their community midwife. It is mostly during this postnatal period that SMHI manifests itself, which has the most significant impact on the mothers, babies, and their families, and in rare cases, such as those described above, can result in suicide or infanticide (Friedman and Sorrentino, 2012; Brockington, 2017).

The intensity of the power that takes control at that point must be terrific, and feelings of loneliness, isolation, and fear may be experienced by the individual. Most women with SMHI are affected by this because they are overwhelmed by dark thoughts and are unable to express their feelings or seek help at the time. How must it feel to be on the edge of feeling helpless and unable to care for your newborn baby, and to be on the edge of harming yourself or your baby at this critical stage after nine months of pregnancy, is something I can only imagine. It is essential to consider that patient’s point of view is significant, yet this can only be accomplished by taking the time to listen and engage with the individual as she seeks to make sense of her experiences. In order to better understand the experience of women with postnatal SMHI as well as how it affects their day-to-day lives as mothers, I began this project. Curiosity piqued my interest, and I became more aware of the plight of women with postnatal SMHI. Throughout this study, the term perinatal mental illness will be used to refer to perinatal mental health issues. Perinatal mental health issues (PMHI) are those which occur during pregnancy or in the first year following the birth of a child (Knight et al., 2018; O’Hara and Wisner, 2014), a complication of pregnancy and the postnatal period. If left untreated, can have a significant and long-lasting effect on the mother, the child, and the family (O’Hara and Wisner, 2014).

1.3 Background to the research

SMHI are also referred to as serious mental illness (Montgomery, 2005), while Hines et al., (2018) refer to them as ‘mental illnesses and Dolman et al. (2013) as ‘severe mental illnesses. This shows that there is an issue relating to the coherent use of terms, phrases and acronyms to represent severe mental illness (SMI). As mentioned above, SMI was not only used to refer to severe mental illness, but also severe and persistent mental illness (Brown et al., 2019; Trachsel et al., 2016; Torres, 2011; Arvidsson et al., 2009; Parabiaghi et al., 2006). Although there exist many different forms of psychiatric illness, this study will refer to SMI as severe mental health issues (SMHI), which will only include schizophrenia, affective psychosis, bipolar disorder and severe depression.

Mental health issues following childbirth are the main public health concern that requires much greater attention (Jones et al., 2014; Rahman et al., 2013). Women and their families face many changes and challenges after giving birth, and they require appropriate support and management to sustain their maternal health and mental well-being (NMC, 2018).

Subsequently after childbirth, women undergo a myriad of physical, mental, and social transformations and difficulties that are unique to every individual (Saxbe et al., 2018; Oakley, 2018; Maguire, 2020). However, the postnatal period is characterised by stress and difficulties accompanying childbirth, as well as discomfort and the so-called "baby blues," among other symptoms (Meltzer-Brody et al., 2018). Women with SMHI are at higher risk of committing suicide if they do not receive treatment during the postnatal period (Tachibana et al., 2020; American Psychological Association, 2013), though they may be reluctant to disclose their mental health concerns and symptoms (Button et al., 2017).

Midwifery professionals focus on public health initiatives, as recommended in national strategy documents including those published by the Mental Health Task Force, (David, 2017) and the Better Births Programme to promote access to maternal mental health services (Costa et al., 2021). Mental health issues become more serious and concerning during the postnatal period, with an increased risk of readmission (Rochon-Terry et al., 2016; Munk-Olsen et al., 2009), relapse, and hospitalisation (Mandelli et al., 2016; Howard et al., 2014; Di Florio et al., 2013; Lagan et al., 2009). Over eighteen percent of maternal deaths in the United Kingdom resulted from suicide among women with SMHI (Knight, 2018) while infanticide also occurred in a smaller percentage of women (Friedman and Sorrentino 2012;

Spinelli, 2009). However, one in five women in the United Kingdom will develop some form of mental health issue during pregnancy or within one year of childbirth (WHO, 2017; Vigo et al., 2016; Surkan et al., 2011). Indeed, it is acknowledged that in 1in1000 childbirths, new mothers will experience SMHI, such as psychotic depression, bipolar disorder, and schizophrenia (Vanderkruik et al., 2017; Paschetta et al., 2014).

A considerable number of studies have also revealed that SMHI during the postnatal period can have a significant impact on the child (McLeish and Redshaw, 2017; Kendrick and Pilling, 2012; Surkan et al., 2011). It has thus been established that maternal mental health issues are the main source of morbidity and mortality and that they contribute considerably to poor neonatal and infant outcomes (Howard and Khalifeh, 2020; Sharma et al., 2017; Noonan et al, 2017; Pope et al., 2014). Although a low percentage, suicide still accounts for about 20 percent of maternal deaths during this period (Howard and Khalifeh, 2020; Vigo et al., 2016; Cantwell et al., 2011; Austin et al., 2011), remaining the leading cause of maternal death. However, Brockington highlights that, overall, suicide or infanticide is rare in the first year of childbirth (Brockington, 2017). The symptoms of the SMHI can linger for up to six to twelve months after childbirth (Ramsauer and Achtergarde, 2018; Brockington, 2017).

According to Hine et al., (2019), the alteration of self-identity, concept, and a reorganisation of oneself, which is a natural part of motherhood, can be a challenging moment for most women, particularly for those with existing SMHI. The resulting physical and psychological changes that occur during the transition to motherhood, especially for first-time mothers, are highly significant (Duarte-Guterman et al., 2019).

Motherhood has been identified as a female experience, linking women through historical, cultural, and geographic boundaries, although the concept of motherhood and its practices differ widely (Duarte-Guterman et al., 2019). This indicates that women with SMHI may have different experiences and perceptions as regards motherhood during the postnatal period. In addition to the challenges of motherhood, women who have already been diagnosed with SMHI may also be dealing with the symptoms of the existing psychiatric condition, which might increase the likelihood of hospitalisation (Meltzer-Brody et al., 2018; Cantwell, 2021).

The traditional diagnosis of SMHI has resulted in societal and cultural stigma, in addition to guilt among women and their families who are suffering from these conditions (Reupert et al., 2021; Fixsen, 2021). The concept of stigma will be addressed in further depth in chapter two.

A broader perspective has been adopted by Fixsen (2021), who uses her own experience to write about the disadvantages of disclosing what she called a 'flawed' identity of people suffering from SMHI, where the individual is viewed as incapable, unreliable and harmful by society. This leaves the individual feeling enraged, ashamed and stigmatised. Other studies have indicated that people who have been diagnosed with SMHI are culturally labelled, resulting in them being marginalised, which has a detrimental effect on their mental well-being and societal standing (Johnston, 2020; Corrigan and Rao, 2012).

Regardless of whether mothers make an easy transition into their new responsibilities (Saxbe et al., 2018; Harwood et al., 2007), there are always positive and negative emotions and experiences. This is due to the necessity to readjust one's old self with a new self, which is especially challenging for women with SMHI (Fordes et al., 2020). Therefore, how women evaluate and perceive themselves as a result of their motherhood experiences is an interesting area of study that researchers has not been explored.

The perinatal period is defined as the period between the time of conception and the first year after childbirth (Coates et al., 2016; Noonan et al., 2017; Brady et al., 2018). Women are more likely to suffer from mental health issues during pregnancy and in the postnatal period (Austin et al., 2008; Mc Glone et al., 2016; Brady et al., 2018; Noonan et al., 2017). In addition, some women may experience a relapse, or worsening of a pre-existing condition, or they may even develop a mental health issue for the first time during the postnatal period (Brady et al., 2018; Higgins et al., 2016; Howard et al., 2014). Postnatal mental health has emerged as a key area of interest in the past few years, with increased investment in new specialty mental health facilities in the UK, particularly the inpatient psychiatric mother and baby units. Funding has therefore been made available to specialised mental health services for women experiencing mental health issues during pregnancy and the first year after childbirth (Howard, 2020; NICE, 2014). The government has passed legislation to ensure that women in every part of the United Kingdom have access to specialised community services and mental inpatient mother and baby units (NICE, 2014), by extending the care period from one to two years in the community.

SMHI can be a health complication of childbirth and are associated with an increase in foetal and maternal morbidity and mortality (Jones et al., 2014; O'Hara and Winser, 2014; Howard et al., 2014; Stein et al., 2014). They may also place a significant financial burden on the health and social care system.

In the United Kingdom, this burden amounts to £8.1billion every year (Bauer et al., 2014). Mental illness is an obstetric emergency in maternity services and falls under the purview of the perinatal mental health team. SMHI, on the other hand, affects not only the mother, but also her baby during the postnatal period, subjecting women to an increased risk of poor mother-baby attachment. During the mother-infant interaction, a complex cognitive and social process is learned and conveyed between the two (Adkins, 2002; Rubin, 1984). Women's views and reactions to the demands of motherhood can have an impact on their experiences, their strength and resilience in coping with postnatal stresses to build a barrier against stress (Faisal-Cury et al., 2004). This can cause bonding to be delayed in women who have symptoms of SMHI and are unwell compared to those who do not have symptoms (Sivaraman et al., 2018). These mental health issues can manifest quickly and deteriorate rapidly in the postnatal period. In addition to being associated with a higher incidence of infanticide (Kingston, 2020), SMHI have also been connected to developmental delays in children (Kingston et al., 2012; O'Hara and Wisner, 2014).

The CoVid 19 pandemic, in addition, has had a significant impact on the transition into motherhood of women who have suffered SMHI during the postnatal period. Some of these aspects will be explored further in the research findings and discussion sections of this study. There have been several perinatal mental health initiatives introduced by the government to improve women's health and enhance access to perinatal mental health services. However, the suicide of a mother is a great tragedy, and for each woman who takes her own life, there are many near misses (Brockington, 2017). This study is designed for women who have been formerly diagnosed with SMHI and have recently given birth. Due to this study being primarily concerned with women, the pronouns 'she' and 'her' will be used throughout. For reasons of compassion and empathy, the feminist perspective will be discussed later in the study.

1.4 Perinatal mental health initiatives

Women experiencing mental health issues during pregnancy and the postnatal period should always receive the care they require, as advocated by the Maternal Mental Health Alliance's 'Everyone's Business' campaign (Granville et al., 2016). This initiative has enabled more care to be conducted in the community, as well as making services more accessible to women experiencing mental health issues during pregnancy and the postnatal period.

Mental health issues were identified as the most severe issue in the national maternity review, resulting in the Better Births Programme, which aims to improve access to better maternity care and maternal mental health services for all women (England N.H.S., 2016). In addition, The Maternity Transformation programme of the National Health Service strives to promote good mental health for all women during pregnancy, the postnatal period, and afterward. The Better Births Programme strives to ensure effective systems across whole care pathways, with an emphasis on openness, transparency, and preventive measures (England N.H.S., 2017).

There have been many interventions put in place over time for postnatal mental health improvement, such as the Five Years Forward View initiatives, which were established by NHS England to support and promote postnatal mental health (England, N.H.S., 2016; David, 2017). As part of this initiative, The Maternity Transformation Programme has added a specialist community team, enabling over 13,000 women to receive support, with the additional opening of an extra four mother and baby units (David, 2017). These initiatives began in 2016 with the Better Births plan to assist women in gaining access to all available care and services. To achieve its objectives, the number of stillbirths, neonatal and maternal deaths, and instances of brain damage must be reduced by the year 2030 (David, 2017). The Mental Health Taskforce launched the Five Years Forward View programme in 2016, with the aim of enhancing the mental health of mothers across England by increasing women's access to specialised mental health support teams during the postnatal period.

Recently, considerable progress has been made in changing attitudes to tackling mental health issues, leading to an increase in the delivery of specialist services in most areas of the country (England N.H.S., 2017; David, 2017).

However, by developing and funding specialist community teams for postnatal mental health (David, 2017), the initiative hopes to improve access to services in the most underserved areas while also increasing the number of beds available in mother and baby units.

According to this initiative, just 15 percent of hospitals in England meet the National Institute for Health and Clinical Excellence (NICE) requirements for offering specialty care (David, 2017). These programmes have aided in the development of guidelines and support tools for mental health issues, which outline evidence-based treatments and interventions, as well as mechanisms for monitoring and evaluating service quality improvements.

According to David (2017), the Mental Health Task Force collaborates with the National Health Service and Health Education England to improve staff understanding and abilities in postnatal mental health issues.

They are responsible for the development and establishment of standards and competency frameworks for different multi-disciplinary personnel across England and Wales, as well as for the administration of a training bursary scheme for workers (David, 2017).

According to the World Health Organization's Special Initiative on Universal Health Coverage for Mental Illness Programme 2019, global and national economic loss are associated with mental health issues. The WHO implementation programme aims to provide each individual and society with easy access to mental health facilities and to achieve better overall health is an Initiative and Target Universal Health Coverage for Mental Health (WHO, 2019). As a result, those suffering from SMHI will have greater access to services and will be 15 percent less likely to commit suicide, although many are still subjected to discrimination and stigma (WHO, 2019), and continue to face a variety of challenges as a result of mental health issues. There is a range of barriers to service delivery including stigmatising attitudes, a lack of knowledge, discrimination, and isolation, all of which contribute to poor service delivery (Smith et al., 2019; Thippeswamy et al., 2018). The table below shows various planned government initiatives.

Table 1 Perinatal mental health initiatives and years

Initiatives	**Years**	**Reference**
An investment of 2.3bn for mental health implementation plan; Increase access to specialist PMH community care for over 12 months after birth up to 24 months; Increase women and their partners' access to psychological therapies; Partners receiving mental health checks and directed to necessary supports.	2020	England, N.H.S. and Confederation, N.H.S., 2020. Perinatal mental health.
To ensure that safe care is provided throughout pregnancy and in the postnatal period by referring all women history of SMI and in first degree relative.	2014 NICE, Antenatal and Postnatal Mental Health:	1) Howard, L.M., Megnin-Viggars, O., Symington, I. and Pilling, S., (2014) Antenatal and postnatal mental health: summary of

		updated NICE guidance. *Bmj*, *349*. 2) National Institute for Health and Care Excellence (2014) *Antenatal and postnatal mental health: clinical management and service guidance*. London: National Institute for Health and Care Excellence.
The five years forward view programme was developed to improve the mental health of the mothers across England, with the view of improving women's access to specialist mental health support teams during the postpartum period, expanding and funding the specialist community teams for the perinatal mental health, providing services to the areas that need them most and providing more beds to the mother and baby unit. According to the program, only 15% of hospitals across England meet the NICE guidelines.	2017; 2016 Mental Health Task Force, Five Year Forward View for Mental Health for the NHS in England.	David, F. "Mental Health (2017): Implementing the Five Year Forward View." *Progress in Neurology and Psychiatry (Guildford)* Vol. 21.4 pp 27-29.
Works together to promote access to maternal mental health services (England N.H.S., 2016). The NHS's Maternity Transformation Programme works to promote good mental health for all women during pregnancy and the postpartum period and thereafter, to ensure effective systems across whole	2016	England, N.H.S., (2016) National maternity review. Better births; improving outcomes of maternity services in England. NHS England, London.

pathways of care, focusing on openness, transparency, and prevention.		
To improve access and outcome for women and their families. To ensure high-quality care for women experiencing mental health issues in the perinatal period	2016	Commissioners, N.H.S., (2016) Perinatal Service Provision: The role of Perinatal Clinical Psychology.
The report works towards the provision of good-quality mental health services to childbearing women, by assisting those providing and planning services at all levels of service.	2015	2015 The Royal College of Psychiatrists – Perinatal Mental Health Services College Report CR197
The documents aim to bridge the gap between long-term ambition and shorter-term action by showing how changes in local service planning and delivery will make a change in the lives of people who experience mental health issues.	2014	Department of Health (2014) Publication: Closing the gap: priorities for essential change in mental health (2014).
Make All Care Count- improving outcomes for women with, or at risk of, poor perinatal mental health (PMH) ensuring access for all women and families	2016 Maternal Mental Health Alliance (Everyone's business campaign)	Granville, G., Sugarman, W. and Tedder, V., (2016) Maternal Mental Health Alliance Everyone's Business Campaign Independent Evaluation Report.

NHS England has been working to ensure that mental health issues are given the same status as physical health issues in view of the delivery of health and social care services (Mental Health, 2011). The announcement of the Government plan 'No Health without Mental Health, shows their concern about mental health issues.

However, despite government concerns and interventions, women continue to experience SMHI in the postnatal period. Indeed, it has been stated in studies that SMHI during pregnancy and the postnatal period are a key contributor to maternal morbidity and mortality, with adverse neonatal, infant and child outcomes (Howard and Khalifeh, 2020). During the postnatal period, women who have SMHI are more likely than those who do not to experience other physical symptoms of life-threatening complications, such as pulmonary embolism (Knight et al., 2018). Little is known about the experiences of women diagnosed with SMHI in the postnatal period as few studies have explored their experiences during this time in relation to motherhood (Jones et al., 2014; Howard and Khalifeh, 2020).

Despite the acknowledgment of the importance of SMHI, women struggle to receive the care that is available to them as various factors prevent them from accessing the care they need, such as stigma and discrimination, which prevent women from expressing their concerns, limit their access to resources and result in a shortfall in the care they receive (Viveiros and Darling, 2018; Wong et al., 2018). As a result of labelling human differences, as well as the incorporation of cultural stereotypes into a social group's mindset by many of its members stigma occurs, and minority members who are labelled suffer significant loss of status and reduced life opportunities (Klik et al., 2019; Mannarini and Rossi, 2019). Stigma has therefore been considered the main social context of mental illness and the reason behind its current negative perception (Klik et al., 2019; Mannarini and Rossi, 2019). Women with SMHI face shame and guilt, however, the compassionate treatment they receive makes them feel understood and safe (Lagan et al., 2009). Therefore, a better understanding of women's experiences with SMHI is required (Salzmann-Erikson and Sjodin, 2018; Doucet et al., 2009; Lagan et al., 2009). Emotional care extends throughout all domains of midwifery; thus, it can be assumed that midwives would be ready and prepared to listen, ask, and answer with empathy to a distressing attitude. Prioritising individuals is also highlighted in the Nursing and Midwifery Code of Practice (NMC, 2018). This research seeks to fill the gap in understanding the experiences of postnatal women with SMHI by documenting their subjective experiences, thoughts, memories, and emotions, as well as the phenomenon of how they perceived what is happening around them during the study period.

1.5 Study Objectives

The aim of this research is to explore how women cope with SMHI, what works for them and their experiences in relation to motherhood during the postnatal period, for women in Northeast and Cumbria. This thesis presents the findings of a grounded theory study that examines the experiences of these women, their concerns about childbirth and their coping processes. This will be accomplished by investigating how women's perceptions of motherhood influence their experiences, focusing on the true meaning of experience. Related multifactorial aspects are examined through the psychosocial, cultural and religious lens to conceptualise women's experiences of postnatal SMHI and motherhood to provide a more contextualised explanation for understanding postnatal severe mental health (SMH). To this end, the study also presents a grounded theory design to increase potential knowledge, understanding and awareness that will aid in gaining insight into women's experiences with SMHI during the postnatal period. Some of the research highlights how women often experience feelings of shame and guilt and that they deserve compassionate care to help them feel supported, understood, and safe in their interactions (Lagan et al., 2009). As a result, a better understanding of women's perceptions and experiences is required (Salzmann-Erikson and Sjodin, 2018; Doucet et al., 2009; Lagan et al., 2009). This study was conducted in the United Kingdom (UK's) Northeast and Cumbria regions and its findings will be published.

1.6 Research Aims and Research objectives.

Research aim

To explore and develop a theory on the experiences of women with severe mental health issues in relation to motherhood during the postnatal period for women in Northeast and Cumbria.

Research objectives: By conducting interviews with postnatal women who are experiencing SMHI, this study aims to:

1. Explore the factors that contribute to the experiences of women with SMHI in relation to motherhood during the postnatal period.
2. Examine how women with a diagnosis of SMHI perceive motherhood in the postnatal period.
3. Gain an understanding of women's concerns about SMHI and what they hope to gain from services in relation to motherhood in the postnatal period, and
4. Identify the met and unmet needs of women with SMHI in relation to motherhood.

Research question

This GT research question is as follows:

1) What are the key factors that influence the experiences of women with SMHI in relation to motherhood during the postnatal period? How do women cope with motherhood challenges and their SMHI?

Chapter 2

Chapter Two Literature review

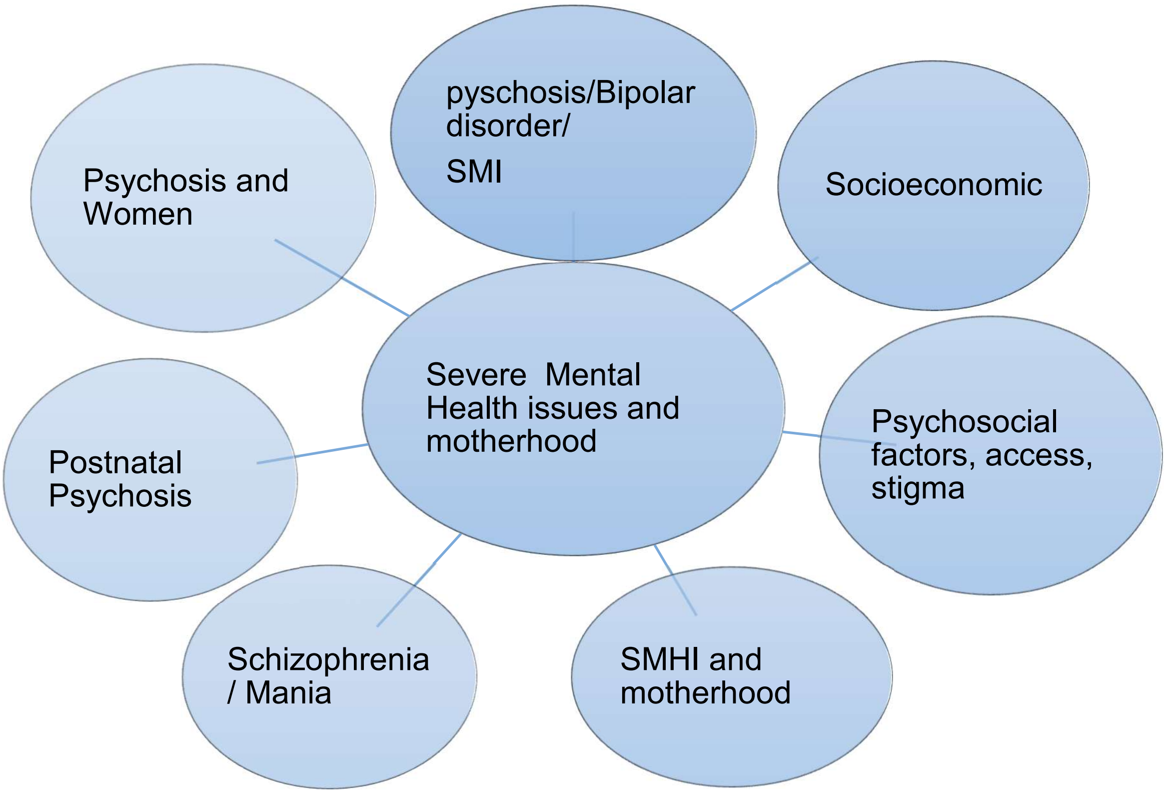
2.1 Chapter introduction

This chapter begins with a brief contextualisation of severe mental health issues, their global occurrence and the specific approach to understanding them used in the literature. The purpose of this chapter is to analyse the literature for definitions of SMHI and to understand the factors which influence the experiences of women with SMHI in relation to motherhood during the postnatal period, including the assessment and management of SMHI. The data for this study were collected using a search of six databases. The structure of chapter two is presented by means of a flow chart as shown in figure 2.

2.2 Literature Research Method

The literature search was drawn from six different databases with varied search terms, as shown in figure 1 below. The databases searched were PubMed, Midline (EBSCOhost), Science Direct, Premium collection, Google Scholar and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). The search for pertinent literature was guided by diagnostic manuals, including the DSM-IV (American Psychiatric Association, 2013) and the healthcare study guidelines developed by the Centre for Reviews and Dissemination (CRD, 2009). To include as many pertinent studies as possible no date constraints were applied. The primary search term was developed around the study objectives and questions and all the essential features of the study questions were coordinated. The search words were refined by applying PEO Population (P) Exposure (E) Outcome (O) model (Khan et al., 2011). The phrases used are demonstrated in the table and figure 1.0 below:

Figure 1.0 General literature search themes



Conducting the Search (inclusion and exclusion criteria)

The inclusion criteria: studies were included; (1) examined factors influencing the experience of women with SMHI in the postnatal period, (2) focused on SMHI, such as schizophrenia and bipolar disorder, and postpartum psychosis, and (3) covered women's access to or barriers to perinatal mental health utilisations, regardless of the research design chosen.

In addition, studies were excluded if they focused on (1) depressive disorder, Anxiety, Obsessive-Compulsive Disorder, and Post-Traumatic Stress Disorder; (2) studies not written in the English Language and therefore not meeting the University regulations requirement; (3) studies that included mental health issues in pregnancy and not occurring in the postnatal period; and (4) studies that focused on medical factors, including women with pulmonary embolism, cancer, or diabetes.

All duplicate studies and studies unrelated to the research's aim, objectives, and questions were removed. All searches were conducted online. The databases can be found in appendix 11. A general review of the literature began in 2018, and the first step was to establish the context of the study; since then, the review of the literature has been an ongoing process. A more in-depth evaluation of the literature with the study findings is offered later in the discussion of the study results section. Before moving on to the literature review, it is necessary to briefly discuss some of the concerns that have been raised about grounded theory methodology.

2.3 Literature and Grounded theory

Glaser and Strauss (1967) argue that reviewing literature should be delayed until after the data collection and analysis have been completed, while Gerrish and Lacey (2010) and Ravitch and Riggan (2012) recommend examining the literature as part of the preparation of the research process. To recognise the development of the theory, Glaser (1992) suggests that research papers be reviewed after data analysis. Some researchers feel that reviewing the literature before or after data collection and analysis will present preconceived ideas that may result in enforcing bias during the process. In other words, categories may develop from the literature and not from the emerging data collected (Glaser and Strauss, 1967).

Other grounded theory researchers, however, believe that reviewing the literature before data collection is useful, since it helps in the identification of gaps in the study and increases the chances of selecting the appropriate methodology for the research study (Charmaz, 2014; McGhee, 2007; Bryant and Charmaz, 2007).

Grounded theory is defined by Charmaz (2008) as a research product and the analytical method used to produce data. It begins with methods of collecting and analysing data, wherein ideas are developed in response to the evidence.

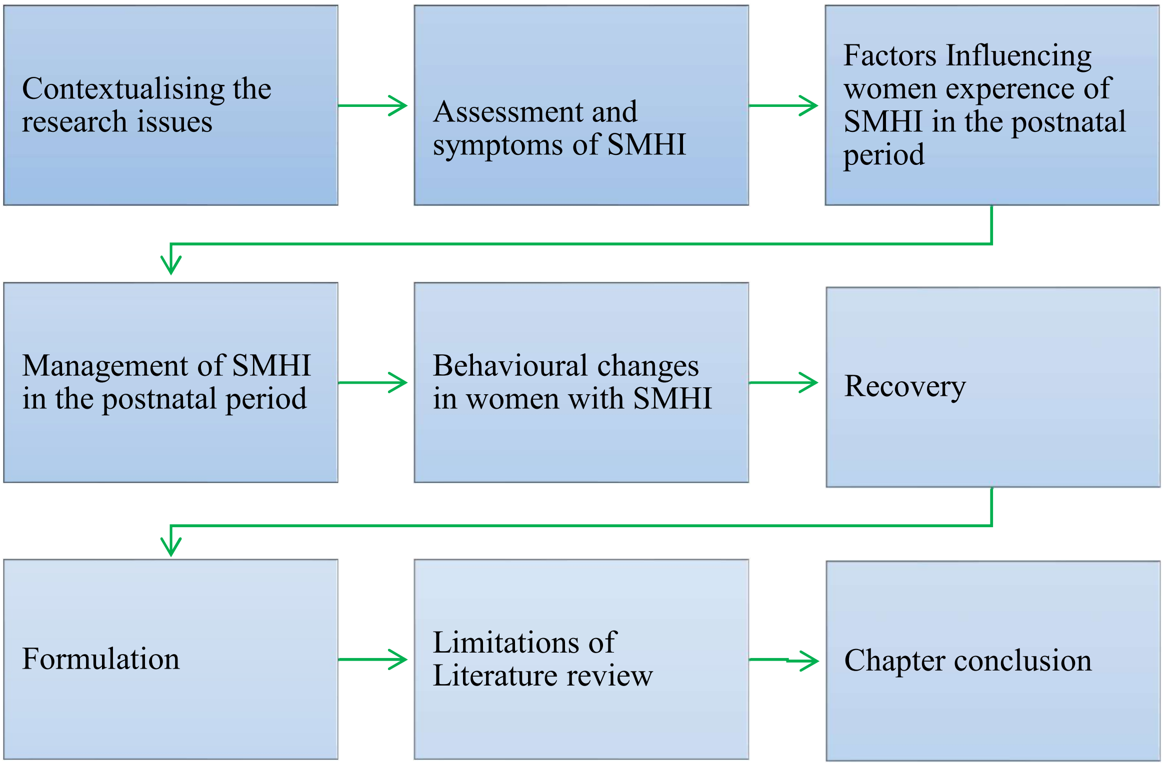
By collecting evidence from people’s lived experiences, the grounded theory method helps researchers gain an understanding of social constructions (Charmaz, 2006).

In other words, grounded theory is the process of progressive identification and integration of categories of meaning from evidence as it is collected (Charmaz, 2008; Hallberg, 2006). Therefore, the work of Charmaz has heavily influenced this study. One of the researcher’s obligations for a doctoral study is the production of a research proposal as part of the study process.

In addition to the considerations presented above, this includes a reason for undertaking the research and an initial review of the literature. Then, researchers must submit study proposals for approval to the University as well as to external ethics committees before beginning their work. To begin, the researcher must identify any gaps in the literature by establishing some concepts, thoughts, and questions relating to the study. Thus, the researcher must demonstrate that the research is not being undertaken exclusively to fulfil a desire, but also to contribute significantly to knowledge. This was supported by Giles et al., (2013) who state that the use of literature can strengthen theoretical sensitivity and rigour and may result in new possibilities and ideas.

However, Corbin warns against becoming too absorbed in the literature and allowing the literature to impact the process (Corbin and Strauss, 2008). It is therefore recommended that researchers should approach their work with an open mindset, not allowing previous knowledge to influence current research and avoid being led by the literature (Corbin and Strauss, 2008). Having been a midwife since 2005 and been encouraged to remain up to date by the Nursing and Midwifery Council (2018), and must be acknowledged, that the research required for this could influence the study in terms of the standpoint from which it is written.

Figure 2: Structure of chapter two



2.4 Contextualising the research issues

Mental health issues have been described in several cultures throughout recorded history (Bhati, 2013); this includes schizophrenia, which has been recognised as a public health risk, although, according to Walsh et al. (2002), the proportion of public violence linked to this is small. Prior to the twentieth century, no generally accepted definition of mental illness existed (Bhati, 2013). In addition, postnatal, or postpartum psychosis, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), is not recognised and cannot be differentiated from other forms of mental disorder. Thus, if a woman satisfies the condition's diagnostic criteria, the DSM-5 only recommends including 'postpartum' if the onset occurs during the perinatal period and or within 4 weeks of childbirth (Monzon et al., 2014; APA, 2013). However, the above DSM-5 views may not be identified in women with known and existing or postpartum onset of severe mental health issues.

Sharma and Mazmanian (2014) argue that the specifying period should be extended to accommodate such changes in women during the postpartum period.

In the United States of America, several working groups have introduced the ideas of severe and persistent mental illness (SPMI) and defined it as a product of the three "Ds", which are "diagnosis, disability, and duration" (Zumstein and Riese, 2020), which define SMI by classification. In order words, it depends on individual experience, exposure and her environment. However, the words or terms continue to be used often in both the public and professional spheres (Jones and Cantwell, 2010). Severe mental health issues can be defined as severe functional impairment and incapacitation (Lowenhoff et al., 2017). According to Jones et al. (2014), the perinatal period like other significant life events, may be difficult and complex for women with SMHI. The notion that other people are aware that an individual may have an SMHI may induce paranoia or may lead a person to feel they do not want to engage with their care. Thus, having been diagnosed with SMHI before childbirth can put the mother in difficulties in accessing services, finding the right support and getting someone who will listen to and understand their needs. Having a care navigator may reduce these uneasy experiences and feelings, as studies have shown that untrained professionals can exhibit a negative attitude towards motherhood roles for women with SMHI, in relation to their competence and warmth (Hauck et al., 2015; Hansson et al., 2013; Chien et al., 2014). Although Kirmayer and Crafa (2014) add that some service users experience diagnosis as a form of relief, there have also been issues noted in the literature relating to a lack of consistency in diagnosis; in other words, the lack of a proper classification system raises very fundamental questions about whether psychiatry is indeed a form of medicine and, more precisely, whether mental illness is understood as a disease process. Diagnosis and classification have long been an issue, and debate continues on mental health issues (Boyle and Johnstone, 2014). This will be explored further under medical model in page 43. Indeed, the WHO and national surveys report (2005) have noted that there is no universally accepted definition of mental health issues and that how they are expressed or seen differs based on the environment or the society in which individuals live, including the social, cultural, economic and legal context (WHO, 2005).

The onset of SMHI immediately after childbirth is well recorded and is linked to an increased risk of relapse at this time (Perry et al., 2021; Raza and Raza (2019). This shows that severe mental health issues may have a role in triggering postpartum SMHI (Perry et al., 2021). SMHI during the perinatal period is regarded as a psychiatric emergency and a mental health concern that may require hospitalisation (Wicks et al., 2019; Heron et al., 2012; Doucet et al., 2012).

Becoming a mother is one of the significant components of self-concept for some women. Indeed, according to Hine et al. (2019), it can transform a woman's personal and social identity. Most women adapt to their new responsibilities and cope with the demands of the motherhood role. However, although motherhood may be seen in women with SMHI (Engyvist and Nilsson, 2014), they may find this transition distressing and challenging, depending on their experiences and resources (Copeland and Harbaugh, 2019). For instance, most women have the support of their family and relatives during the postnatal period and, in the absence of such support, Brunette and Dean (2002) assert that there is fear of engagement with the welfare system which might imply the loss of custody, a situation that is approximately three times more prevalent among women with severe mental health issues than in those without.

One of the unmet needs of women with SMHI following childbirth has been reported as being confronted with many difficulties due to fear of losing custody of their infant in some cases (Ramsauer and Achtergarde, 2018), and or actual loss of child custody previously in others (Jones et al.,2014). Support whether socially or through family has proven to help enhance mother-baby interaction and increase access to information, which in turn lowers the feeling of isolation (Hero et al., 2012; Doucet et al., 2012). Thus, having a mental health issue, as highlighted by Malka et al. (2020), is not in itself associated with motherhood distress, whereas coping styles and resources are.

In addition, sleep deprivation is one of the challenges with which all women are confronted after childbirth. For women with SMHI, inadequate sleep may slightly worsen their condition (Ramsauer and Achtergarde, 2018), and they are likely to relapse in the postnatal period as a result (Banerjee et al., 2020; Lim et al., 2018; Jones et al., 2014). Relapse can often occur within the first year after childbirth which is noted by Wakil et al. (2013) to be the result of discontinuing medication during pregnancy and lactation. This is adopted by Jones et al. (2014), who claim that relapse and rehospitalisation may occur after discontinuation of antipsychotic drugs.

2.4.1 Medical model justification

According to Huda (2019), the medical model should be defined as a care model in terms of how practitioners communicate with patients in terms of assessment methods, categorisation of individual health concerns, and how they address the health issues of their patients.

In most health circumstances, expertise, abilities, competence, and experience are necessary to ascertain the kind of problem a patient is experiencing, their likely trajectory, how to recognise and diagnose them, and which treatments will be helpful (Haegele and Hodge, 2016). The social and medical models of disability rhetoric are two significant models that have been employed by various scholars. In the medical model, access to treatment or services is determined by diagnosis, whereas in the social model, access is based on experience or self-referral. In addition, the objective of interventions in the medical model is treatment or stabilised function, whereas, in the social model, the objective is an adjusted environment, comprehension and social equality (Haegele and Hodge, 2016).

Likewise, disability is regarded to be the loss of physical or mental structures and functions, which may be triggered by disease, trauma and injury, or medical conditions (Forhan, 2009). Since medical doctor’s work from a biological standpoint, disabilities are perceived as a medical product. In the discourse of the medical model, disability is conceptualised as an individual health issue that causes restricted ability and is viewed as inadequate (Bingham et al., 2013; Palmer and Harley, 2012). There are numerous ways to interpret the meaning of disability. How it is comprehended is crucial because the language used to define a person's disability shapes their perceptions and interactions (Bryers and Teijlingen, 2010). It is argued that the concept of disability is impacted by practitioners or professional groups and individuals with the authority to create the term in society and to govern understanding within specific disciplines (Brittain, 2004).

Comparable to ill-health disability, difficulties with the mind or body are considered an issue that requires medical attention so that the affected individual can integrate into society (Brandon and Pritchard, 2011; Forhan, 2009). This approach is very prescriptive, meaning that individuals are labelled disabled based on their inability to perform their usual activities (Roush and Sharby, 2011). People are distinguished by their qualities and characteristics; this is also evident in the medical model, in which disability is recognised as a distinguishing feature of the person (Hogan, 2019).

The medical model incorporates facts about medicine that influence study and theory regarding both physical and psychological issues on the grounds of their causes and treatments. A model is neither an assertion of fact nor a political ideology; rather, it is a tool for assisting patients. Thus, the effectiveness of a model is situational.

In psychoanalytic theory, the medical model implies that psychopathology is the outcome of a person's biology, i.e., a physiological disorder in the structural brain, neurotransmitters, genes, the sensory system, from a brain injury or Down syndrome. In this case, a medical model is a relevant tool for diagnosis, outcome, and investigation. However, most psychiatric illnesses utilise the medical model, resulting in a poor understanding and inefficient treatment strategies. In cases other than psychiatry, the medical paradigm of mental illness will be considered. In the absence of strong biomarkers, it has been impossible to distinguish between typical and pathological diagnoses (APA, 2013). This is challenging in clinical settings, where the initial symptoms are not necessarily pathological and may be faced in individuals for whom a mental disorder diagnosis would be inappropriate.

Medical settings other than psychiatric units rely on the medical model and, in some cases, diagnostic tests to determine ill health or the warning signs thereof, where signs and symptoms are suggestive of basic physical defects. For example, a rise in body temperature is a warning sign or symptom that may present as the patient experiences stress or pain. Changes in usual body operations that impact the individual are referred to as a syndrome or illness in the medical model, wherein treatments such as drugs or medications are targeted at addressing the disparity. Healing, according to Roush and Sharby (2011), is seen as an essential part of recovery and functioning for the individual with a disability (Humpage, 2007). Therefore, the medical model values the classification of illness using signs and symptoms. This is because, due to their diagnostic nature, doctors are directed to the use of medications in the treatment of an illness that aim to remove the triggers of the condition or reduce its symptoms (Bingham et al., 2013; Forhan, 2009). The medical model is thus characterised by a deep dependence on medical professionals (Humpage, 2007).

From the sociological perspective, health and illness are viewed as social constructions, with physical and mental factors playing a secondary role. Hence, the sociological perspective on health is integrated and embodies the interpretation of the mind, body, and society. While psychological perspective gives us an in-depth knowledge of the concept behind professional practise, which enables us to strengthen and sustain the social functioning of individuals in a healthcare context.

However, this does not consider the individual's experiences, values and triggering factors; indeed, key considerations are given to the patient's illness over social and psychological factors (Farre and Rapley, 2017). The criticism of the psychological model is the perception that health is independent of the sociocultural setting in which it occurs and can be defined one way across all populations (Van Teijlingen, 2005). The model is also criticised for its view of the health system as socially and politically neutral and not as a source of social or cultural power embedded into the structure of the society (Huda, 2019). Also, the medical model differs from sociological theories of care, which are linked with mediocre outcomes and health disparities (Wade et al., 2004) when compared to the socially deprived model. Instead, it generates labels and categories on the individual's biological functions (Hogan, 2019).

However, despite its benefits for diagnosis and treatment, labels and categories can leave people with disabilities with few options (Hogan, 2019). One of the arguments surrounding medical models is that they should not exert control over the social views of the disabled person. Even though doctors have competence in identifying, treating, and curing diseases, they have a poor reputation in relation to disabled people (Humpage, 2007). The medical approach is also linked with negative perceptions of disability (Brittain, 2004). This is because the medical model combines disabilities and sickness roles while analysing disability from a deficit model perspective (Mitra, 2006).

In this study, the medical model has been considered since it contrasts with the social model of disability (Mitra, 2006). While the medical model includes the concepts of diagnosis and labelling, the social model imposes disabilities on those with impairments (Bingham et al., 2013; Palmer and Harvey, 2012). This study considers the medical model since defines a specific situation (such as patient with severe mental health issues) and is linked to the functionality or diagnostics of such an occurrence (Brittain, 2004).

The medical model necessitates a method for how this knowledge is acquired, how it is enhanced through research or interactions with other clinical circumstances, and how it is utilised to make patient-beneficial recommendations. Hence, the medical model in this study is employed as a system that a practitioner would employ in clinical or research activity to assist diagnosis of clinical problems and predict their prognosis and reactions to treatment. Therefore, the medical model of care entails assessing a patient, formulating decisions and implementing solutions based on observing the patient's response to the intervention through additional examinations or assessments, which may result in a modification of decisions and treatments. These assessments are conducted by speaking with patients to obtain their medical history, as well as by completing a medical assessment, performing necessary tests, and obtaining extra details from relatives.

Several medical models may be utilised by the same practitioner based on the clinical concerns that are currently being addressed. For instance, the biomedical model, which emphasises biology and biological involvements, also incorporates the impact of the sociocultural environment, individual factors, and beliefs on health and illness (Huda, 2019). It also allows for the possibility that social or psychological factors may play a bigger role in the pathogenesis of some disorders than biological factors such as medicine.

2.5 Assessment and symptoms of SMHI in postnatal women

Assessing someone's mental, physical, and sociological health requires the systematic gathering of significant data to develop a full picture of a person's overall health (Wrycraft, 2015, p6). The presentation of symptoms may vary depending on the time of onset and the diagnostic tool used but may have some common characteristics (Ramsauer and Achtergarde, 2018), although according to Stuart, (2009), during an episode of SMHI, the person may not be aware that others are not experiencing the same symptoms and may wonder why others are not reacting in the same way. Several studies argue that some women from different cultural backgrounds are more likely to report somatic symptoms (Roca et al., 2011; Watson et al., 2019; Sihre et al., 2019) and may deny psychological symptoms (Simon et al., 1999; Sihre et al., 2019). This is supported by Rowland and Marwaha (2018), who suggest that signs or symptoms of severe mental health issues may be associated with culture and environment. On the other hand, SMHI may alter a person’s way of thinking, feels, and behaves and may cause a wide range of cognitive and behavioural symptoms (Pressner et al., 2017; Meltzer-Brody et al., 2018). Despite the classification of SMHI, the most common symptoms are a rapid change in mood (high or low), depression, severe confusion, hallucinations, and delusions (Perry et al., 2021; Heron et al., 2008). However, this may differ for women who have had a previous episode or are at a higher risk of a recurrence of severe mental illness (Hazelgrove et al., 2021). Furthermore, there are physical conditions that are regarded as the cause of some SMHI in the postpartum period, such as infections, eclampsia, and thyroid disorder (Jones et al., 2014).

Women first-hand experience of SMHI in the postnatal period

The majority of women perceive motherhood to be demanding and stressful because some mothers have no time for themselves or other family activities (Sihre et al., 2019). Previous pregnancy and birth experiences, such as pre-term deliveries and foetal anomalies, as well as personal and family mental health concerns and life events, can exacerbate mental health problems (Essali et al., 2013; Jones et al., 2014; Glover et al., 2014). There is a lack of integrated and women-centred care services, leaving women with limited access and a feeling of vulnerability within the fragmented maternity and mental health services (Higgins et al., 2016). Thus, women feel that their mental health has been neglected, while their infants or physical conditions have received more attention; this may be due to the absence of perinatal mental health specialist midwives in some services.

There also exists a lack of support from staff due to time, awareness, and commitment constraints, although some women report being observed and monitored while caring for their infants, which is consistent with the findings of David and Allen (2007). Most women claim that support services do not listen to them, leaving them suffering in silence due to the lack of opportunity to express their emotions and the need for a safe environment to discuss and be listened to (Watson et al., 2019). Other women's first-hand experiences, such as negative childbirth experiences are associated with symptoms of posttraumatic stress disorder and poor adjustment to motherhood (Holt et al., 2018), which in turn impact their mother-child relationship, resulting in some difficulty in their motherhood experiences (Ramsauer and Achtergarde, 2018). They also report being unable to fall asleep, resulting in sleep deprivation as they adjust to breastfeeding and caring for their newborns (Christian et al., 2019). The inability to fall asleep during the post-natal period affects women with both clinical and non-clinical needs and is believed to be one of the triggers of postpartum psychosis (Christian et al., 2019).

The journey to recovery is challenging for the majority of women since many of them feel a sense of isolation and loneliness, which is frequently exacerbated when they experience symptoms sporadically (Forde et al., 2020).

Women with pre-existing mental health issues report a lack of awareness, information and knowledge regarding the influence of childbirth on postpartum psychosis (Jones et al., 2014), which is consistent with previous research, (Engqvist et al., 2011). A study by Roxburgh et al. (2022) indicates that women with SMHI encounter inadequate access to mental healthcare services, although their experiences at other healthcare institutions, such as the GP or A&E, are mixed (Roxburgh et al., 2022). In contrast, Nagle and Farrelly (2018) state that inadequate staffing, a lack of empathy and a lack of proactivity are disruptive to the delivery of care. Notwithstanding prior data by Heron et al. (2008), some women fear that having too many people involved in their care could lead to increased confusion and postpartum psychosis-related distrust.

2.6 Factors influencing women's experiences of SMHI in the postnatal period

A small number of studies have looked at the psychosocial variables that may have an impact on women's experiences of SMHI. The social determinants of health are influenced by the cumulative sets of social and economic circumstances into which people are born, grow up, live their adult lives, and work. These include people's living and working conditions, housing, education, financial security, the built environment, and the health care system (WHO, 2014). Studies on SMHI have focused on the underlying biology, including hormones, (Bloch et al., 2003) as well as immunological factors (Weigelt et al., 2013) and some genetic elements (Jones and Craddock, 2007). Some literature has also investigated obstetric and medication-related factors (Di Florio et al., 2014; Munk-Olsen et al., 2014), although there is no consistency in this. Outside of the postnatal population, research has made substantial progress in understanding both psychological and social variables that may cause or increase individual vulnerability to SMHI, such as childhood trauma, including sexual, physical, emotional and psychological abuse (Verese et al., 2012b; Bendall et al., 2008). Some of the factors and potential triggers of SMHI in the postnatal period are detailed below.

Psychosocial factors

Recently, attention has focused on difficulties surrounding traumatic childbirth experiences, where most first-time mothers face challenges in adjusting to motherhood roles, leading to psychotic-like experiences during childbirth (Holt et al., 2018). In a study conducted by Hui et al. (2013), participants who had a diagnosis of schizophrenia after their first episode of psychosis were more likely to experience relapse later (Hatab and Mohammed, 2020), although the study did not state if this applied to women who had a second or third child.

Psychological and social factors are important triggers of postnatal SMHI such as depression (Meltzer-Brody et al., 2018; Seeman, 2020) and postnatal psychosis (Perry et al., 2019). Women with SMHI often report difficulties in social interactions or are too overwhelmed to function in a group setting (Highet et al., 2014). Tandon et al.'s (2010) study suggest that SMHI such as schizophrenia could be influenced by the environment as well as heritability in some cases.

The relationship between life stressors, such as trauma, and the onset of postnatal psychosis may lead to relapse (Mark et al., 1992). According to Allen et al. (2014), populations with SMHI that are exposed to specific stressful social, economic, and environmental factors are more likely to suffer from mental health issues. Mental illness is strongly related to social inequality, and the bigger the inequality, the greater the risk of disparity. Variations in social, economic, and environmental conditions result in health disparities, which are described as systematic, socially created, and unfair health inequalities (Whitehead and Dahlgren, 2006). Measures must be made to enhance the conditions of daily living. Inequities in health happen both within nations and frequently follow a social gradient, therefore occurring both along a continuum and affecting the entire population, not just the most disadvantaged individuals. Exposure to social isolation and deprivation for women with SMHI, particularly in ethnic minorities (William and Mohammed, 2009), as well as discrimination (Wallace et al., 2016) and inequalities in health-care access and support (Prady et al., 2016; Watson et al., 2019; Anderson et al., 1989), are triggers for relapse of SMHI. Individuals at risk of readmission may therefore benefit from psychological support through routine networking, as well as support focused on their surroundings (Zhou, 2011).

Socioeconomic factors

Social and economic factors relate to social and occupational dysfunction (Muntaner et al., 2004). Social determinants of health are the cumulative sets of statuses into which people are born, grow up, live and work, as well as their conditions of housing, education, financial security, built environment and health systems (WHO, 2014). A wide range of socioeconomic factors, such as family support, religious affiliation, and financial conditions, influence the occurrence of SMHI (Thomas et al., 2016; Di Florio et al., 2013; Fisher et al., 2012). This may lead to an increase in cases of relapse in postnatal women with reduced income (Vigod et al., 2016; Stein et al., 2014). Studies have found no association between social class and the risk of experiencing SMHI (McNeil, 1987), or an increased likelihood of living in a poor home setting (McNeil, 1988). However, it is not clear how the author defines these factors. As previously stated, people from different ethnic, racial, and socioeconomic backgrounds can react differently to mental health issues. Ethnic minorities with SMHI are said to have higher mortality rates than the white British population; however, these findings are not conclusive. According to Glannouli (2017), it is also noted that ethnic minorities are more religious, which raises spirituality in individuals (Glannouli, 2017). From the preceding statement, religious identification is thought to be beneficial to a person's SMHI treatment and rehabilitation.

Education and Awareness

Deinstitutionalisation and the availability of community-based treatments has many implications for service users, their families, service providers and society at large (Mowbray et al., 2000) by allowing individuals to be treated in the community. During the perinatal period, which spans from pregnancy to birth, some women and their families often have minimal knowledge of perinatal mental health (PMH) services.

There is thus a need for broader awareness of these services to improve knowledge and help-seeking behaviour in women with SMHI. To this end, programmes and campaigns, such as the Everyone’s Business Campaign led by the Maternal Mental Alliance, are necessary for creating awareness to reduce the stigma and increase availability of service to women with SMHI (Smith et al., 2019). Smith et al. (2019) further emphasise the need for raising awareness of PNMH among BAME, Chinese and South Asian women and their families, as these groups are the most unlikely to be familiar with PNMH services and able to differentiate between the presenting symptoms of perinatal mental health issues. This level of information, awareness, and knowledge then becomes invaluable in helping women with SMHI navigate through the postnatal period. Education also helps to develop women's intellectual abilities and comprehension of health groups and ideas (Levin-Zamir et al., 2016). Thus, education is the most fundamental tool for empowerment because it equips people with the knowledge and skills, they need to make informed decisions about their health and well-being (Baker et al., 2011). Studies by Upadhyaya et al., (2014) report that there is no link between educational level and SMHI, however, Perry et al., (2016) found that women with SMHI who experience relapse were less likely to have completed higher education.

Hormonal factors

The hormonal changes that occur during pregnancy and the postnatal period, as well as the pathological process of postpartum psychosis, have been a major focus of research (Maguire, 2020). Before and during menstrual periods, women commonly experience fluctuations in their hormone levels, which can have an impact on psychotic symptoms (Brzezinski-Sinai and Brzezinski, 2020; Ray et al., 2020; Seeman, 2012). Instability in hormone levels, such as an increase in prolactin and a drop in oestrogen and progesterone levels, suggests that hormonal factors are likely to be involved in the cause of the disorder (Bergink et al., 2013). Oestrogen and progesterone levels drops following childbirth which can lead to change in mood, anxiety and irritability that recovers within a week after birth. Both oestrogen and progesterone interact with monoaminergic functioning, where monoamines are involved in mood and psychotic disorders outside the perinatal period (Barth et al., 2015; Kesby et al., 2018; Ashok et al., 2017).

Studies have established that these monoamines are known to play a role in mood and psychotic disorders outside the perinatal period (Kesby et al., 2018; Belmaker, 2008). This view is supported by Bergink et al., (2013) who write that an imbalance in the immune system, together with an increase in immune system stimulation, is thought to be a contributing factor to postnatal psychosis in women. The above claims need to be explored further to establish whether hormones should be considered as a cause of SMHI especially as, case reports by Dennerstein et al. 1983 and Kulkarini et al. (2002) have shown that women's psychotic symptoms improve after synthetic oestrogen and progesterone therapy. In contrast, Kesby et al. (2018) criticise this view as being overly simplistic as some women may be sensitive to hormonal changes that occur in the perinatal period (Heringa et al., 2015). Indeed, the exact mechanism by which these hormone shifts precipitate cognitive shifts that result in postnatal mental health issues is yet to be understood (Payne and Osborne, 2019), although Perry et al. (2021) found that there is a definite link between postnatal SMHI and hormonal factors, which may develop beyond the role of oestrogen and progesterone, and that this might involve interaction with other reproductive hormones and other neurotransmitters. Feminist scholars have long noted that premenstrual syndrome is best described as a culturally bound syndrome (Johnson, 2014). Indeed, it has been suggested that there is a link between premenstrual syndrome and physical, sexual and emotional trauma (Gogos et al., 2019: Nolan and Hughes, 2022). Recent evidence on the psychiatric diagnostic system has suggested that feminist thought has heavily criticised the role of hormones in experiences such as depression in menopause (Springen, 2017; Loppie and Keddy, (2002). Overall, it is still not clear how hormone relates or contributes to SMHI.

2.7 Management of SMHI in the postnatal period

It has been reported that women with SMHI have a reduced life expectancy when compared to the general population, which is a major source of concern (Department of Health, 2006). Maternal suicide is often a predominant concern as it is a leading cause of mortality in women with SMHI (Meltzer-Brody et al., 2018). According to Chrzan-Detkos et al. (2021), severe mental health issues are the second major cause of death in the first year after childbirth; care support and management are therefore essential for women with SMHI during the postnatal period. Indeed, the need for a clear pathway for appropriate intervention, including the full involvement of healthcare professionals, is vitally important. The identification of women at increased risk has been a focus of NICE (2014), as the onset of warning symptoms of SMHI in the perinatal period can facilitate timely referral and management (Byatt et al., 2018). Women with SMHI must receive the necessary interventions for them to thrive. This includes hospital appointments, specialist treatment (Berry-Millet and Bodenheimer 2009; Boult et al., 2001; Mezey et al., 1999)

and accessible locations to provide people with standardised care, as well as intensive follow-up and management, which is done through further appointments (Honka et al., 2011). Care navigation for women with SMHI is discussed in chapter three. Health care professionals who are not part of the psychiatric team may be able to assist women with SMHI in identifying resources that are accessible to them, particularly during the postnatal period, to facilitate an effective transition to motherhood. While some may be able to manage their symptoms with the appropriate support and treatment, the majority of women going through the transition to motherhood may require some support with day-to-day activities. According to Jones et al. (2014), the needs of the woman, her partner and wider family need to be considered in the management of women with SMHI. Support in preparations for motherhood and the postnatal period should start from pregnancy; (Jones et al., 2014).
There is also a need to strengthen women's psychological interactions in addition to continuing to use medicines and psychosocial therapies, such as:

- The use of individual therapy to re-establish the status quo in one's thoughts and stress level, and

- enhancing communication and social relationships, as well as utilising family support.

A number of studies have found that many women with severe mental health issues choose to stop their medication during the perinatal period as a result of concerns they may have regarding the effects of psychotropic drugs on their babies during breastfeeding (Dolman et al., 2016; Byatt et al., 2018; NICE, 2014). However, Kronenfeld et al.'s study in 2018 reviewed the effects of chronic use of psychotropic drugs during lactation and found that it was not associated with growth or developmental defects.

Recent records have seen an increase in the number of women who require immediate in-patient admission (Coles, 2018), as poorly managed episodes can increase the risk of mortality in both the mother and baby (Brockington, 2017). However, women's primary concern is on how to contain their symptoms and maintain safety during the perinatal period (Forde et al., 2019). Many interventions in SMHI, such as practical and social support, have been proven to enhance women's access to various social groups and information while reducing feelings of isolation (Plunkett et al., 2016; Heron et al., 2012; Doucet et al., 2012), and accessing psychological intervention (Forde et al., 2019; Bighelli et al., 2018; Valiente et al., 2019). Women need to be supported to cope with the transition into motherhood (Hangan, 2006), although, this support must be tailored to each individual's needs to achieve a better outcome (NICE, 2014; Cox et al., 2003). Family support plays a substantial role in a woman's recovery process by helping to recognise symptoms and provide support to access services at the right time (Plunkett et al., 2016).

In addition, having a designated perinatal mental health specialist midwife is of paramount importance in maternity or other teams outside of psychiatry for early identification and prompt management to reduce relapse (Sihre et al., 2019; Howard et al., 2014; NICE, 2014; Sharma et al., 2017; Howard and Khalifeh, 2020). Therefore, healthcare professionals, particularly those outside of psychiatric management, should understand how to support, manage and refer women with SMHI, since the timely intervention and appropriate management have been highlighted as key to a beneficial outcome. An integrated mental health care pathway was developed for perinatal mental health services for this reason (Attfield et al., 2017). The pathway includes the provision of additional mother and baby units, as well as improved access to community perinatal mental health teams and the delivery of treatments to women with SMHI (National Health Service England, 2018; Better Birth Programme, 2018). The person providing care must have a sound knowledge of mental health issues and should be able to identify women who are at increased risk of relapsing following childbirth.

2.8 Behavioural changes in women with SMHI

Many studies have described the behaviour and interactions between a mother and her infant following childbirth, particularly for women with SMHI (Ramsauer and Achtergarde 2018; NICE, 2014; Noorlander et al., 2008; Bosanac and Burrows, 2003). Consequently, bonding issues between women and their babies were identified (Farre-Sender et al., 2018). Other researchers have investigated the negative effects of poor bonding (Hipwell et al., 2000), which was considered by Kolk et al. (2021) to affect women's mental health.

Maternal bonding with an infant is defined by Nolvi et al. (2016) as how emotionally connected a woman is to her baby. According to Farre-Sender et al. (2018), many other issues are likely to reduce the level of maternal-infant bonding outside of a diagnosis of mental health issues, such as childhood abuse, which is associated with post-traumatic stress disorder and behavioural issues, delays in a mother's emotional responses towards her baby (Brockington et al., 2017), or delays in responding to her baby cues (Meltzer-Brody et al., 2018). Bosanac et al.'s (2003) study indicate that a lack of stimuli, reduced eye contact and difficulty responding to cues between the mother and infant may have a negative impact on mother-infant interaction. However, their study failed to demonstrate whether the mother had relapsed or was in a recovery phase, which is important as not all women with SMHI relapse following childbirth, particularly those who receive pharmacological treatment (Meltzer-Brody et al., 2018; Shulman et al., 2018), although, childbirth and the immediate postnatal period have been found to exacerbate relapse in women with SMHI such as schizophrenia (NICE, 2014) or any life stressor (Bosanac et al., 2003).

Some women with no support experiences issues with child custody following admission to psychiatric units (Bosanac and Burrows, 2003). This reinforces the reason why the experiences of women with SMHI in relation to motherhood should be explored. A study conducted by Maeve et al. (2013) on female in-patients in mother and baby units found that using video feedback intervention to improve a woman's interactions with her baby was supportive. However, Bilszta et al. (2012) state that a single intervention cannot be separated from other factors, for example enhancing parental confidence. Other interventions, such as cognitive behavioural therapy are more successful in some mothers with early onset of SMHI. NICE (2014) has recommended cognitive behavioural therapy (CBT) intervention for women experiencing the early stages of psychosis. The adoption of CBT outside the domain of maternal health-seeking is dependent on several factors related to awareness, socio-economic status and cultural beliefs and practices. However, CBT is one of the non-medical interventions utilised for mental health treatment that apply to other areas. According to Freeman et al. (2015), CBT is an evidence-based talking therapy that focuses on the relationship between an individual's thoughts, behaviours and emotions, and how their thoughts and behaviour impact their emotions and help people to deal with overwhelming issues more positively. As a result, a change in thought and behaviour will impact positively on women's experience of the transition to motherhood.

Taylor and Steel (2008) emphasise the function of personal engagement with CBT in articulating one's psychological state, hence helping one to discern between the conditional and absolute self. Laws et al. (2018), explained the activities and ways of facilitating and promoting mental well-being to reduce relapse, by helping women to make sense of their psychotic experiences and to reduce the associated distress and impact on functioning (Wykes et al., 2005).

Individual coping styles have been identified in the literature as being influenced by different factors, whether positively or negatively, such as interpersonal coping, religion and spiritual coping (Folkman, 2011). Research studies have recognised various coping strategies (Carver and Connor-Smith, 2010) that help in the recovery process, which are viewed by Vaillant (2000) as a mature and complicated mechanism, whereas Miller (1987) perceives them as a stable aspect of personality. However, other researchers (Folkman and Larzarus, 1980) consider coping as a dynamic process shaped by situational demands and the person's resources. The timing of events might also affect the coping mechanisms of individuals (Endler and Parker, 1990). For example, the ability of a younger mother to cope with motherhood might be completely different from that of a mid-age or older mother (ibid).

2.9 Recovery

In the literature, the term 'recovery' has been used with many definitions. The typical definition is focused on the medical model of illness. There are two primary medical definitions of recovery: the first relates to curative treatment, and the second to recovery from a discrete occurrence. Recovery from schizophrenia for instance is synonymous with the medical term 'cure'. Therefore, the medical definition of recovery can indicate "being cured" or "not having any symptoms." Recovery for those with mental health disorders focuses on the individual's entire life, not only on their illness or symptoms (Retta et al., 2011). Recovery can be personal and have different meanings for many individuals. The aim of recovery and its strategy is regaining control of one's life, which may or may not involve living with symptoms. That is, all symptoms and indicators of the sickness have vanished, and the individual has returned to his or her previous level of functioning. This may involve developing or sustaining hope, strength, and the ability to overcome challenges.

Women experiencing SMHI have different views on recovery; thus, one version of recovery according to Anthony, (1993) is attaining a productive and fulfilling life, regardless of the presence of recurring symptoms, wherein the person recovers from the psychological devastation of the illness. It is a unique very personal process of transforming one's mindset, attitude, values, feelings and hopes (Anthony, 1993; p15). Andresen et al. (2011) interpret the meaning of recovery based on a medical model of illness, for example, recovering from an episode of relapse or being cured of the ailment. Previous studies have defined recovery as a positive change in one’s experience (McGrath et al., 2013), and self-efficacy as an increase in hope. The concept of recovery indicates that the individual may recover or have the ability to function although the condition is not cured. Traditionally, most women hope to recover from life-transforming events such as childbirth (Dekel et al., 2019), both physically and psychologically (Ayers et al., 2016). As one gets past the overwhelming impact of mental illness, recovery entails finding new meaning and purpose in one's life (Anthony, 1993) and developing a positive sense of self that is of low illness but full of resilience (Hine et al., 2019). Throughout the recovery phase, women with SMHIs emotional reactions are described by Lyons (2003) as including stress, guilt, and detachment, wherein women experience the loss of early motherhood with their baby due to SMHI during the postnatal period. Family or carers’ support and involvement are necessary during the recovery process, and they should be included in the care planning of their loved ones (Engqvist and Nilsson 2014; Mohamied 2019).

Women who relapse following childbirth will generally be admitted to an inpatient psychiatric unit (Mother and Baby Unit, (MBU) (Gillham and Wittkowski, 2015), and medical intervention is necessary during this time (NICE, 2018; Jones and Smith, 2009). This is not always possible, however, as most hospitals have fewer beds in MBU than in the general ward, although studies have shown that general wards are less inclusive than MBU, as women are admitted without their babies and there is a less family-centred approach (Griffiths et al., 2019; Glangeaud-Freudenthal et al., 2016). Meltzer-Brody et al., (2013) found that inpatient admission is the preferred treatment option for the majority of women. Recovery may take several weeks, or months based on individual needs, although, with appropriate care, most symptoms will reduce within weeks (Bergink et al., 2016). Some researchers also point out that, for recovery to improve, women need to find something positive in their experience of SMHI (McGrath et al., 2013).

However, a lack of understanding of postnatal SMHI within a woman's support system affects the recovery process and duration creating more difficulties (Doucet et al., 2012; Plunkett et al., 2016), although recovery is considered a process that is progressive and nonlinear, with checkpoints and milestones (Heron et al., 2012; McGrath et al., 2013).

2.11 Limitations of the literature review

Given the substantial investment in perinatal mental health, the literature continues to show that severe mental health issues remain a significant challenge. Some of the literature excluded due to language or due to a short abstract may have valuable information. The selection process is quite time-consuming. The literature shows that women's experiences of SMHI in the postnatal period are determined by factors such as sleep loss, hormones, awareness, psychosocial factors, isolation, culture and religion (Engqvist et al., 2011; Highet et al., 2014; Perera et al., 2014; Halperin et al., 2020; Jones et al., 2014; Dolman et al., 2013).

However, the evidence presented in this section suggests that SMHI in the postnatal period are still a challenging issue. There is therefore a need to understand the experiences of women with formally diagnosed SMHI during this time, and to understand their needs and coping strategies used in motherhood. Evidence from the literature has shown that the studies, programmes and initiatives that have previously been carried out were focused on women already known to have SMHI, with less focus on women who might develop severe mental health issues following childbirth. However, few studies have been carried out to explore women's experiences of severe mental illness during the postnatal period (Blegen et al 2012; Klausen et al., 2016; Krumm et al., 2013). Studies on SMHI during the postnatal period tend to focus on factors affecting women's mental health (Gressier et al., 2017), using quantitative and survey methods (Moorkath et al., 2019; Stein et al., 2014; Bilszta et al., 2010). This study utilised a qualitative, iterative grounded theory methodological process to examine the experiences of women with SMHI in relation to motherhood during the postnatal period and to explore their feelings, thoughts and lived experiences from their perspective. Thus, to understand how best to support such women, this study investigates how to improve women's experiences during this time. It is hoped that the research findings of this study will be used in primary and secondary care.

Few women are aware of the mental health services available to them in the postnatal period, and this lack of awareness of available services is highlighted in the literature on this subject. Nevertheless, service users and staff are rarely consulted regarding women's experiences of SMHI in motherhood; hence, most women are not aware that they might develop SMHI after childbirth.

2.12 Chapter conclusion

This chapter has reviewed the literature and has shown that severe mental health issues in the perinatal period are associated with maternal morbidity, relapse and hospitalisation. The literature has demonstrated that many factors which affect SMHI can result in triggering them and lead to a prolonged hospitalisation, which in turn can affect mother-infant interaction. There are some cultural issues which can act as a positive or negative influence. This provides a basis for navigating care for women with severe mental health issues, as well as details on the philosophical and methodological approaches used. The following chapter discusses navigating care for women with diagnosed SMHI in the postnatal period.

Chapter 3

Chapter Three - Navigating Care for women with Diagnosed Severe Mental Health Issues in the postnatal period.

3.1 Chapter Introduction

This chapter explores how women with formally diagnosed, severe mental health issues are guided, oriented, and directed through services to meet their needs, especially during the perinatal period. It provides an overview of care navigation and its definitions as well as why care navigation is important for women with severe mental health and other chronic issues, forming a discussion on secondary evidence and the benefits of care navigation to service users.

Chapter overview

Navigating care for women with severe mental health issues can improve health outcomes by maintaining an environment where women feel safe discussing any difficulties they are facing in a supportive, caring, and stigma-free environment. This study followed the guidance for integration of perinatal mental health into maternal and child health services when navigating care planning and managing women with severe mental health issues. See figure 3.1 navigation pathway summary for getting help. The postnatal period can be a challenging time for most women and even more so for women with mental health issues, including those with non-psychotic mental health problems (Howard et al., 2014). It is, therefore, expected that women have different individual transitional experiences in motherhood. A previous study has shown that women with severe or chronic health issues are known to have needs; their care or services are provided by care providers in different places, all of which must offer appropriate care (McMurray and Cooper, 2017). Other studies have identified the fact that these unmet needs are associated with inadequate communication which is poorly coordinated (Kuluski et al., 2013; Burgers et al., 2010). Megnin-Viggars et al. (2015) highlight the idea that engaging with healthcare services during care management decisions in order to receive the necessary support from the healthcare team, including medical, and social support, is highly important for women with SMHI.

However, care may be mismanaged due to lack of information or ineffective communication (Burgers et al., 2010; Kuluski et al., 2013). This concept requires further exploration. The increased complexity of the healthcare system and the rise in socioeconomic disparities in society have made it clear that there is a need for navigation for women with diagnosed severe mental health issues. The aim is to ensure that the care pathways are followed in navigating care for women in order to receive appropriate information that best meets their needs at all points throughout the continuum of care, and to minimise barriers to help-seeking behaviour (Ingram et al., 2015). McMurray and Cooper (2017) report that navigators, whether in primary or secondary healthcare, contribute significantly to the health care system by promoting patient-centred care, in which patients receive timely and appropriate information and support for improving health knowledge and awareness.

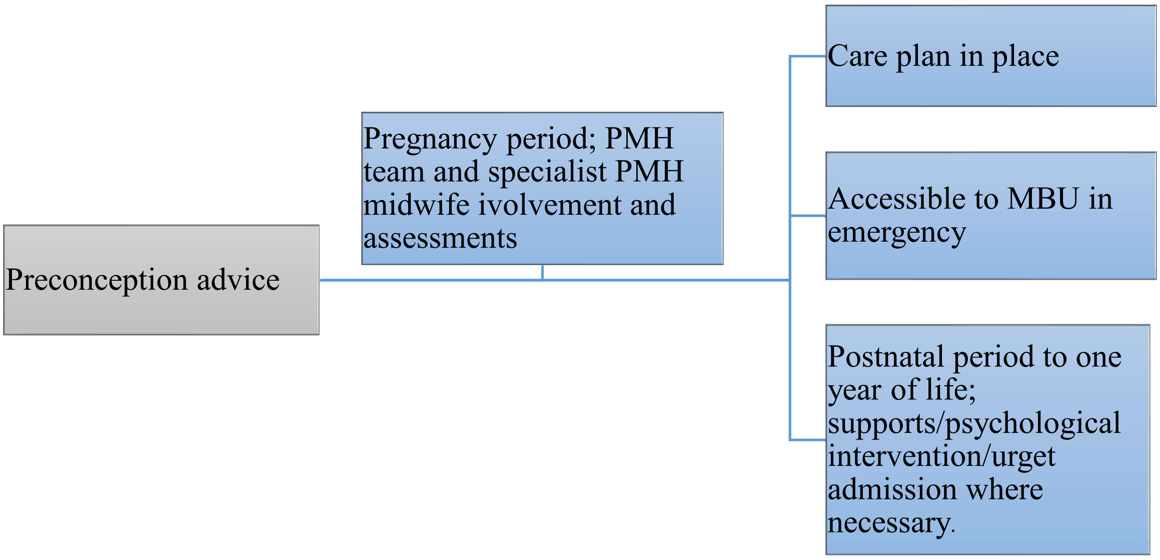
Navigation is defined in different studies as an organised, directed approach that is formed to minimise barriers and enhance access to basic services by widening support to assist individual patients in their care management (Waid et al., 2021; Fishman et al., 2018). This is similar to the definitions found in Freund et al. (2008) and also Yee et al., (2021). Different countries, including the United Kingdom, are investing in more effective primary and secondary care resources to reduce costs and provide coordinated patient care across the care continuum (Davis et al., 2005). In England, there is a huge demand for proper care navigation plans within the NHS due to the increase in complex healthcare service delivery and in social inequalities in the population (Carter et al., 2018). Women rely heavily on the advice of healthcare providers to assist them in making the best decisions possible based on the services available to them (McMurray and Cooper, 2017). However, service users continue to experience care navigation gaps in the healthcare system in terms of meeting patients' needs (Rell Pros-Wellenhof, 2007). This also applies to women with SMHI, according to Smith et al. (2019), who highlight the barriers in accessing health care services, especially for women with severe mental illness. Many studies address concerns about organisational barriers such as negative attitude and stigma, and other challenges including cultural and language barriers which can make care navigation difficult (Smith et al., 2019; Bayrampour et al., 2018). To overcome barriers in the healthcare system, Tierney et al. (2019) state that care navigation should be developed with the individual to improve their experience and outcome.

This can be information they receive, as well as worries about whether they will have problems or become unwell (Heron et al., 2012). Most women with diagnosed severe mental health issues suffer in silence, incapacitated by negative feelings and emotions. Bril-Barniv et al. (2017) address the concerns that women with SMHI are often afraid to disclose due to what others might think of their coping strategies. Thus, care navigators may play a part in leading the management of individuals with severe mental health issues in the perinatal period across the diverse services in the United Kingdom. Wells et al. (2008) describe care navigators as health care providers who offer different services for a specific set of health care needs. Following this publication, Wells et al. (2008) highlighted that care navigators offer support and help to remove barriers to accessing health care as well as providing services in a way that is collaborative, holistic, inclusive, and responsive to people's needs and preferences in the contexts of their lives.

Most US studies report that many healthcare teams have found care navigation to be successful since it was first recognised as a concept in the 1990s (Yee et al., 2017; Austad et al., 2020; Freeman, 2012; Anderson and Larke, 2009). To achieve this, campaigns urged policymakers and service managers to hire patient navigators to help people bridge the delivery gap (Freeman, 2013). Individuals require direction and information to help them gain access to healthcare services and assist them in focusing on non-medical needs, such as social factors that might affect their health and wellbeing (Tierney et al., 2019). Navigation indeed requires skills and knowledge which allow the navigator to determine the position and direction of necessary tasks (Rell Pros-Wellenhof, 2007). Studies have also highlighted that care navigation is an essential task for all clinical and non-clinical staff in steering patients in the right direction and should be everyone's business (Austad et al., 2017; Mumtaz et al., 2014), because not all women with a history of mental health issues are aware of the resources available to them during pregnancy and the postnatal period (Mandelli et al., 2016; NICE 2014; Vigo et al., 2016).

Figure 3.1 navigation pathway summary for getting help.

England, N.H.S., Improvement, N.H.S. and National Collaborating Centre for Mental Health, (2018).



3.2 Why care navigation is necessary in the postnatal period for women with SMHI

Care navigation is a patient-centred intervention where trained personnel identify patient-level barriers, including financial, social, cultural, logistical, and health issues that are obstacles to accessing timely health care (McKenney et al., 2018). This role, therefore, involves sharing care and expertise, while helping women and families through their transition to motherhood. McMurray and Cooper (2017) highlight that the use of specialists with a unique model of care and reallocation of clinical responsibilities within the multidisciplinary team will accelerate the role of a care navigator. This is not just for women during the perinatal period but across the entire health care continuum. With effective care navigation, women who are unaware of available services will still be sent in the appropriate direction with the help of their care navigators (McMurray et al., 2018), since not all women with a history of mental health issues are aware of the resources available to them during pregnancy and the postnatal period (Mandelli et al., 2016; NICE 2014; Vigo et al., 2016).

The perinatal mental health team (PMHT) helps women gain support from care navigation through a wide range of caregivers (Penny and Windsor, 2017), and to obtain social and emotional support (Yee et al., 2017). The PMHT is a group of professionals who provide care to women during the perinatal period, providing and coordinating care between the maternity and mental health teams, identifying which patient will benefit most in care navigation.

Patients remain connected with the PMHT to access resources that will improve the quality of care and experiences of women with mental health issues during the postnatal period. Previous negative pregnancy experiences (for example, poor delivery stories shared by others, and personal circumstances) can all influence a woman's expectations and her transition to motherhood (Krumm and Becker, 2006; Melender, 2002). Such perceptions can be changed using the help and services of care navigators.

Women are usually frightened to reveal their difficulties for fear of how others might perceive them and whether they have been coping (Mandelli et al., 2016; Coates et al., 2016). A care navigator should have a cultural awareness to be able to coordinate activities. This might include professionals being aware of other cultural norms and practices (Riggs et al., 2017; Sharma et al., 2020; Joseph et al., 2019), such as women being attended by a female doctor due to the religion of the patient (Riggs et al., 2017; Murray et al., 2010). The most frequent users of the healthcare system include those with complex and chronic conditions, who rely on guidance from health professionals to help them make appropriate choices through the many touchpoints of available services. Having a care navigator helps women gain support in order to cope with any underlying chronic health conditions (Riggs et al., 2017), and assists practices and patients in accessing the essential resources available to them (Austad et al., 2017). There is a need for care navigators within the maternity service to facilitate and navigate care for women with severe mental health issues during the perinatal period (Freeman, 2012), and to ensure all mothers and babies are safe during this time (Maternal Mental Health Alliance, 2014). This is because care providers within the maternity are not necessarily aware of the local options available for women with SMHI; therefore, to keep abreast of all relevant information and services, the care navigators will coordinate care with the community mental health team. Having care navigators for women with severe mental health issues will help manage workload while attending safely to patient needs and thereby enhancing the smooth transition of both mothers and their babies during the postnatal period.

3.3 Care navigators in the postnatal period for women with SMHI

Healthcare providers work collaboratively across health care boundaries, providing women with information and direction at every stage of their perinatal period. This helps to identify variations from norms for a smooth transition into motherhood (Midwifery 2010; Austad et al., 2017). In most maternity units, healthcare providers, including midwives, play the role of care navigators for women and their families. This includes women with regular and complex issues, such as severe mental health issues which require a specialist clinical midwife's knowledge during their early postnatal period. These trained professionals help women navigate the systems by providing them with as much information as possible to make an informed decision and by directing them to the appropriate professional care they need (Braham et al., 2020). As mentioned earlier, care navigators are not necessarily aware of the local resources which can be effectively allocated based on individual needs; therefore, effective collaboration with community health care providers is important. Indeed, perinatal mental health teams are based in both the hospital and in the community, providing services to support women experiencing mental health issues related to pregnancy and the postnatal period for up to one year after childbirth (Howard and Khalifeh, 2020). According to the Maternal Mental Health Alliance (2013), the specialist perinatal mental health teams play an important role in improving the quality of maternity services and in the implementation of integrated care for women with mental health issues. The specialist perinatal mental health midwife should be a part of every woman's care plan. Recently, most maternity units had a named specialist mental health midwife who can provide coordinated care services to women with diagnosed severe mental health issues. Various care navigation programmes have been established in different parts of the world (such as the USA, Canada, Australia and even the UK), but, despite widespread implementation, challenges remain in defining the navigator processes and roles (Cantril and Haylock, 2013). For instance, the health professional at the initial point of contact in the perinatal period is often in a primary care position in general practice, or in a maternity unit which must be identified. Midwives work in a multidisciplinary team, providing care and directing women to services. This involves working across health and social care boundaries with an understanding of how best they can join in helping women and their babies/families to get the best care, through maximising professional experiences (Austad et al., 2017).

These professionals are trained to help patients through the healthcare system by providing a coordinated care plan (Montello, 2005) with as much information as possible, to make an informed decision. Care navigators come from different backgrounds including midwives, occupational therapists, medical assistants, social workers, health visitors, and nurses, with nurses being the most common among these groups (Bodenheimer and Smith, 2013; Doolan-Noble et al., 2013; Enard, 2013; Ferrante et al., 2010; Lindsay et al., 2014). Most other health care practitioners are involved in the provision of care to women in the maternity unit (apart from midwives), especially during the postnatal period for women diagnosed with severe mental health issues.

There is a need for planned care navigators for complex cases (such as women with severe mental health issues and other chronic issues) and for care navigators to understand how service users perceive themselves in relation to their mental health issues in order for them to engage well in their care management. The failure of a care-navigation system may result in a service user not receiving the type of services and support that a named midwife or a named navigator can provide (Walker et al., 2019). Montello's study (2005) points out that care navigation may be conducted in a hospital or community setting, incorporating the planning and implementation of the coordinated care plan. Using a community referral approach would enable health care professionals to refer people to a range of local and non-clinical services that help to widen patient involvement in taking care of their health. Effective care navigation requires a personalised care plan for each woman to provide postnatal care information and support based on individual requirements (Freeman, 2013). According to McMurray and Cooper, (2017), care navigators seek to ensure that the advice they offer is tailored to the patient's condition and needs, their level of health literacy, and the social and cultural determinants of the problem in question, which may or may not be appropriate. Studies have highlighted that care navigation takes into consideration individual, family and cultural perspectives, especially during the postnatal period (Ong et al., 2014; Probandari et al., 2017; Russo et al., 2015), as well as the possibility of interference from family, and cultural involvement (Ong et al., 2014; Probandari et al., 2017; Viveiros and Darling, 2019). Such interference may lead to delays in obtaining treatment or isolation from services (Russo et al., 2015; Viveiros and Darling, 2019).

Therefore, Natale-Pereira et al. (2011) remind clinicians that effective communication, training and information sharing are the key factors of effective care navigation. Where there is poor communication, this may cause fear and distrust in patients and stakeholders (Natale-Pereira et al., 2011). For instance, studies have identified effective communication as a means of breaking the language barrier and fostering cultural understanding, which helps in the transformation of activities and objectives (Kurth et al., 2016), thus allowing healthcare professionals to bond and connect with service users (Kurth et al., 2016). These relationships, if developed between the care navigator and the service user, create an enabling environment for an in-depth discussion on those factors which influence the smooth transition to motherhood, such as stress, inadequate sleep, infant care, breastfeeding and home keeping (James et al., 2017). Other factors include promoting women's psychological and social activities to tackle any issues concerning family lifestyles and body image issues if necessary (Fahey and Shenassa, 2013).

There is no doubt that an effective care navigation approach in the maternity setting and community, as shown in figure 3, will reduce undue stress, increase access, minimise unnecessary re-admissions, and promote independent living (Pang et al., 2021; Albert, 2012) for women with severe mental health issues (Yee et al., 2021). To this end, Health Education England (2017) published a core skills framework for care navigators acting as a bridge between community, health and social services which covers skills such as effective communication and interpersonal interaction.

Social policies on perinatal mental health services provision

Social policies are sets of rules and regulations designed to improve the effectiveness of care for individuals with mental health issues aiming to change societal norms and living conditions so that people have access to care. The social policies outlined in the table below are aimed to support women who are at risk for or are experiencing mental health problems. One of the goals of these policies is to reduce quality care disparities in prenatal mental health by closing service delivery gaps and standardising care (England, NHS 2018). The provision of a specialised community perinatal mental health team as part of a collaborative effort to enhance the outcome of care for women with mental health disorders.

However, efforts to improve perinatal mental health at the institutional and practitioner levels must be informed by national recommendations. In order to provide timely access and community assistance for those with severe mental health problems, most policy documents call for increased funding for mental health services (NHS Mental Health Implementation 2019; World Health Organisation, 2022). The goals of the NHS Five Years Forward Vision were to increase access to specialist perinatal community teams and provide additional Mother and Baby inpatient beds as well as offering crisis support services for mothers and babies at the right time. This is supported by the Royal College of GPs (2016) statement on the treatment and management of women with mental health issues during the perinatal period (Royal College of GPs 2016; NICE, 2014). The perinatal mental health care pathways were created by the National Collaborating Centre for Mental Health, in accordance with the National Institute for Health and Care Excellence (NICE), with the involvement of an expert. For liaison with professional mental health midwives and perinatal mental health clinics, women with SMHI should have access to community resources, support groups, and alternative treatments (Higgins, 2017). In addition, women and their families were seen to benefit greatly from educational opportunities (Higgins, 2017).

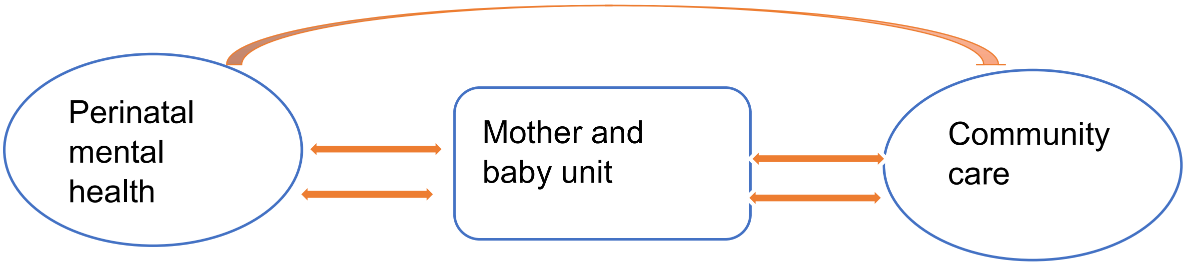
On the other hand, Bauer et al. (2014) offered their thoughts on how much mental health care costs the NHS, where the cost of perinatal mental health issues to the public sector is five times the cost of improving services. Some of the policies on perinatal mental health care are presented in the table below:

Social Policies	**Year**	**Reference**
The key principle across the pathways is timely access to evidence-based perinatal mental health care for all women who need it. This should remain a priority even when a woman moves between different pathways as her needs change.	2018	England, N.H.S., Improvement, N.H.S. and National Collaborating Centre for Mental Health, (2018) The perinatal mental health care pathways. *London: NHS England*.

Support services for women with SMHI were listed as desired by practice nurses, including local/community services, support groups and alternative treatments for women to liaise with specialist mental health midwives and perinatal mental health clinics. In addition, education for both women and their family members was regarded as a valuable form of support.	2017	Higgins, A., (2017) Perinatal mental health: an exploration of practices, policies, processes and education needs of midwives and nurses within maternity and primary care services in Ireland.
Increased funding for mental health services to improve access in a timely manner and provide support in the community for people with severe mental health problems.	2019	NHS Mental Health Implementation Plan 2019/20 – 2023/24 July 2019
The guide was designed to help providers to "develop and sustain high-quality, integrated mental health care for maternal and child health services.	2022	Guide for integration of perinatal mental health in maternal and child health services World Health Organisation (2022).
The guideline covers early detection, recognition, assessment, management and treatment of mental health issues	2014	NICE. (2014). Antenatal and postnatal mental health: clinical management and service guidance: Clinical guideline [CG192]. London: NICE.
Perinatal mental illness costs the NHS £8.1 billion each year.	2015	Centre for Mental Health, LSE Personal Social Services Research Unit. The Costs of

		perinatal mental health problems report summary
The college produced a statement regarding treatment of parents with mental health issues during the perinatal period including when to refer to secondary care and how to access it.	2016	Royal College of GPs (2016) Position statement about Perinatal Mental Health.
The policy states that women should be asked about their emotional wellbeing at every contact.	2016	NICE. Antenatal and Postnatal mental health Quality Standard

Figure 3.2; Navigation Process for women with SMHI



There is a need for an effective care navigation system for women with diagnosed severe mental health issues in both primary and secondary sectors of the National Health Service. Women and their families should receive individualised care during the perinatal period from a trained care navigator who can point them in the right direction with available options.

3.4 Chapter conclusion

Navigation in maternity is associated with decreased costs, greater patient satisfaction, and a reduction in misinterpretation or information errors. For smooth care navigation during the transition to motherhood, more training, support and research are needed for health care professionals to have a better knowledge of severe mental health issues. Care delivery should be personalised based on the individual's specific needs. Guidelines and frameworks can provide a coherent approach for an effective care navigation process. There has been no previous review on maternity care navigation programs and their association with postnatal outcomes concentrating on women with severe mental health issues.

Chapter Four

Chapter Four - Philosophical and Methodological Position

4.1 Chapter introduction

Chapters four and five present a detailed description of the methodology, the theoretical framework, and the conceptual building of the study design. The theoretical viewpoint of symbolic interactionism and social constructionism are also discussed. Personal reflective accounts will be used in this chapter to demonstrate the researcher's viewpoint and the procedure utilised (Crotty, 2013). This chapter is divided into two sections, with the first describing the preparations made before approaching participants and data collection. The second section covers ethical issues and consent, the study site and data management. The theoretical perspective and the difference between the grounded theory originators are then explored.

In nursing, evidence-based practice (EBP) refers to the collection, evaluation, and integration of well-formed research data with clinical knowledge and an understanding of patient and family concepts and choices in order to guide clinical judgments (Hain and Kear, 2015; Sackett et al., 2000). Singh and Estefan (2018) highlight that grounded theory methodology is very beneficial in nursing and midwifery research since it may be used for a wide range of subjects. Thus, in this thesis, the methodology of constructivist grounded theory is employed. This is because the constructivist grounded theory acknowledges the subjectivity of the researcher's involvement in the construction and interpretation of data which highlights the difference between Charmaz's approach and other conventional social constructions (Charmaz, 2014).

Most research philosophies agree on ideas and concepts as important only if they support action. In positivist research, realities are constant and can be measured objectively, but realities in naturalistic research are constructed, continually changing, and are understood subjectively (Corbetta, 2003; Rahman, 2020; Kroeze, 2012). This difference in views has led to the development of research approaches. These alternate paradigms such as interpretive and constructivist theories, feminism, and phenomenology, have recently come to be viewed in a completely new light (Hammersley and Traianou, 2012). Each of these paradigms is distinct from the others and is generated from its own set of beliefs and assumptions in relation to the philosophical problems that form the basis of the study strategy (Guba and Lincoln, 1994). Thus, a study's philosophical assumptions can be based on any of the following:

- The belief in reality (ontology),
- How knowledge is researched or known (epistemology),
- The research process (methodology) (Lincoln and Guba, 2000; Creswell, 2007).

This chapter discusses the guidance for utilising a qualitative approach, and the selection of philosophical assumptions (ontological, epistemological and methodological) that influence the study (Charmaz, 2014).

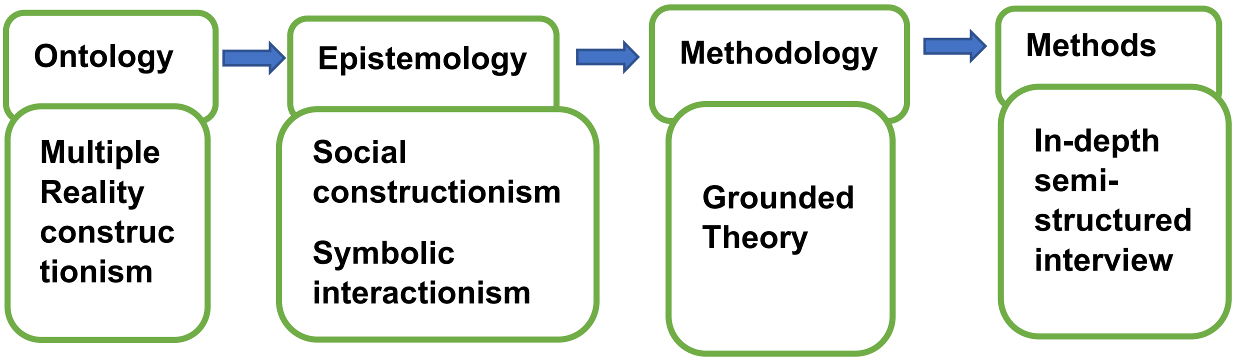
The chapter presents a comprehensive overview of the research paradigm that served as the foundation for the study. The study's aims and objectives allow for the establishment of ties and connections that will aid in the selection of a philosophical approach. As a result, the research question is addressed using a qualitative approach. The guiding philosophical assumptions of this study have been stated from the start (Guba and Lincoln, 1994). However, a philosophical stance serves as the basis for the methodology employed. It also explains the reasons why a research project is being conducted in a particular way (Crotty, 1998). The study's aims and objectives are to allow for the establishment of connections and relationships with philosophical views and choices, contributing to a clear understanding of the research journey that has been conducted. The qualitative research paradigms are well-suited to the research in this study to gain an insight into the research problem, uncover concepts, and delve deeper into the experiences of women diagnosed with SMHI in relation to motherhood during the postnatal period. By providing a context for comparison, the grounded theory methodology enables a greater understanding of the procedures employed in this study, as well as the ideas and values that underpin them. The methodological principle of grounded theory and the research design are also reviewed in this and the next chapters.

4.2 Research process

The research process refers to the processes undertaken to construct, structure and organise the research study (Charmaz, 2014). This section analyses the research study's philosophical, theoretical and methodological ground. The assumptions and ideas that characterise the researcher's worldview, and the various other alternatives, will also be described in detail, taking a philosophical stance.

The interpretive approach used in the study requires the interpretation of the study's characteristics, including human concerns. Myers (2008) states that the interpretive researcher assumes that social constructions such as language and shared meaning provide access to reality, which influences the study interpretations. This section presents thus an account of the research process and the theoretical framework that was used in capturing the research paradigms relevant to the study. The GT technique used in building the methodology aids in understanding the study through the process of constant comparison, by coding and categorising responses (Aldiabat and Navenec, 2011). Grounded theory methodology gives a structured framework for describing research operations (Rieger, 2019). Figure 4.1 below provides an overview of the research process adopted for the study, which will be explained in detail later in the study.

Figure 4.1 Research process (after Crotty, 2013)



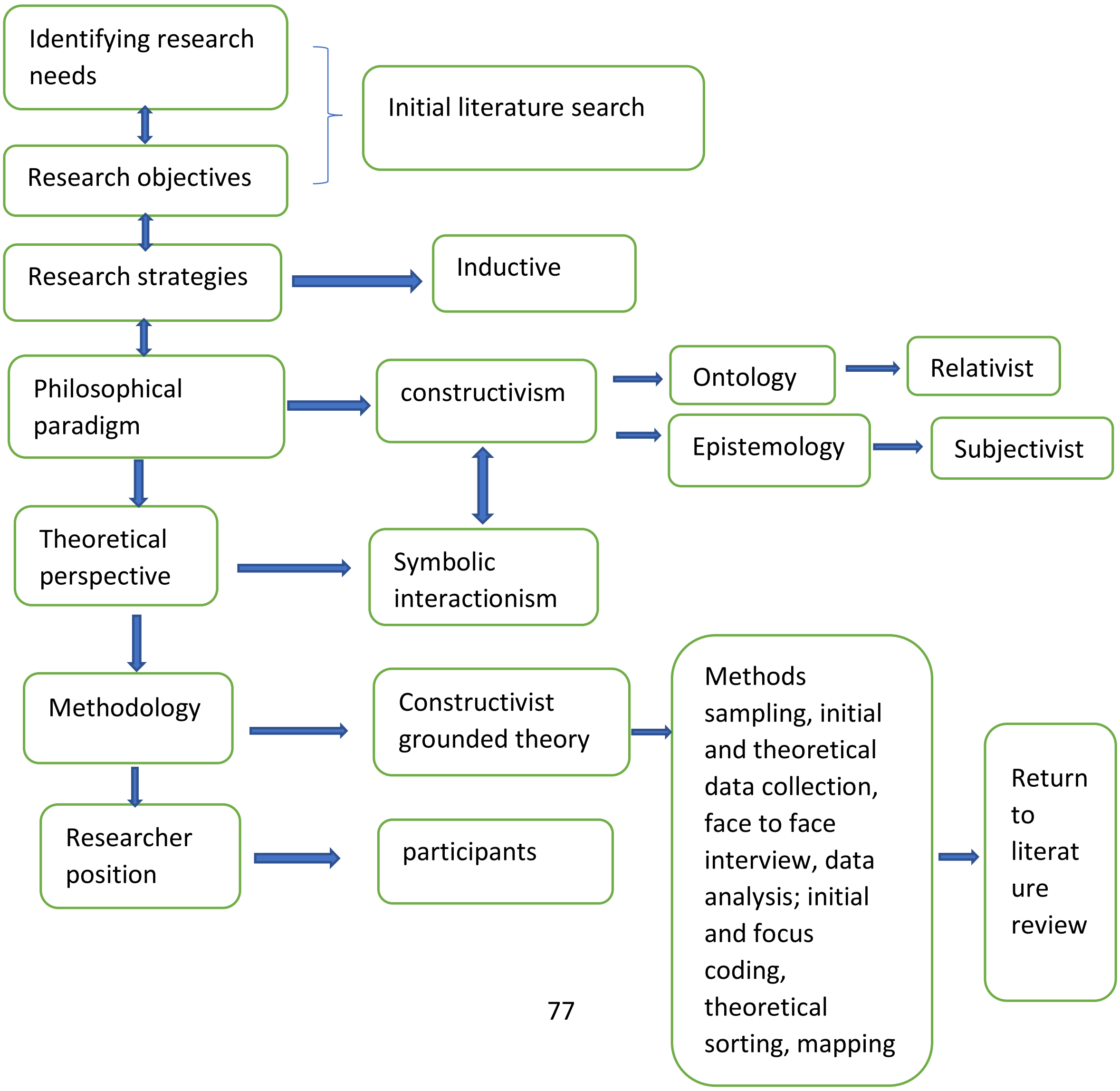
Ontology – Ontology involves dealing with reality, or what can be known about reality (Guba and Lincoln, 1994). The researcher works with the participants to make sense of their meaning. In this study, reality implies that women's experiences of SMHI in relation to motherhood during the postnatal period may be multiple, in terms of what can be known about the experience, how the researcher constructs this reality, and the ontological position of the study.

Epistemology - Epistemology is concerned with the nature of knowledge and how we know reality. The reality is understood and interpreted, and the underlying significance of the events and activities are discovered (Guba and Lincoln, 1994). In relation to the current study, epistemology expresses the question concerning what is known about women with SMHI and highlights the relationship between the research and the researcher (Charmaz, 2014).

Methodology - The methodology shows the process and how the researcher investigates that which was believed could be known (Charmaz, 2014; Charmaz and Thornberg, 2021), depending on the nature of reality and knowledge. In this process, reflexivity is engaged to account for any influence or variable while interpreting the collected data (Lynch, 2000).

Methods – These are the tools and processes that are utilised by the researcher (the inquirer) to help to create knowledge and refer to how knowledge could be gathered, sometimes called the research tools. This study used online, face-to-face, qualitative interviews to gather data.

Figure 4.3 Philosophical perspectives/ Theoretical framework



The position of the research study (figure 4.3)

The above figure 4.3 is the position of the research study. The argument is inductive because the truth of the arguments provides the rationale to conclude that the result is probably true. A qualitative research paradigm enables the examination of a phenomenon which utilises detailed, accurate, and occasionally informal method (Bryman, 1988; Denzin, 1994; 1989; Denzin and Lincoln, 2008). The qualitative research approach used in the study seeks to make meaning of a given phenomenon by utilising diverse methodologies to explore the actual environment, thus, producing descriptions replete with the participant's interpretations of the phenomenon (Charmaz 2014; Corbin and Strauss, 2008; Machin et al., 2012). These attached meanings are determined by interactions and connections within the environment (Fraser, 2004) as they relate to women with diagnosed SMHI. Truth is believed to be dependent on one's viewpoint, which in turn is determined by the social relationships around us and of which we are a part (Gergen, 2009). The chosen research approach recognises the individual participants' construction of their lived experiences and the influence of their social world on the epistemological claim of symbolic interactionism. Given the intricate nature of human perceptions of experience, a qualitative research paradigm was considered appropriate in addressing the study aims and objectives.

The approach adopted for the study draws on relativism and the epistemological perspective derived from symbolic interactionism and social constructionism, although time and effort are required to comprehend the similarities and differences across grounded theory approaches (McCann and Polacsek 2021). Certain study methods or designs may be more appropriate to produce specific kinds of evidence (Jamali, 2018).

The grounded theory methodology used in this study was chosen based on the research aim and objectives and on the alternative approaches. associated with GT. The GT constructionism process was utilised to enable the researcher to become immersed deeply in the data, adapting to the process of constant comparison and interpretation of the data (Charmaz, 2006).

4.4 Social constructionism (SC)

Social constructionism relates to our common-sense, knowledge of ourselves and understanding of our living environment. Thus, Burr (2003) warns us to consider how we view the world, focusing on the individual components of socialisation. Social constructionism explores the role of the individual in the construction of his or her own experience (Galbin, 2014). Social constructionism acknowledges the existence of objective reality and is concerned with the formation and understanding of knowledge (Burr, 2003). Therefore, its orientation is epistemological rather than ontological.

Our understanding of the world is derived from social forces and observations that result from interactions between communities throughout history; our language, socialisation and understanding of the world around us contribute to the formation of our social group. History and culture are essential to the formation of knowledge and understanding, which are maintained by consistent interaction with others. However, one of the characteristics of social constructionism is that it urges researchers to be sceptical about their environment-related ideas (Galbin, 2014).

Social constructionism posits that there are many constructions of reality that are made possible via the collaboration of the researcher and their social world (Charmaz, 2014; 2006). A social constructionist approach is an attempt to reconcile or link oneself with reality, and it has a considerable influence on Grounded Theory (Charmaz, 2014). Constructionism considers the ever-changing qualities of probing inquiry, as well as the discrepancies in historically, socially, and culturally established opinions, among other things (Charmaz, 2014). Studies highlight the fact that social constructionism has a collective or shared social focus that incorporates the social world (Gergen and Gergen, 2004; Hall, 2013), whereas indirect realism, attributed to Berger and Luckmann (1991) or Hammersley (1992), states that reality is socially defined. Social constructionism is concerned with the subjective experiences of everyday life (Charmaz, 2014; 2006); for example, in the context of the EXMEPP study, participants' perspectives and perceptions of what they regard to be their reality is observed through interactions (meaning and actions). According to social constructionists, our world views and perceptions are shaped by the culture and the place in which individuals live (Burr and Dick, 2017; Charmaz, 2006). Although the terms 'social constructionism' and 'social constructivism' have been used interchangeably in the past, they do not signify the same thing today.

Social constructivism holds that experience is generated intellectually or rationally by an individual's cognitive process rather than being found by the mind, as is commonly believed (Schwandt, 2003). However, social constructionism is concerned with the subjective experiences of everyday life (Andrews, 2012). It is the subjective experience of everyday life, referred to as 'reality' in this context, rather than the objective reality of the natural world. Constructionism is regarded as a concept that does not have a definitive truth but is instead built through interactions between people (Crotty, 2013). Social constructionism can help us see and view the world in new ways, by integrating various ideas that can be used to communicate and understand the world's basic principles (Collins, 2010), as facts are interpreted (Lippman and Curtis, 2017), where the researcher and the participants create the observations, and findings emerge from their interactions (Guba and Lincoln, 2004). Understanding the concept is essential to evaluating its impact on the methodology. This is because that there are differences in the subsequent remodelling from the standpoint of the constructionist (Charmaz, 2014). Social constructionism has certain similarities with interpretive and symbolic interactionism, among other aspects, since they hold similar philosophical viewpoints, through interpretive interactionism may seek objective interpretations of everyday life experiences.

In this study, the participants and the researcher work together to understand, reveal, and interpret their lived experiences, while the researcher presents these experiences more coherently to viewers (Charmaz, 2014). The constructionist approach employed in this study attempts to gain a better knowledge of the lived experience of postnatal women with SMHI through the eyes of the participants who have gone through it themselves. Women who have been diagnosed with SMHI go through the same stages of pregnancy and childbirth as other women, but their experiences and perceptions are different (Jomeen et al., 2017). The understanding of these women's experiences is socially or culturally constructed, based on the practices of a particular society (Opare-Henaku, and Utsey, 2017). For instance, during the postnatal period, baby care and feeding for postnatal women with SMHI follow the same routine, but with more distinct social or cultural feelings and emotions associated with them. However, Horwitz (2012) states that the interactive conceptions of mental health concerns highlight the consequences of social categorisation by placing women inside social meanings and interpersonal relationships, among other things. Thus, the housing, religious, spiritual, and emotional characteristics found in a community or social group could have an impact on one's thoughts, feelings, and behaviour (Horwitz, 2012; Horwitz).

According to Grbich, (1999) an idea formulated in one's mind, introspectively and emotionally, is likely to play a role in the creation of meaning. This study process therefore involved cooperative discussions between the researcher and the participants to understand their experiences and how they constructed meaning from them. Our inability to distinguish ourselves from what we already know, as well as the abundance of known and new information within this field, is an additional factor that contributes to differences in the choice of method. Social processes are formed, and consciousness is created as a result of human interactions. Therefore, what we think to be time and fact is the result of social mechanisms such as values and beliefs that take place against the backdrop of cultural context, rather than the cause of those mechanisms (Collins, 2010). Since there can be no truth until social constructions are agreed upon to make sense of the objective world, the reality is created as a result of the human agreement on the facts of the matter, so the structure of one's choosing may change if it is decided upon (Berger and Luckman, 2016). Social constructionists attempt to make sense of the social world and believe that knowledge is produced rather than formed in the process of learning (Andrew, 2012). According to O'Reilly and Lester (2017), social constructionism involves the understanding of individual principles as well as the processes by which they are generated. The participants in the current study all had distinct circumstances which resulted in the construction of different realities for each of their experiences.

It is intended that the viewpoints of participants in this study will be translated and analysed to make sense of their lived experiences. Social constructionists accept that what individuals create as real becomes the reality that can be discovered. Rather than taking an ontological standpoint, social constructionism is focused on the construction and processing of information and interpretation of this fundamental. Society is currently considered to be a subject of both subjective and objective reality, and this is regarded as a positive development. As a result, meaning is dispersed appropriately, comprehending a reality that is taken for granted. Interpretive constructionism also focuses on the process through which conceptions are produced, developed, and transformed, rather than on the concepts themselves (Schwandt, 2003).

In this study, truth is complex and depends on the individual's interpretation of what is happening. Therefore, it is not possible to hold a categorically clear view of ontological reality as a matter of course.

Ontological reality exists as subjective, conceptual, rhetorical, and formative measures that intervene within the object and knowledge (Aldiabat and Navenec, 2011). The findings of a study conducted by Berger and Luckmann (1991), and the thoughtful perceptual realism of Hammersley (1992), are in opposition to one another because reality is socially specified, even if this reality points out or deals with the subjective experience of everyday life and how the world functions rather than the objective reality of the natural world. As we act and participate, we develop definitions for our surroundings, according to social constructionism, yet we have no other perceptions, except those that are examined by scientists (Berger and Luckman, 2016).

The aim of using GT methodology is to establish or construct a theory on the subject matter regarding the situation in terms of the benefit to people's lives. The researcher then aims to interpret and explain the construction in a way that can be easily comprehended.

4.5 Relativism

Realism research philosophy avers that reality is independent of the human condition. Researchers are often regarded to be involved in the construction of social worlds rather than the presentation or expression of an unnamed independent reality, as is the case with realism and relativism (Hammersley and Atkinson, 2007). The difference between these two schools of thought is that realism deals with the reality, whereas relativism embraces many subjective formations of reality (Lincoln and Guba, 2005). According to relativists, the truth or reality is whatever we know at any point in time about the immediate situation (MacDonald, 2001; Lincoln and Guba, 2005). The premise of a relativist makes the topic of an inquiry's findings less or more meaningful in terms of their contribution to knowledge (Gergen and Gergen, 2004).

It is critical to gain an understanding of the participant under investigation by gathering and interpreting the thoughts and voices expressed during oral communication or arguments. Formal debate or spoken dialogue describes how discourses assist us in making sense of things that are not physically present in a situation (Parker, 1992). As a result, discourse can be conceived as a system of information, cognition, or communication that influences our experience of the world (Corbin and Strauss, 2008). According to Berger and Luckmann (1991), the social structures that are established or formed as a result of ongoing encounters have the potential to become an objective reality.

A progressive move within qualitative research approaches to adopt a relativist point of view has caused Hammersley (1992) to challenge the applicability of the conclusions produced by studies employing this method, given that each account presented can claim validity. The approach assumes that the findings are true independent realities, which is contrary to the findings of quantitative research.

As seen through the eyes of the participants in this study, the reality is that the collection of data (one-to-one), as well as the constant data comparison, provide evidence of what influences one's experience of SMHI in relation to motherhood during the postnatal period. Throughout the study, the conceptions and concerns of women are analysed to make sense of their lived experiences. Although the primary goal is to learn about participants' experiences with SMHI in relation to motherhood during the postnatal period, it is also intended to highlight the factors that influence these experiences. The factors may change completely depending on one's understanding and beliefs about the condition (Corbin and Strauss, 2008; Charmaz, 2006). Underlying the constructivist grounded theory approach (Charmaz, 20014; 2006), a person's understanding is gained through the act of finding connections, evaluating concepts, and feeling anxious. Our understanding of the expressions or forms that we construct may be at odds with the findings of research, which themselves may have been understood differently in a different time or place by a different group of individuals (Wisker, 2008).

This EXMEPP study investigates the many realities by delving deeply into the meanings that people attribute to the events that they have undergone. However, when compared to the researcher's own experience, the aspects listed above cannot be separated and are supposed to be critical components of the analytical process. When it comes to SMHI, women's postnatal experiences, as well as the elements that impact these experiences, are influenced by a variety of collective forces operating in an unexpected and challenging way. In the study, no single reality was decided; rather, various realities and truths were studied and built upon to fully appreciate and develop our understanding (Corbin and Strauss, 2008). In the study, every effort was made to capture or acquire as many participants' perspectives as possible (to the greatest extent) in order to develop and bring out the differences in the analytical approach. There is no justification for claiming that one report is superior to another; if the research does not provide a beneficial contribution to knowledge, its efficacy may have been required in the context of health care research (Murphy et al., 1998).

People's experiences of mental health issues during the postnatal period are significantly influenced by a wide range of characteristics.

4.6 Symbolic interactionism (SI)

Symbolic interactionism is defined as the interaction or collaboration between a person and the social world, and how social complexity (Denzin, 1978). It is a dynamic theoretical perspective that implies language and symbols play a key role in the forming and transmission of concepts and actions (Charmaz, 2014). In the context of the interactionism school of knowledge, humans interact with one another to build symbolic worlds. Symbolic interactionism was founded based on three fundamental beliefs: that individual behaviour is determined by the sense surrounding an event; that meaning exists in social interaction or contact; and that meaning is focused and altered using interpretive measures (Blumer, 1969; Hall, 2013). People's symbolic context, which they establish and build upon during social interactions, forms the basis of symbolic interaction. Society's interpersonal ties are of particular interest to symbolic interactionism as a branch of art that focuses on these relationships. People's development can be seen as a theory of transformation in which individuals impart and transfer their interpretations of concepts to their surroundings through active involvement and effective interaction that is affected by language (Charon, 2007; West and Turner, 2010).

Symbolic interactionism can be considered a friendly approach used in the collection of data on individual or group life and behaviour that obtains its interpretations from naturalistic studies (ibid). In the context of pragmatism, symbolic interactionism is defined as a theoretical position in which the community, fact, and self-interact with one another through language and communication (Collin, 2010). The researcher establishes close working ties with the research area to determine the potentially significant factors and achievable solutions, and then formulates a thought or concept and interprets it in a way that is acceptable to the study area. Interactionism focuses on the process rather than the final output. It is the goal of this researcher to use the symbolic interactionism process to gain a better understanding of the significance of the experiences of women with SMHI as they transition into motherhood during the postnatal period.

There is an important link between the study and the participants in GT, but it is unclear how this connection will influence the emerging notions in the future (Cutcliffe & McKenna, 1999). At this point, the researcher agrees with Charmaz's constructivist perspective, which holds that a theory is "made" through social contact or collaboration between the researcher and the participants, with the researcher and the participants commenting on the meaning of the study data and the process of conducting it (Charmaz, 2006; 2014).

The researcher (working as a social agent) generates evidence from the information recorded based on a variety of factors, including her own personal and professional experience, as well as social contact with the phenomenon under study (Charmaz, 2014). However, the constructivist approach demands that the researcher cannot be a passive participant in the research process. In this study, the researcher’s role is important because she will bring to the study previous research skills and personal experience but has a critical perspective on the study process. To properly conduct the research study, the researcher must first understand the existing body of literature (Bryant and Charmaz, 2007). In the current study, the researcher benefited from having a solid awareness of the literature, which helped her stay current and avoid duplicating old ideas. The university requested a literature review during the first proposal stage, and this included a basic comprehension of the issue under study; thus, it is impossible to omit this literature review phase. In contrast, Glaser (1992) opposes the review of literature while using the GT method. However, due to the reasons above, it was not possible to employ Glaser's approach in this study and Charmaz's approach was used instead. Regardless of the approach taken, the fundamental premise of GT methodology was upheld.

4.7 Methodology

The research methodology is the theoretical framework that helps in the determination of which techniques or best practices are to be employed in addressing the research question under consideration. To put it another way, the methodology is the process through which the researcher uncovers that which is discoverable during the research process (Guba and Lincoln, 1994). GT is an epistemologically based method that uses observational analysis to integrate analytical and other approaches to social life (Clarke, 2005). There is a distinction between GT and several other types of research methodologies.

For example, when compared to other research procedures, such as quantitative approaches, the researcher begins with an open mind and allows the evidence collected to develop the hypothesis. GT also places a greater emphasis on description than on explanation.

The systematic technique employed in using this methodology allows for the theory to develop from data gathering and analysis without being influenced by the study ideas; thus, it is reflexive and sensitive to the data collected (Creswell, 2007). This study aims to develop a theory around participants' experiences of SMHI in relation to motherhood during the postnatal period. GT methodology does not simply report on participants' experiences (categorisation), as other qualitative research methods do, but goes further to develop theories around the participants' experiences as they relate to the study (Holloway and Wheeler, 2010).

Another advantage of using GT methodology in the study is its adaptability throughout the process of analysis, allowing for the continuous comparison of data regarding similarities, differences, and linkages to develop the research pattern (Holloway and Wheeler, 2010). There is a constant interplay between data collection and interpretation (constant comparative analysis), and GT offers the advantage of letting the data be evaluated as early in the project as feasible (Myers, 2008). The study therefore develops a theory using evidence from the data collected. Before deciding on the appropriate approach for the study (based on the research issue and theoretical viewpoint), several methods are compared in the initial stages of the study investigation (Gibson and Hartman, 2014). The constructivist grounded theory interpretations serve as the basis for the study's strategy. The technique for the study is then carefully chosen based on the phenomenon being investigated and the research goals that are being pursued. The ontological and epistemological involved in this study have contributed to the determination of the type of strategy that was appropriate in achieving the study's aims and objectives. The combination of philosophical and methodological viewpoints, and the influence on the study goals, is well established and the analytical methodology employed to conduct this study was thus influenced by its goals and objectives (Creswell, 2007; Corbin and Strauss 2008; Holloway and Wheeler, 2010). To address and study human actions, a range of theoretical methodologies were employed. For example, it was decided to conduct the study using a qualitative research approach, which offers insight and understanding into the experiences of women who have been diagnosed with SMHI in relation to motherhood during the postnatal period.

Understanding and knowledge of their experiences, and the circumstances that influence their experiences and ideas, was made easier as a result of using the GT methodology. The interpretative nature of GT (Beck, 1997) will be discussed further in this study. The grounded theory methodological technique that is used focuses on the participants' real-life experiences rather than the researcher's prior information and grasp of the study. The researcher's previous midwifery experience and training made it difficult to maintain a common approach since she was already aware of postnatal SMHI concerns with motherhood. The study was undertaken with an open mind and sensitivity to the data being collected and the researcher's ontological and epistemological perspective on multiple realities and knowledge-building through the symbolic interaction of people and their social environments was observed. The participant's perspectives concerning the researcher were also discussed. Participating in a study is a social event, in which grounded theory researchers are continually constructing the social process as part of the research study, as stated in Charmaz's studies (2014; 2006).

4.8 Development of Grounded Theory

Qualitative research and GT methodology is the most used qualitative approach for human participant studies. Grounded theorists recommend that research begin with an open mind to achieve a better interpretation of the research data. This can lead to the discovery of important qualities, on which the researcher's theoretical and logical reasoning can be based so that a grounded theory is established (Bryant and Charmaz, 2007). Charmaz's perspective on grounded theory is that it involves formal, but general principles for gathering and interpreting qualitative data to formulate theories from the data itself (Charmaz, 2014). Establishing a topic of interest helps the researcher to remain inspired and selecting at research paradigm that is consistent with the study assumptions on the existence of truth encourages a successful research idea (Mills et al., 2006). GT's most distinguishing feature is its focus on practice from the start. Indeed, Glaser and Strauss's initial work in practice helped to make a significant difference in the standard of nursing and hospital care. Studies highlight that, since the early 1990s, many philosophers have shifted grounded theory away from the positivist recorded experience of Glaser and Strauss (1967), with Charmaz (2000, 2008) and also Clarke (2003, 2005) offering a clear constructivist methodology.

However, this constructivist method continues to follow some of Glaser and Strauss' fundamental philosophies, and some elements, such as relative, and open-ended methods, have thus been kept. The shift occurred as the result of a disagreement between the GT originators (Glaser and Strauss) on how GT should be conducted (Cutcliffe & McKenna, 1999), where Strauss's method was predominantly established through the work of Strauss and Corbin (a former student of Strauss).

Throughout the coding concept stages, Charmaz's methodology offers clear guidance to facilitate and manage data (Charmaz, 2006; 2014). The differences between the grounded theory originators mentioned above are illustrated in table 3. Differences in GT occur on a methodological slope, represented by its epistemological reasoning (Mills et al., 2006). However, the method chosen for this study is based on the interaction between the researcher, the participants, and what can be known. The correct choice of constructivist GT method is necessary, especially for this study, because it places the researcher as the originator of the reconstruction of experience and context (Mills et al., 2006).

Table 3 The difference in Strauss' and Corbin's, Glaser and Charmaz approaches to GT is illustrated in the table below

Strauss and Corbin modified	Glaser	Charmaz	Components
Formed based on the review of the literature, but subject to change as the research progresses.	Evolves from the research phase/process	Influences how data is collected. Can be altered if more significant or pressing questions arise.	Research question
Theoretical consideration and developing theory are enhanced by initial and the following literature reviews.	Following data collection conduct a literature review	There is no prescribed location. If written early, it should be revisited to critique and confirm.	Literature review

Multiple realities (relativism) are socially created over researcher/researched interaction (researched as though experts over their lived experiences).	The Positivist viewpoint of objective and reality, (realism) represented the researcher as an expert observer	The theory is interpreted or construed rather than an exact illustration	Rational/assumption
Process of deductive data analysis that is well-structured (Coding)	The data analysis process exists as inductive and unformed.	Purports these as flexible guidelines rather than strict rules	Data analysis
An in-depth grounded theory descriptive work is form	Development of grounded theory	In-depth constructive work is form	Research outcome
The research is distant and detached	The researcher is engaged with and actively interprets the data	The researcher constructs rather than discover	Role of the researcher

To improve the initial GT method in order to make it more relevant in today's world, Corbin suggested that theory building is no longer the only way to build new insight, which is in line with current thinking (Corbin and Strauss, 2008). The initial grounded theory is known as "classic," while Charmaz's latest grounded theory is referred to as "constructivist." Charmaz stressed the significance of the complete participation of the research participants in the development of the theory (Charmaz, 2006). During data collection, the GT process allow for the participants' full involvement in theory formation. During the coding process and analysis, Charmaz recognises the interaction between the researcher and the study participants, and the interaction of the researcher with the data (Charmaz, 2014; Charmaz, 2006). In each of these cases, the researcher is actively involved. Thus, a social constructionist and symbolic interactionist epistemological stance is held in this study.

However, as will be discussed later, computer programs (such as NVIVO) were used in the qualitative data analysis. The qualitative data analysis program has replaced manual and clerical tasks, saved time and allowed vast volumes of qualitative data to be processed (Seror, 2005).

4.9 GT Strengths and criticisms

Preceding the formation of GT, qualitative research was criticised as a weak and ineffective form of investigation that impaired a systematic methodology, so GT was accepted as a response to this criticism. However, Glaser encountered issues with delivering a systematic method with regards to the research study, which was especially clear in Strauss & Corbin (1990); nevertheless, Bryant and Charmaz argued that systematic methodology was used as a basic guide for dealing with GT (Bryant and Charmaz 2007). Since the use of GT is dependent on the researcher's expertise and skills, it is recognised as a guide for both inexperienced and experienced researchers (Bryant and Charmaz, 2007). According to Charmaz (2006), researchers may encounter conceptual, academic, and further issues common to most qualitative research approaches. GT's main advantage is that it offers a solid basis for qualitative analysis to develop explanatory theory (Bryant and Charmaz 2007; Glaser and Strauss 1967).

However, the uncertainty of the criteria used for assessing certain aspects of GT. This ambiguous guideline, according to Charmaz (2011), can indicate a lack of intellectual power or a conceptual weakness. Titscher et al. (2000) have criticised GT for avoiding basic research approaches such as defining the problems, assumptions, methods, and techniques, including the research credibility and the results. It is a method that can offer a good understanding of a theoretical phenomenon and its potential solutions to problems. GT explains some of the problems around qualitative studies by taking collected data beyond rich explanations and concepts to form theory, (Charmaz, 2014). Some GT researchers have been criticised for presenting a detailed grounding of data (Crotty, 1998). As previously mentioned, Corbin, one of the well-known GT researchers, argues that the goal of a study should not only be to produce theory, but also to provide a rich and detailed explanation of findings (Corbin and Strauss, 2008).

The passive position in a study during data collection and the importance of data collection (Glaser and Strauss, 1967; Glaser, 1992) have been the subject of criticism and debate, as seen in positivist approaches (quantitative methodologies). It has also been argued that a researcher cannot possibly exclude personal experiences from data collection (Thomas, 2006). On this point, Glaser and Strauss were criticised by Bryant and Charmaz (2007) for attempting to outsmart the positivists by ignoring when and how data were obtained.

4.10 Chapter conclusion

The study of human lived experiences is a complex exercise involving a procedure that can capture these experiences from the participants' beliefs and perceptions, although they can never fully be captured. To obtain and secure some of these complicated human experiences, GT qualitative methodology was chosen as the most logical option for this study. This chapter has discussed the fundamental philosophical ideas that are linked to health and social science research. The arguments presented assisted in the selection of the most suitable methodology for this study. GT offers a solid basis for qualitative analysis to develop explanatory theory (Bryant and Charmaz 2007; Glaser and Strauss 1967). This study adopted inductive rather than deductive reasoning, thereby allowing the theory to form before being altered by field experience while collecting and analysing data. The following chapter discusses the research design used in the study.

Chapter Five

Chapter five - research design

5.1 Chapter introduction

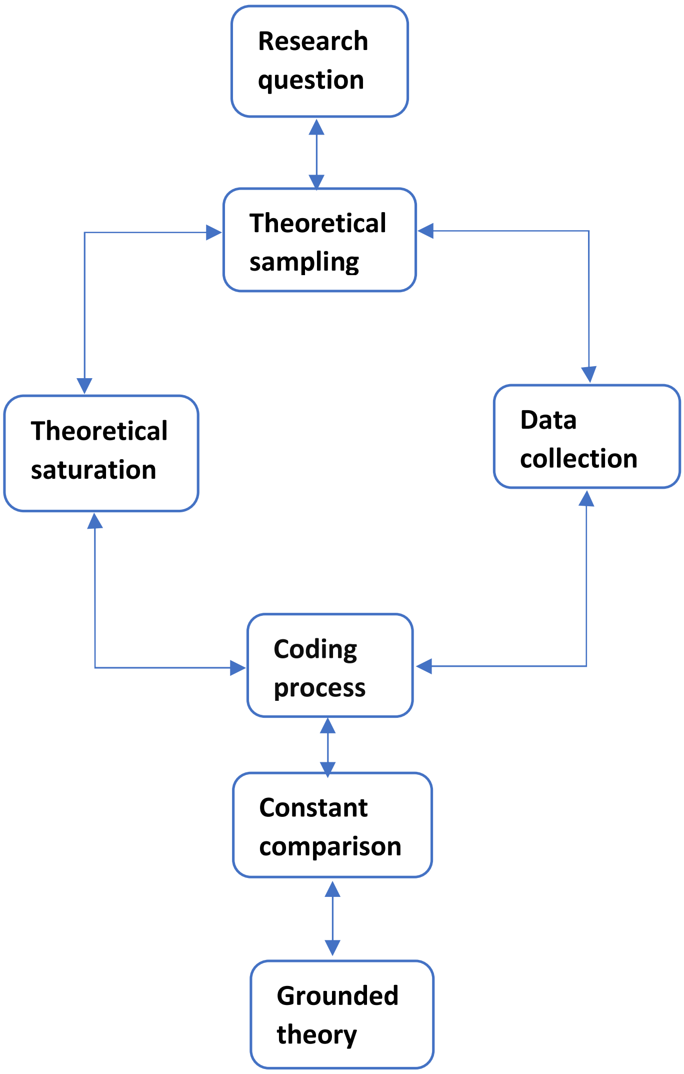
This chapter describes the activities that were carried out before, during, and after data gathering, including the tools and methods that were employed. The past and present perceptions of the inquirer have an impact on the study, both directly and indirectly, and the research method is influenced by the study aim.

There are three stages described in this chapter that occurred simultaneously, as is consistent with the GT approach.

- Phase 1: Includes all preparations and actions undertaken before approaching potential participants, as well as all the procedures performed before the study. This includes reviewing the literature on GT, ethical considerations/dilemmas, ethical approval procedures, the study site, and recruitment/sampling methods.
- Phase 2: Covers the research study, including the data collection method, the research setting, the research interaction and collaboration.
- Phase 3: Concludes the data analysis process with a summary of the chapters, as well as the efforts made to improve rigour and retain reflexivity.

As shown in the diagram below, the GT method places a heavy emphasis on data collection and analysis:

Figure (5.1) Analysis and data collection (Steps in Grounded Theory Research Design Rose et al. 2015, p127)



In this Figure (5.1), the data collection and analysis process is shown as a process with key dimensions, emphasising the iterative nature of constructivist grounded theory (Rose et al., 2015). This fits with Dick's theory (2007) that data collection, note-taking, coding, and memo writing should all be done at the same time. All of the key features of this study design were reviewed, and their relevance to the study was investigated and discussed; hence, this figure is for explanatory use only and was not implemented in full detail.

5.2 Preparation before data collection

Literature review and GT

At the start of chapter two, a brief description of various claims surrounding the initial literature review in GT was introduced. Rather than focusing on the reasons concerning a preliminary literature review (Cutcliffe 2000; Charmaz, 2006), this section discusses the benefits of introductory literature. Traditionally grounded theorists: such as Glaser and Strauss (1997), have advocated against undertaking a literature review before commencing data collection, as doing so can introduce predetermined assumptions that can lead to this process being forced (Glaser and Strauss, 1967). This could result in bias, in which categories may be generated based on the literature rather than emergent evidence. Instead of preconceived assumptions, theory should indeed be allowed to evolve from the data.

Corbin and Strauss (2008) also warn about becoming unduly absorbed in the literature before the collection of data, as well as letting it overly affect the study process, which could restrain the researcher (Becker, 2007; Corbin & Strauss, 2008). As a result, literature must be handled carefully and therefore should not be used to direct the researcher (Becker, 1986; Becker, 2007). However, studies have highlighted that reviewing literature initially can indeed be valuable in a variety of ways (Charmaz, 2014; Corbin and Strauss, 2008):

Firstly, it can demonstrate the overall objective of the research and provide questions for the initial observation and interviews. Although the answers to these first questions may alter as the inquiry progresses, they are crucial to fulfilling the ethical committee's requirements.

Secondly, the literature is never used as data on its own, but concepts form from it are evaluated by comparing data on a functional and structural basis to uncover similar categories and variations. In the present study for example, having a positive approach toward women with postnatal psychosis had a significant impact on them due to their previous individual experiences. It helped the researcher become more sensitive to data complexities. Thus, the frequency with which basic theories in subject areas are found in the literature, along with evidence from data reveals the importance of these theories in a way that would be impossible to do without previous experience. When there is a disparity between the evolving results, including those in journals and current literature, it generates arguments during study analysis. The researcher is prompted to enquire 'What is going on?

Is there something crucial I am missing? Are the circumstances of this research different? And if so, how does it influence what the researcher sees? Therefore, the researcher continuously evaluates to understand what the existing data are indicating. Considering this research goal of understanding the experiences of women with diagnosed SMHI in relation to motherhood during the postnatal period, introductory literature was a good starting point because scientific literature may reveal data-gathering opportunities that the researcher has not previously considered. From the above benefits, theoretical sampling was therefore recommended. Developing outcomes or findings through existing research studies not only demonstrates thorough scholarly work, but also provides for growth and development, validation, and improvement on field experience and knowledge (Corbin & Strauss, 2008). What matters is not how the previous knowledge is used, but whether it is utilised at all. However, from a different perspective, the findings may also reveal a weakness in the study, such as incorrect or inadequate explanations, although, the skills and experience of the researcher, which come from their profession, age, gender, and culture, allow them to respond sensitively to the findings (Corbin & Strauss, 2008). It has also been shown that prior experience can obstruct data accuracy and data reading (Corbin and Strauss, 2008). However, experience can enable rapid understanding of the important facts that exist in the data. Before contacting research participants, one of the first steps was to secure ethical approval for this study. This will be discussed in the next section.

5.3 Ethical consideration and process

Accessing or entering research sites, as well as selecting or recruiting participants, could raise ethical concerns in any study and should be carefully considered and resolved before the study begins. This study achieved university approval and standards, and ethics clearance was pursued, completed, and achieved before commencing. The first practical move was to obtain initial project approval from the University of Northumbria. After submitting a written research protocol/proposal, the project approval was obtained within three months of starting the study. This was one of the study goals. As soon as the project approval was obtained, approval from the university ethics subcommittee was requested and then received, after making the required changes as recommended by the committee.

The university ethics subcommittee, for example, recommended that the consent form should be amended to include letting participants know and acknowledge that the research's output would be used for academic and publishing purposes and that they could request a copy of the study findings. It also aided in the risk assessment of the study and the development of strategies for coping with any problems that could arise during fieldwork. The number of participants to be recruited was also affected. The study originally aimed for 20 participants; however, the University ethics committee reduced the participant number to ten. This was based on the statistical number of women with SMI who go on to have babies. All documents related to ethical approval will be in Appendix 2. This study underwent a thorough review by the ethics committee to ensure that the study's location, environment, and resources were suitable for the research. The input from the University Ethics Committee helped provide a foundation for the future external submission and review by the IRAS and NHS ethics committees.

As the ethics process requires, the next step was to apply to the regional NHS Research Ethics Committee (REC) and the designated research sites and Research and Development department (R&D). This step was important as the study participants were National Health Service (NHS) patients. Attending an ethical panel meeting was part of the final process where some of the ethical issues concerning the study were addressed for clarity purposes. This step is designed to protect the rights and welfare of both the research participants and the researcher. I attended the ethical review panel meeting with my supervisor. One of the concerns expressed was how to ensure that the participant information sheets relayed the fact that the interviews were conducted only in the hospital and not in the participants' homes. This was to minimise risk to the researcher and ensure that participants must not suffer any major harm as a result of the nature of the study.

Ethical approval was granted as soon as this issue was rectified. Although some people may view the ethics protocol as a 'tick-box' exercise in the study process, was beneficial since the study involved human participants, and thus it was vital to ensure that any harm to potential participants was minimised, while their welfare was protected. The ethics process could be perceived as causing a delay in research, especially when time is limited. Indeed, this process could take anywhere from four weeks to a year or more.

It took ten months for the university ethics committee to approve this study. Thereafter, there were no major changes to be made and the National Health Service Research Ethics Committee (NHSREC) ethics process took two months. The safety of a lone person conducting interviews in people's homes raised ethical concerns and, despite the fact that the NHS and the University have a lone worker procedure, the NHSREC strongly recommended during the panel interview meeting that this study's interview be held in the hospital rather than in the participants' homes. This removed the need for the standard practice of informing the supervisor, care coordinator team, and supervision team when the researcher was inside at participant's home and was for the safety of the researcher.

Data anonymity, as part of data confidentiality, protects the participants' identities from harm (Vainio, 2013; Saunders et al., 2015) and, in particular, the vulnerable group from further marginalisation and stigmatisation (Liamputtong, 2007). Data anonymity is viewed as an ethical requirement as suggested by Surmiak, (2018). According to Lofland et al., (2006), maintaining the confidentiality of study participants is a responsibility and a matter of trust for researchers. In this study, individuals' personally identifiable information was anonymised using pseudonyms or coding.

Other ethical considerations, such as personal identification, data protection and management, and avoiding potential harm and suffering, are addressed during this study process (Ross et al., 2018). As previously stated, gaining ethical permission aided in the identification of potential concerns and the implementation of actions to resolve them. However, according to Guillemin and Gillam (2004), there is a distinction between institutional ethics and ethics in practice. Ethics in practice is described as an ongoing process that remains the responsibility of the researcher, wherein most concerns are difficult to predict, despite obtaining approval. However, the extensive literature on ethical issues and institutional ethics observed by earlier researchers may provide important insights on which present and future researchers might depend to assist them in planning their time (Wiles et al., 2007). The researcher places high importance on ethical concepts and principles, such as respect for dignity, anonymity, informed consent, personal rights, and cultural and individual values, and uses them to guide the research work. In this study, the interventions always seek to promote good health and reduce harm to people.

This study ensured that the ethical principles of benevolence and honesty were preserved during data collection. With regards to ethics, close attention was given to how to handle conflicts of interest at different levels. These influenced how the research was conducted. This study adhered to ethical principles and guidelines for good clinical research practice, including transparency and fairness, informed consent, and confidentiality.

5.4 Consent with full knowledge

The informed consent process requires this study to give the participants information that is appropriate and easy to understand, for them to make an informed decision before participating (Kadam, 2017). Therefore, potential participants were offered an information pack that comprised the following:

- letter of invitation
- contact form
- participant information sheet
- informed consent form
- supervision team's contact information

All the information pack forms are included in the appendices for reference. The study information pack ensured and enhanced the participants' understanding of the purpose of the study so that the potential participants had all the information they needed when deciding whether to participate in the EXMEPP study. As part of the process of informed consent, the participants were informed of their right to share the study information with a close friend or family member if they wished. In case the potential participants required additional information or had any concerns, the supervision team's contact information was also provided.

Participants willing to take part in the study were asked to initial and sign the consent form. At every interview, verbal consent was gained, and participants were reminded that they were under no obligation to continue with the study and could opt out at any time if they no longer wanted to participate. If participants wished to withdraw from the study at any point, they were assured that this would have no impact on any healthcare services they were receiving, especially if they were distressed or felt their privacy was being invaded (Robson, 2002).

They were also informed that their information record would be deleted at this point if they wished, and the interview stopped. Any data already collected was used in the analysis, as mentioned in the information pack; however, anonymity and confidentiality were maintained during this study.
All demographic data, such as name, age, and address, were kept confidential. To guarantee that participants did not incur any financial costs, a pre-stamped envelope was provided in the information pack for participants who were unable to sign the reply slip right away. Participants who visited the hospital and showed an interest in the study were invited to tick either "yes, I would like to participate in the EXMEPP study’’ and then enter contact information so that the researcher could contact them to set up interviews, or "no, I would not like to participate," in which case no further contact would be made. Before the Covid 19 pandemic, the study plan was to interview people in a hospital environment and after the participants gave their consent and contact information, a room was reserved for these interviews which were to be scheduled during the participants' next hospital visit to reduce costs. However, following the government and university's rigorous rules and restrictions, this was changed from a face-to-face to an online interview. This has impacted the study by delaying the study stat date.

All approval applications and required changes for online interviews were made, and approval was obtained to continue the study. The researcher-maintained contact with the participants to provide them with more information regarding the online interview method. The majority of the interested participants returned their reply sheets with a signed consent form on time. Appointments were then arranged when convenient for the online interviews. At the start of each interview, the consent forms and information sheets were reviewed. This was done to ensure that participants were aware of the research details and were still willing to be interviewed by answering any questions they had. Lastly, participants were praised for their participation in the study and asked to indicate on the consent form whether they wanted to receive a summary of the study’s findings.

5.5 Confidentiality

The Data Protection Act of 2018 ensures confidentiality and data security for all participants in the study. The participants' personal information was processed following the Data Protection Act 2018. The fundamental fact is that confidentiality between the researcher and the participants is regarded as an obligation for the study and a right of the participants. In the study, participants' personally identifiable information was kept confidential. To safeguard participant confidentiality and privacy, paper and electronic data were encoded, anonymised, and password protected. Participants were also identified by codes and pseudonyms after the raw data containing their personal information were coded. Demographic data such as age, gender, and education attainment were requested and were used for this study only. Data received during the interviews were anonymised by assigning each piece of information a unique coded number to study and explore the information while adhering to the GDPR act 2018 without linking the information to the participant (Cornock, 2018).

During transcription, any personally identifiable or sensitive data were anonymised or removed. To ensure privacy, information was not provided to a third party without a participant's approval. For this reason, all the information gathered was kept in a secure location and managed properly. Participants were told on the participant information sheet that, if they told the researcher that they or someone else was at risk of harm during the interview, then the researcher was obligated to report it. In this event, the protocol was to first report the issue to the participant care coordinator or team lead after discussions with the participant. Then, the team should assess whether a course of action was necessary and inform the participant while the researcher notified the supervisory team. They were also informed that confidentiality may be breached if there was a high risk of unavoidable harm.

5.6 Negotiating Access/Approaching Research Sites

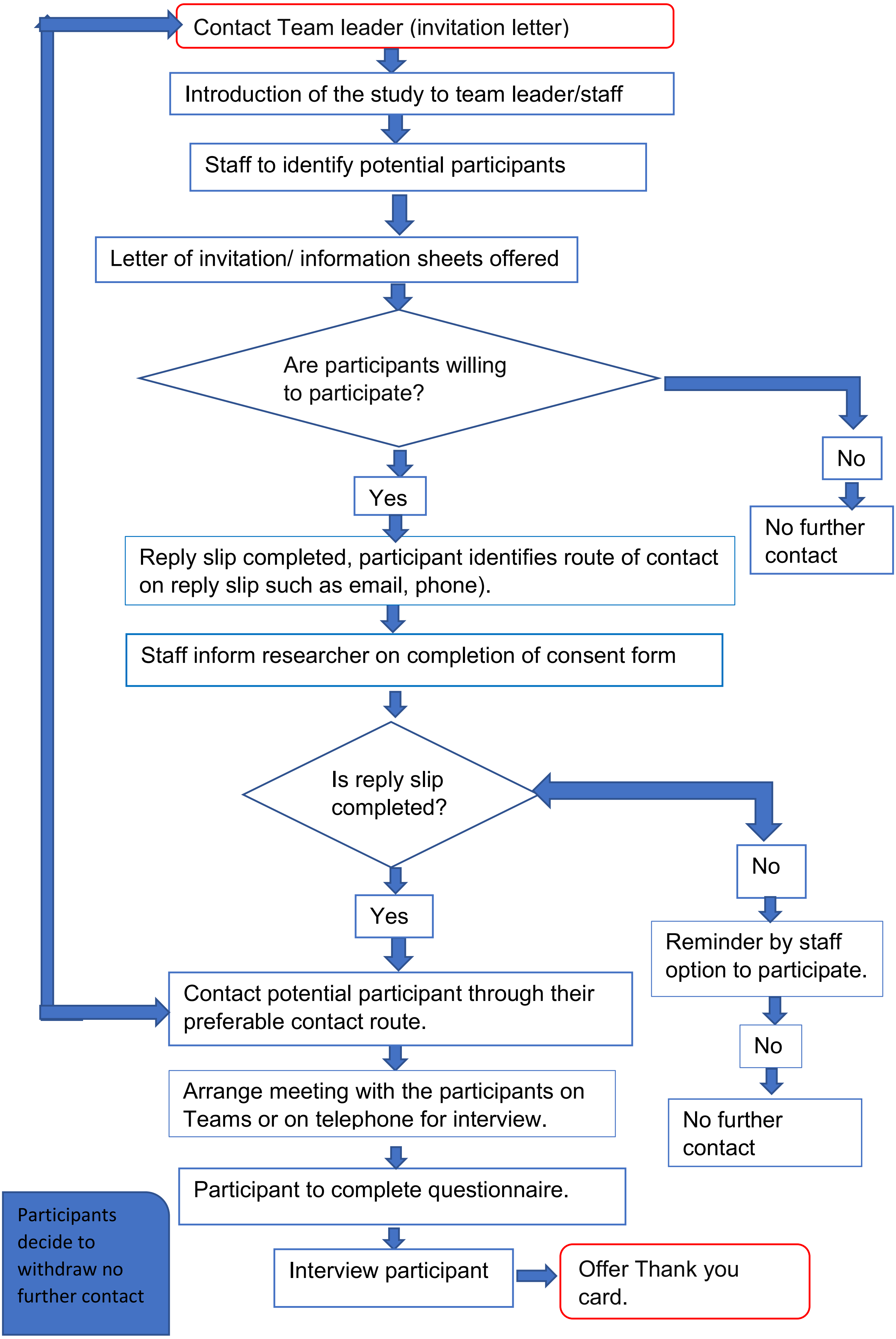
The study took place at hospitals in Northeast England to identify local women who experience SMHI during the postnatal period. Before beginning the EXMEPP study, ethics approval was arranged, as mentioned above, and the research site was approached for the recruitment of potential participants after all ethical clearing was gained and a letter of access from the NHS hospital research site was received.

The participants were then recruited by the hospitals. Thereafter, all of the activities of the study plan that involved the participants such as screening, identifying, approaching and contacting the participants were organised at the study site (Mother and Baby Unit and a trust in the Northeast) following the ethics guidelines. This was because the potential participants were NHS patients, and the researcher was not authorised to access the patients' personally identifiable information until they had provided their consent, as per the data protection policy.

This ensured good research practice (Hegney and Chan, 2010) since it confirmed that the study participants were not subjected to force or persuasion, thereby, improving the study's quality. The initial recruitment was therefore undertaken without the participation of the researcher. Participants were known to have SMHI and had given birth within a year of the commencement of the study. The team leader or the care coordinator who cared for the participants in this research study, identified the participants, who provided demographic information using a questionnaire. The care coordinator invited the eligible potential participants from different ethnic backgrounds into the study, irrespective of their status, using the inclusion and exclusion criteria. Everyone in the study was respected according to their cultural and religious beliefs and was informed of their right to withdraw from the study if they wished to at any time.

A recruitment letter including a study participation information sheet (PIS) was provided to eligible participants and a reply slip was completed. Then, the researcher contacted each participant to arrange a meeting at a convenient time. The care coordinator also gave his consent before the interviews could be conducted. If the reply slips were not completed, no further contact could be made. Participants were accessed using the algorithm steps. The algorithm provides an overview of the research study for participants to decide whether to participate in the study. The actual process of gaining access to participants, as explained above, is depicted in the figure 5.2 below; it is referred to as the 'Accessing Participants Algorithm'.

Figure (5.2) Accessing participant (Algorithm)



Participants' inclusion and exclusion characteristics were based on the research topic. The inclusion criteria were that the participants should live in the Northeast and Cumbria and have had a diagnosis of SMHI in the postnatal period. This means that the participants had already been identified and given a diagnosis of SMHI. Variations in sample distribution, according to Charmaz (1990), can improve the conceptual robustness or strength of the findings, since the depth of each participant's perspectives and opinions is enhanced if a diverse group of people is included in the study.

The inclusion of a range of participants from different ethnic groups, religions, and educational levels was specifically relevant to the study. Various ethnic minorities were recruited in this study to provide maximal variation in the sample in terms of cultural groups, age, and parity. However, the participants had to be of childbearing age and to have given birth within one year. The exclusion criteria included those participants without a diagnosis of SMHI, women who could not speak, read or write in English, and women below the age of 18 or above 49 years.

Table 4. Inclusion and exclusion criteria

Inclusion criteria	**Exclusion criteria**
• Women with known or newly diagnosed severe mental health issues. • Women aged 18- 49 years and above. • Women who have had their baby within one year of the start date of the study. • Women who can provide informed consent and can take part in an Interview. • Women who can understand and read English.	• Women without the capacity to give informed consent. • Women who do not speak English. • Women under the age of 18 years or above the age of forty-nine. • Women with serious medical problems such as cancer. • Women who are in-patients and are not yet ready to be discharged home, and/or women who have lost their baby, either as stillbirth or through miscarriage.

5.7 Renegotiating for Online Access

Due to the impact of Covid 19 on the research activities, the study was compelled to switch from face-to-face to online data collection through Microsoft Teams or telephone interviews. The University set aside a section on its ethics webpage that allowed most remotely working studies to be converted to online data collection without difficulty if the study adhered to the Covid 19: Remote Working and Data Protection rules. By completing an amendment tool, the researcher notified the University ethics and the REC/NHS of the change to the online interview method. This was classified as a non-substantial amendment to the study, following the guidelines established by the university. Confirmation from the sponsor that the study could proceed with online data collection was also received. However, this resulted in additional delays to the research process. Upon approval, the amendment tool notification was sent to the research site for acknowledgment and confirmation from the University. The safety of the researcher and the participants, including the protocols and guidelines established by the university and the government for Covid 19, were adhered to during the study.

5.8 Recruitment of Participants

Women of childbearing age who had had a baby during the previous year and had been diagnosed with SMHI were eligible for recruitment. The study includes participants who were under the care of a mental health team and whose babies were between 12 weeks and one year of age at the time of data collection. Twenty invitation letters were sent out and fourteen participants were identified. Three declined because they felt that they would be unable to endure or handle the interview. Another withdrew because she did not live in the Northeast and Cumbria. The recruitment sample was comprised of postnatal women diagnosed with SMHI. The screening was based on the participants' records, allowing enough time to identify the eligible participants according to the eligibility criteria (Table 4). To validate or tally with the eligibility criteria, a demographic history was gathered. There was no physical harm to the participants in this study.

Depending on the circumstances surrounding the participants' experiences, some psychological or emotional distress was possible as a result of disclosing sensitive issues in their lives. However, no discomfort was reported or detected during the interviews. Slightly emotional participants were able to continue with the study without difficulty, expressing that they were happy to continue, although any distress or anxiety generated by participation in the study could have been managed by referring participants to their care coordinator for debriefing. Throughout the online interviews, the researcher constantly monitored the participants’ emotional reactions (such as shaking or sobbing) none of these occurred, and frequent breaks were provided throughout the data collection process. Most importantly, the participants’ dignity and rights were respected by allowing them to opt out of the study at any time. However, none of the above-mentioned problems were encountered.

The founders of GT propose that data should be collected and analysed until theoretical saturation is attained, especially if the goal of the study is to develop a theory or a rich description (Corbin and Strauss, 2008; Charmaz, 2014). Initially in this study, it was planned to use a purposive sampling technique to recruit and interview ten or more women who had experienced SMHI in the postnatal period. At this point, fourteen women had expressed interest in the study by filling out the reply slip with their contact information and signing the consent form. The researcher contacted the participants and scheduled interviews at a suitable time.

Ten of the fourteen women who had expressed an interest were recruited for the study. Thus, only ten participants were interviewed. However, Covid 19 had a big impact on recruitment. For example, three women who had signed the consent form were then unable to participate owing to the additional stress brought on by the Covid 19 epidemic: they believed it was not the right time for them to get involved in the study. Other limiting factors were inconvenient timing and other priorities or commitments. This number was regarded to be achievable and adequate for data saturation. Data saturation refers to the point in data collection where no new ideas about the emerging theory develop. Even when data saturation was reached, every attempt was taken to interview all individuals who were interested in the study. To broaden the scope and to provide diversity in the data, the study included different ethnic groups. Those who did not speak English as a first language may have found it challenging and were therefore excluded from the study, although the use of interpreters may have aided in their recruitment.

An alternative recruitment method might have been through GP surgeries but was not, which may have been successful since people have already established positive relationships with their doctors and are more likely to trust them. It has been found that removing the researcher from the original consent procedure reduces coercive power and improves the quality of the research (Hegney & Chan, 2010). The goal of the research methodology (GT) is to provide a comprehensive and in-depth description of each unique experience, which is then viewed within the next level of conceptualisation: evolving theory. The theory is rooted in the data, rather than the generalisability of research findings, as in quantitative techniques. The study is based on extensive, comprehensive, and relevant data, so the quality and reach of the data make a significant difference (Charmaz, 2014). The theoretical sensitivity, sampling techniques, and continuous comparative analysis used in the study all contribute to the successful application of GT methodology. The data findings and analysis in this study therefore led to a credible theory that provides a detailed explanation of the experience of those postnatal women diagnosed with SMHI under investigation.

5.10 Sampling Strategy

The overall sampling approach used to recruit participants for this study will be described in the following sections. According to Morse (2010), the sampling approach in GT is significantly distinctive from other qualitative approaches.
Thus, theoretical sampling using the GT approach specifically will be examined.

5.11 Target Sample Population

The researcher was guided by the research questions to choose the right sample group. This enabled the researcher to identify participants who had a unique experience of the issue under study. This is a key feature of the GT approach (Morse, 2007; Corbin and Strauss, 2008). It was hoped that by identifying women who had been diagnosed with and had experienced SMHI or relapses after childbirth, a significant amount of evidence about their experiences with SMHI and motherhood could be garnered. Some of these women had had previous relapses and experiences, which enabled them to express a high level of reflection, knowledge and understanding of their SMHI and motherhood experiences. It is crucial to choose an acceptable target sample group for GT research, but it was also fundamental to go further than that in this case to discover categories and patterns (Corbin and Strauss, 2008). The target sample of potential participants recruited for participation in this study was existing service users of the NHS Trust within Northeast England. The ten women who were involved had been diagnosed with SMHI and had had babies within one year in different settings and locations. They were actively involved in sharing their personal experiences with the researcher. The majority of the women were interviewed using an online platform via Microsoft Teams. GT sampling requires researchers to look for participants with relevant knowledge and experience in relation to the study (Glaser and Strauss, 1967), thereby enabling theoretical sampling which is a key grounded theory method (Charmaz, 2006; 2014).

The researcher recruited a group of data-rich participants with a wide range of features and experiences. The participants come from a variety of backgrounds, ages, educational levels and parities (Table 4.1) and this proved to be very useful during the study. Individual sample selection was facilitated by presenting different variables throughout the target study sample (Morse, 2007). This approach is aimed at collecting data on the following:

- the age range of participants
- the context in which motherhood was experienced
- the length of time of the postnatal SMHI experiences
- what was helpful during the period, and
- their immediate need

Participants were questioned to know if it was their first time becoming a mother by asking:

- how many children they had previously had, and
- how long ago they had given birth

The purpose of the sample questionnaire was to gather baseline data that might be used to support relevant choices of theoretical sampling. The questions were framed very well as the result of a combination of existing theoretical awareness derived from the researcher's professional experience (Glaser, 1978) and new insights derived from the literature review in the early phase (Charmaz, 2014).

Table 4.1. Participant Demography

Name	Gender	Parity	Education	Delivery (Age of the baby)	Maternal age (18-49)	Health issues/Mental health diagnosis	Hospital admission	Treatment	Ethnicity	Religion	Mode of Delivery
EXMEPP 001	Female	4	Un-assigned	6 weeks to 3 months	18 to 49 years	Bipolar disorder/postpartum psychosis	6-8 weeks	Yes	White British Background	Not stated	Normal delivery
EXMEPP 002	Female	1	Tertiary education	3 months to 12 months	18 to 49 years	Raynaud's Syndrome/ postpartum psychosis	0-3 weeks	Yes	White background	Not stated	Normal delivery
EXMEPP 003	Female	2	Tertiary education	3 months to 12 months	18 to 49 years	Hypothyroidism/postpartum psychosis	3-6 weeks	Yes	Indian	Muslim	Normal delivery
EXMEPP 004	Female	1	Tertiary education	3 months to 12 months	18 to 49 years	IGA Nephropathy/postpart	Not applicable	Yes	White and other	Christian	Normal delivery

						um psychosis			backgrounds		
EXMEPP 005	Female	3	Secondary school	3 months to 12 months	18 to 49 years	Schizophrenia	3-6 weeks	Yes	Asian/Indian	Muslim	Normal delivery
EXMEPP 006	Female	2	Tertiary education	3 months to 12 months	18 to 49 years	Postpartum psychosis	6-8 weeks	Yes	White and other backgrounds	Not stated	Normal delivery
EXMEPP 007	Female	1	Tertiary education	6 weeks to 3 months	18 to 49 years	Severe depression/ postpartum psychosis	3-6	Yes	White background	Not stated	Normal delivery
EXMEPP 008	Female	1	Tertiary education	3 months to 12 months	18 to 49 years	Postpartum psychosis	6-8 weeks	Yes	White and other backgrounds	Not stated	Normal delivery
EXMEPP 009	Female	2	Tertiary education	3 months to 12 months	18 to 49 years	Severe depression/	3-6 weeks	Yes	White background	Not stated	Normal delivery

						postpartum psychosis					
EXMEPP 10	Female	1	Tertiary education	3 months to 12 months	18 to 49 years	Postpartum psychosis	6-8 weeks	Yes	White background	Christian	Normal delivery

Parity: No of times a woman was pregnant

Tertiary education: includes College and the university or any qualification after secondary education.

5.12 Purposive Sampling

Most qualitative research employs purposeful sampling, which is generally performed before the data collection process begins (Coyle, 1997). Purposive sampling has a strong tradition, and there are as many perspectives on how clear and fundamental it is as there are on its complexity. A purposive sampling includes engaging participants who are, by definition, the ideal participants for the study, for example, those who have direct experience or knowledge of the issue being researched. Purposive sampling improves the rigour and quality of the study and the reliability of the data outcomes by fitting the sample to the research's goals and objectives (Gentles et al., 2015). For example, the purposive sample method in this study of women's experiences of SMHI in the postnatal period (EXMEPP) was recruiting those women who had experienced SMHI in the postnatal period within one year of childbirth. This was one of the inclusion criteria. However, the GT sampling approach requires the use of extra resources, as discussed below.

5.13 Theoretical Sampling

Theoretical sampling is a sampling method that is led by concepts that are important to the developing theory (Corbin and Strauss, 2008; Holloway and Wheeler, 2010). Theoretical sampling uncovers differences and similarities in research subjects' experiences with a given research issue. The evolving theory guides or impacts the additional data collected, with a specific emphasis on context. As a result of the growing concepts, more samples are routinely linked to individuals, regions, and forms of inquiry (Goulding, 2005). However, following this idea in its entirety may not always be feasible. Charmaz acknowledged this and offered several techniques for researchers to develop a theoretical sampling, such as during data collection (Charmaz, 2014). Thus, theoretical sampling in the study centres on the new theory (Wiles et al., 2007) that governs the entire research design (Duffy et al., 2004). Theoretical sampling is not a set-in-stone method. It concerns not only the population, location, or expanding the statistical generalisability of the findings or the people, but also the data and developing theory. Theoretical sampling in this study required an initial conversation with women who were best suited for the interview (purposive sampling).

Open coding was used to quantify the first few interviews, the purpose of which was to search for the initial interpretation of meanings and categories in a discussion. Further samples emerged as the researcher compared examples in the data, (Strauss and Corbin, 1998), and then decision were made on where to collect the next data to explain and clarify the dimensions of the emerging concepts to aid understanding (Charmaz, 2014; 2006). In the current study, participants identified segregation due to Covid 19 as a reason for not receiving medical attention on time. This could potentially have an impact on the study. It was therefore decided to see if this was a common experience, and this topic was thus explored more deeply in the following interviews until it reached saturated. Due to various practical restrictions linked to the ethical review and approval processes, it was not permitted to theoretically choose participants in this study. Instead, data were obtained through an ongoing comprehensive study assessment of the interviews. In GT, the interviews should be guided by the analysis of the initial interviews and are important to the inductive-deductive approach (Glaser and Strauss, 1967).

However, because of ethical concerns, theoretical sampling based on locations was not possible in this study. This study's participants were NHS patients, and the research partner was an NHS site. Participant information was not accessible until they had been recruited into the study due to NHS data protection and confidentiality policies and access to the study site was not possible for the researcher and to decide where to find a similar instance that would help to increase and develop the research ideas that came from the data. The argument could still be made, therefore, that qualitative researchers will never know where or who will offer the variations they seek in a developing research idea; instead, they will be directed by what is available, which may offer some explanation.

5.14 Conducting Online Work

People's lives were protected from the Covid-19 pandemic by using social distancing measures and other methods, such as restrictions on face-to-face meetings. At the time, clearance was granted for the study to continue, although there were national and international restrictions on movement, including face-to-face interviews. During the pandemic, online communication quickly took over as the primary method of conducting activities like conferences, data collection, and teaching. Most activities were carried out online, making computers, tablets, and mobile phones the most effective means of communication. As a result of the advances in communication and information technologies, more participants can be interviewed and new insights gained (Kenny, 2005).

As previously stated, the Ethics Committee had approved the use of the online interview method in data collection before the study began.

Digital technology for data collection does, however, come with some obstacles and challenges (Fielding et al., 2016). Face-to-face data collection was replaced with online data gathering for this study. In this way, while collecting data online can be difficult, the study had a chance to avoid or resolve the challenges of the social distancing policy on research activities. Some participants thought Microsoft Teams was preferable to non-visual communication methods such as talking on the phone.

Online interviews were found to be less expensive than face-to-face interviews during the study (Braun et al., 2017). Microsoft Teams and voice recording were used as data collection tools and participants were informed about the online interviewing method. Participant visibility was a major consideration because they were able to look at or talk to the researcher or other person on camera. Participants' apprehension about being seen on camera, as well as interruptions, such as from family members entering the room to tend to the baby, were also problematic. However, the online interview method was generally convenient for both the researcher and the participants because interviews were conducted from the comfort of the participants' own homes. Despite this, some participants are particularly sensitive to the use of online communication or appointments in this study, it was reported that, irrespective of the advantages of online appointments, some participants still preferred to see the researcher face-to-face or to speak over the telephone.

At first, recruitment was slow due to a lack of interest among study participants; in addition, due to the focus on the pandemic, the data collection process encountered some problems, including network signal loss, unclear recorded data, dropped calls, and connectivity challenges (Weller, 2015). Since public knowledge of online technologies such as FaceTime and Zoom was low (Weller, 2017), this study employed a tape-recording device alongside online technology to capture participant perspectives on the study. The information acquired was fully secure following the University's policies and the General Data Protection Regulations GDPR of 2018; all collected information was kept safe and secure.

5.15 Research Setting

Considering the sensitivity of the study, there was a chance that emotional and unpleasant issues might arise during the interviews. The main goal of the researcher at this stage in the study was to make participants feel as calm and at ease as possible during the interviews. Furthermore, it was clear that, given the nature of the research study, distractions would have been unhelpful. Using a public setting for the interview would therefore have been improper and unsuitable, especially for the focus group, due to the surroundings and numerous distractions that would have been present. Because the interviews were done in their own homes, the participants appeared to be more relaxed and at ease than might have been the case in other locations.

The benefit of conducting interviews in participants' homes is that they were not inconvenienced unreasonably because they were not required to travel. It gave them a sense of control and assurance that they were not being exploited.

The at-home online interview method used for the study data collection was also observed to have the potential to improve openness, while simultaneously posing a confidentiality difficulty (Yee and Andrews, 2006). Conducting interviews in participants' homes may also result in unnecessary distractions, challenges, and several unexpected methodological and ethical issues. Technical difficulties included the equipment occasionally losing signal or becoming a little ‘crackly’, causing the participant’s speech to become distorted.

Another problematic instance occurred when older children repeatedly entered the interviewing room in search of attention, causing the interview to be disrupted.

In another case, a baby was continuously crying, and time had to be given to the participant to deal with this. The interview later continued as the participant was keen to carry on, despite this causing disruption until the baby settled. Further disturbances involved pets. On one occasion, a participant’s dog, despite being kept in another room, continued to bark, which was a constant distraction during the interview. Other participants left their dogs in the same room with them, which helped the dogs relax and ultimately caused less disruption. There was not an enforced rule in the study. It was important to remain calm and allow the participants to continue in whatever manner they wished, to ensure they continued with the interviews. However, it appeared that the participants felt in control during the interviews because they were in their own homes (Yee and Andrews, 2006).

The main priority was to ensure their comfort and autonomy, which are essential components of a positive researcher-participant relationship. See appendix 10 for interview questions used.

5.16 The Research Relationship

Research participants' interactions cannot be estimated, which is why a mutual relationship between the researcher and the participants is required for a successful research outcome (Denzin and Lincoln, 2008). Memories and experiences may be recalled during the interview process, providing possible issues and difficulties for the researcher (ibid). This study was conducted through a qualitative inquiry as it aims to understand the depth of women's experiences during this time. It was difficult to separate the researcher from the study's subject in this qualitative research. However, it is likely that the researcher might become disengaged from the research goal when the output of the investigation is objective, duplicated, and quantified through quantitative inquiry. Issues related to the researcher's knowledge and professional background may be raised. However, my research identity, as well as my background were self-evident. Other personal identities, such as profession, motherhood, and country of origin, on the other hand, were more difficult to reveal and came from participation (Blackwood, 2006). When these personal questions were asked by the participants, it felt necessary to react because not doing so could be interpreted as abuse, wherein the researcher takes information without giving it.

It is not always easy to maintain a distanced position on an issue, especially when participants' life stories relate to those of the researcher. During interviews, the researcher is conscious that sometimes interaction through lived experiences can lead to misinterpretation and generalisations. This could disrupt the interview process; thus, some of the researcher's experiences were not disclosed to the interviewees (Vincent and Warren, 2001). It was easy to create a rapport after living in the Northeast for over a decade. In addition, it appeared that the researcher's identity as a female student contributed to gaining the confidence of the participants. In the study, gender identity did not present any significant difficulties because all the participants were female. The study's main goal was to learn about the participants' lived experiences with SMHI and motherhood after childbirth, as well as the factors that may have influenced their outcomes.

As a result, it had been suggested that the researcher should pay attention to how she presented herself as this could have an impact on the relationship between the researcher and the participants (Berg, 2001; Gerson and Horowittz, 2002). The researcher maintained a positive and appropriate relationship by making timely phone and email contact. A reflective dairy was maintained throughout the process of data collection. Participants were contacted to arrange and agree on a date for the interview as soon as their interest in the study was confirmed. They were given contact information and a consent form to sign. The interviews were performed as quickly as possible following receipt of the consent forms. Participants were then given the choice of getting a thank you card either by post or via email at the end of the interview. As a result of Covid -19, some of the participants declined to receive a thank you card. One of the ethical principles underpinning human-centred research is benevolence, or ‘’doing good", and causing no harm. This is consistent with nursing and midwifery principles, which emphasise taking on a caring role. Giving participants the correct information and allowing them to make their own decisions (autonomy) is an important part of research (Beauchamp and Childress, 2001). Therefore, if any of the participants required assistance or information, the researcher recommended that they call their care coordinator. Some of the participants' concerns included being regarded as mentally ill patients rather than women or mothers, which might have made them feel stigmatised and labelled. Moreover, there were concerns about the therapeutic nature of the interview, which could vary depending on the level of rapport established between the researcher and the participant (Eide and Kahn, 2008), and which the researcher may not be prepared to address. The researcher in this study developed and maintained a positive relationship with the participants to fully comprehend the incidents being described and to assist the participant in becoming more relaxed throughout the online interview. Some participants perceived this interview as a kind of birth reflection, which helps women discuss the concerns and experiences they had during labour and delivery (Eide and Kahn, 2008).

In this way, the interview was a reassuring and comforting process for some participants. One mentioned that the process made her feel better because she had never been asked to talk about her experience with anyone before.

She was advised that she may still contact her care coordinator to arrange for a birth reflection visit to talk about her experiences. Some participants declined to speak about their experience since they were aware of how traumatic it may be. Throughout the data collection process, the researcher’s role was reviewed, so as not to impact the study.

This included maintaining the research position while also remaining committed to the caring duties of a midwife. This is because the interview process is an active one that can induce not only memories and reflections, but also disturbing issues and life changes for both the researcher and the participants. Although it is known that researchers bring their personal and social selves into the research process (Reinharz, 2002), Yee and Andrews (2006) advise caution when sharing beliefs, values, or emotional attachments with participants, although they acknowledge that keeping the required distance during data collection can be problematic.

According to Letherby (2012; 2000), identifying with the experiences of the participants not only builds strong relationships but can also bring to the fore a greater understanding of the social process. However, if the researcher wants to mine raw data, and improve and refine it into a cohesive story that can be communicated to a wider audience through publishing, this must be minimised. Some qualitative researchers can limit the amount of self they bring to their work to a larger extent than others. To allow the participants to speak their memories without being led in this study, a safe emotional distance was kept from the participants by the researcher during the data collection interviews. This was documented since it improves the study process's transparency and value. It was not always practicable to maintain perfect separation, however. When a participant established a good connection with the researcher and perceived her as a friend, they were able to communicate personal information that was very sensitive to them; for example, whether the family refused to let her go anywhere by locking her indoors until she was well.

Other participants, who came from different cultural backgrounds, talked about how they had too many visitors after their baby was born, all of whom wanted to view the baby but not help her with anything. This led to a feeling of unspoken empathy because, after giving birth, many women share this type of experience, depending largely on culture and beliefs. Self-disclosure of these types of stories leads to a genuine exchange of personal information based on empathy, which in turn can improve the data's quality (Sixsmith et al., 2003). However, on this occasion, it occurred after the interview and had no bearing on the EXMEPP study.

5.17 Data Collection

Data collection methods are tools used in collecting data that have an impact on the data. Some tools, however, are more effective than others. Grounded theory methods, when put together with understanding and production, provide powerful instruments for creating, analysing, and interpreting data (Charmaz, 2014). The data collection method chosen will allow this study to respond to research questions imaginatively with creativity and rationality. In order to adhere to the principles of qualitative research, Mason (2010) points out that saturation should be achieved in the majority of cases. GT analysis follows an iterative process of interview, transcription, coding, initial analysis, then another interview (figure). By doing so, the initial interviews provided the basis for forming and developing some key points for the next interviews, with the help of sampling and memos. During data collection form online interviews, ongoing memoranda and coding were written and completed. In every interview situation, the researcher made every attempt to keep diaries and theoretical memos, which would be useful during the later interviews. This indicates that the study continued to use the grounded theory method of constant comparison. Adequate time was also given between interviews to facilitate the comparative analysis process (Duffy et al., 2004; Corbin & Strauss, 2008), before moving on to the next interview. Initial data collection and analysis informed the further collection and analysis of subsequent data following the GT process. This cycle was repeated until it was determined that the approach had reached saturation with data. Some researchers may be so passionate about data collection that they perform a cycle of interviews without conducting continuous analysis (Strauss & Corbin, 1998).

Recorded interviews must first be transcribed, which is a time-consuming process.

On two occasions recorded interviews were listened to multiple times and memos were written before collecting the next data set. Thus, the previous interview informed, improved and indicated new areas of focus for the next interviews. In some cases, analysing previous data before collecting new information may not be feasible.

The point of saturation, as defined by Gibson and Hartman, (2014) became clear when further data collection would not have meaningfully contributed to the construction of the GT. With rich data, researchers create solid, well-founded theories. The type of data obtained by the researcher is governed by the topic and available resources. In a GT research project, researchers collect different data and employ different data collection strategies.

This study adhered to theoretical sampling to get the most out of the sample and data analysis. When conducting this GT study, the data collection method and process were carefully considered. Choosing the sort of interview, even while it is in line with GT, can be a difficult process (Duffy et al., 2004). Using GT, there are doubts about the appropriate interview method; this question was addressed by the researcher based on the research objectives. After the evaluation of different data collection methods, an online semi-structured interview method was chosen, although it is very difficult to capture the true reality of the lived experience of women with diagnosed SMHI in the postnatal period.

Furthermore, since this experience is in the retroactive account of past events, the observation method would be improper. There may be emotional, traumatic, and sensitive subjects that are inappropriate to discuss in a focus group. The researcher, therefore, decided that an online semi-structured interview would be the best way to make them feel at ease and in charge while also establishing a rapport with the participants. Researchers can acquire more concentrated information from semi-structured interviews by asking research questions. The researcher introduces the conversation, listens, and leads the participants accordingly (Duffy et al., 2004). This method enables the exploration of issues that are particularly relevant to the research objectives and questioning of the explanations of participants' comments (Rose, 1994). As a result, the researcher asked the same important questions repeatedly. The intensity and the order of exploration vary; the researcher can also draw on her past knowledge (Charmaz, 2006; 2014). Although a semi-structured interview was chosen, the researcher discovered that the initial interviews and data collection were conducted in an unstructured manner. In other words, participants were willing to share their personal experiences and resilience (Charmaz, 2014; Charmaz, 2006). Since there was no set format for the interview questions, participants were able to state or explain their reality from their own perspectives. Their concerns were recorded, which enhanced the efficacy or emergence of issues that the researcher had not considered or thought relevant to this study (Fielding, 1994; Guba and Lincoln, 1981). It is necessary to listen to the participants tell their stories by describing their reality throughout the initial stages of the data collection process (Charmaz, 2006). GT is frequently used where much less is understood of the research problem, as highlighted earlier (Morse, 1994a). The researcher developed an online semi-structured interview guide for the questions to be asked, copy of which can be found in Appendix 10 (Charmaz, 2006; Wimpenny and Gass, 2000).

Whether the participants talk openly of their actual concerns, or the researcher asks some questions, the outcome is often restructured or constructed from the facts (Charmaz, 2006), as mentioned earlier (Murphy and Dingwall, 2003; Silverman, 2000). However, these stories present descriptions of specific views and opinions such as ideas or concepts that, throughout the interview, one must observe as unspoken verbal norms. On the other hand, the EXMEPP interview represents what the researcher and the participants bring to the study, as well as the opinions and the rapport formed as a result of the interviews. A semi-structured interview was adopted for this study to allow the exploration of new ideas that were relevant to the study as they evolved (Duffy et al., 2004; Rose, 1994). The questions were worded or asked in any format (Fielding, 1994) and were presented to invite participants to share their own experiences of postnatal SMHI and motherhood.

Extra caution was exercised in asking questions, as Glaser recommends, since this could force data rather than just allowing it to unfold, (Glaser, 1992) and possibly stifle the emergence of interesting ideas (Charmaz, 2003). In GT, interviews are directed conversations (Charmaz, 2003). However, the way questions are phrased and timed may have an impact on participants' opinions. As a novice researcher, it was necessary to be especially cautious; for example, before asking the opening questions, the participants were first congratulated on the births of their babies to make them feel at ease before being asked to recall the experiences, which helped create a rapport with the participants.

Nonverbal communication, which could have impacted participants' responses and exerted undue influence was also monitored and controlled by practising a mock interview with work colleagues and with family members at home through a process of graded performance with feedback. This exercise helped to build confidence before beginning the actual data gathering process. Audio recordings of the interviews were made and transcribed thereafter.

Another technical and practical challenge that needed to be addressed was the audio recording of the interview. The application of this technological method for data collection has been met with questions and concerns and has been criticised as interfering with the process and increasing the risk of technical flaws or problems occurring (Lincoln and Guba, 1985).

Using devices can be a more effective instrument for collecting data than handwritten notes (Charmaz, 2003). When participants were informed of the study, they all agreed to have their voices recorded.

However, during the interviews, important points were also taken down as notes, including statements made after the tape recorder had been turned off. Interview data must be properly analysed to provide the most accurate description of the participants' responses (Silverman, 2013). Many researchers overlook the importance of sequence in what they do or say. If the sequence is not valued, the data generated in the interview may be minimised (Silverman, 2013). It would also be inconsistent with the methodology of this research study to rely solely on interview responses to support claims made by the researcher (Silverman, 1980). In-depth interviews have advantages and disadvantages, which are summarised in the table below by Hennink et al. (2011).

As a result of the significant difficulties stated above, it is recommended that researchers consider all practicalities before data gathering so that data quality is not compromised or hindered by technical challenges (Rose, 1994). As recommended by Easton et al. (2000), the recorder and any other necessary equipment required was tested to make sure that it was in good working order. A worksheet was also created as a prompt for things that needed to be accomplished prior to, during, and then after the interviews (Duffy, et al., 2004). For example, it was necessary that the recorder was turned on and the volume was set correctly, the battery was charged, and a new file was opened for the new interview. The interview questions were well-guided according to Charmaz's interview guide. However, questions were rephrased repeatedly to ensure that participants understood what was being asked, and to give room for probing and in-depth understanding of the lived experiences; participants were also given opportunities to raise topics that were not addressed in the interview guide. The complete list of questions in the interview guide is given below:

- Could you tell me about the experiences you have had since you gave birth?
- How do you feel about these experiences? Or what are your feelings about having a baby? Do you think that these experiences have in any way affected your feeling and emotions? Do you think that this has affected your mental health and wellbeing?
- What do you hope would have been more helpful during this time?
- Did this provoke any feelings of fear?
- What do you think may have contributed to these experiences and feelings? What might have helped your experiences and feelings and what do you think did not help with your experience and feelings?

The researcher will probe for further answers based on the participant's response to the above questions.

- How are you coping with being a mother and having mental health issues? (**probe more here to** find out about family, money, friendships, religion or physical, emotional, and or spiritual aspects)
- What things do you currently do to help you manage your mental health well-being and parenting? What helps and what does not help? Who, if anyone, is involved? In what way are they involved?
- How would you describe your coping method/ journey during this period? What was it like?
- What are your thoughts and feelings on how services can help make this period (experience) better?
- Is there anything you would like to add, or would like to summarise in your own words?

Participants were given the option to ask questions or make additional contributions at the end of each interview. This provided some insight into the participants' perceptions and allowed them to express themselves in a way that was not previously asked of them during the interview. The development of the interview transcript was accompanied by the creation of notes and memos, which demonstrates the management and continuity of the data analysis (this will be explored in more depth later). In the section devoted to this research journey, personal reflections and insights into interviewing will be discussed in detail.

5.18 Transcribing and Analysing Data

In this study, all data were transcribed and analysed by the researcher. In the case of interview transcription, using a transcription service can save both time and money (Corbin and Strauss, 2008), but it can also introduce transcription errors (Duffy et al., 2004) which will take longer to correct, and which may negatively impact on the quality of data if they are not detected (Duffy et al., 2004). The value of transcribing one's interview tapes was proved in this procedure, which allowed data analysis to be undertaken after the interviews had been completed.

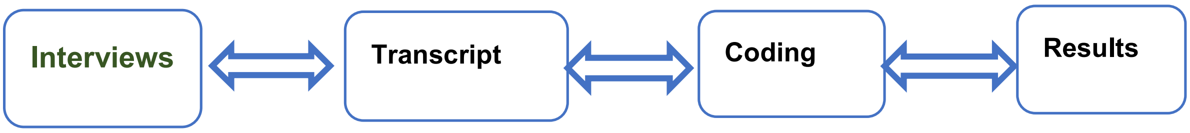
However, the transcribing process, as well as the immersion in the data, proved to be too onerous; thus, when the transcription and data engagement process became too tiring, lengthy, theoretical memos and diaries were kept, and these helped in the next interview process. GT requires the construction of ideas and theories that combine knowledge and generalisation while remaining grounded in empirical evidence (Charmaz, 2014). Individuals' ability to see the whole picture of what the data is saying may result in challenges and conceptual dilemmas. To address these concerns, discussions were held with the researchers’ supervisors, who looked at the data from a different perspective and offered some ideas. It is possible for new ideas to occur while doing other things, such as reading literature in general. Following a break from the data collection and analysis, the researcher returned to the data with a clear, fresh perspective to continue collecting and analysing data.

5.19 Initial Data Analysis

Qualitative data analysis is a continuous process that works with data in a more in-depth manner (Friese, 2019). It translates data into meaningful concepts that help people better understand what they are seeing and has a positive impact on their professional experience. As a result of this, greater understanding and the application of existing knowledge, ability and skills are made possible through data analysis.

During analysis, there is a robust process of thinking and trying out ideas, before creating or expanding data by generating or developing ideas, before arriving at what appears to be the right outcome. According to traditional practice in GT, data collection and analysis should take place concurrently with theory and concept development (Chun Tie et al., 2019). The qualitative analysis focuses on increasing understanding of the rich data while making sense of its phenomenon (Lester et al., 2020). Data should therefore be analysed as they are collected (Charmaz, 2014; Strauss and Corbin, 1998). Time constraints can also mean that it may not be possible to analyse previous data before conducting the next interview. The interview transcripts in the study were analysed using three types of coding, according to Charmaz’s (2014) model; these coding stages are open, focused, and theoretical (figure).

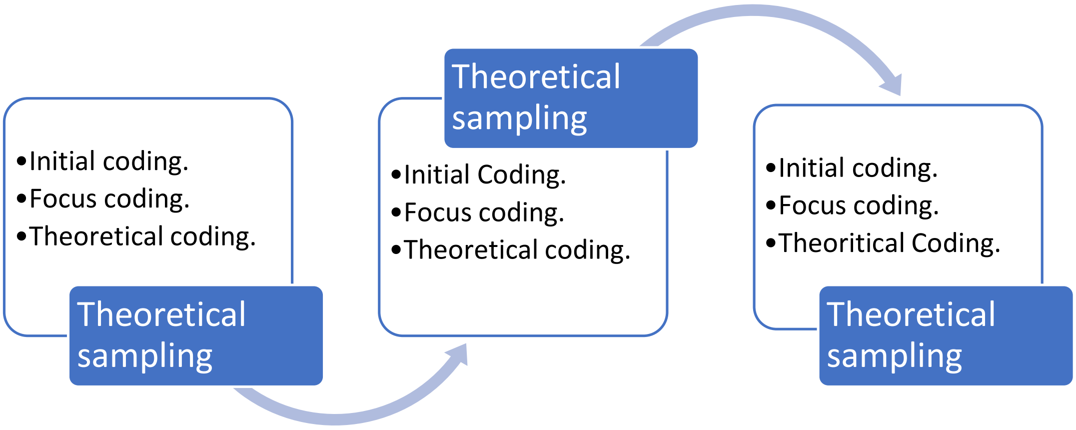
Figure 5.3: Iterative data analysis process



It is interesting to note that GT approaches, as well as the coding processes, have evolved. GT authors such as Glaser and Strauss (1967), Glaser (1978), Strauss and Corbin (1990, 1998), and Charmaz (2014) all take different approaches to the same problem, (see table below for a comparison). The GT technique developed by Charmaz (2014) was employed in this study, with the addition of situational analysis tools, according to the results (Clarke, 2003; 2005). While data were being collected, they were being analysed, allowing for the identification of new categories during the procedure (Corbin and Strauss, 2008).

Even though there are computerised means of data analysis, such as NVivo, all the data analysis for this study was done manually, with the help of the NViVo software only as a support tool. NVivo is a computer tool that can be used to analyse data; however, this study's findings were derived through a combination of manual data entry, NViVo and data which were mixed using word-processing software (Carmichael and Cunningham, 2017). Focused coding and theoretical categories were developed by following cues in the data from initial coding (Birks and Mills, 2011; Charmaz, 2006, 2014). According to Charmaz (2014), the corrective methods in this section of GT are designed to reduce the possibility that researchers will introduce their present assumptions into their findings. While analysing data, a grounded theorist generates "qualitative codes" by identifying what is observed in the data (Charmaz, 2014), as seen in Figure 5.4. Coding is used in this process, serving as an 'essential link' between the data and the meaning that can be drawn from them (Charmaz, 2006). Code is a brief phrase that symbolically gives an overall feature attributed to a part of phonology which is based on visual data (Saldana, 2013). Transcriptions were colour-coded and used for further analysis later in the process to detect emergent categories.

Figure 5.4: Stages of coding



The above figure illustrates the processes of coding in this study which are discussed below.

5.20 Initial Coding

Initial Coding is the process of coding a transcript line by line, which requires grouping data to provide a full analysis of all possible meanings, as well as the distribution of appropriate conceptual labels to each line of data that has been transcribed (interpretive meanings). A thorough analysis of data during the initial interviews was carried out to aid in the formation of categories that were deeply rooted within them and grouped into nodes, as they are referred to in the NVivo software programme. The NVivo 12 data analysis software was then used to aid in the coding and analysis of data. In addition, it facilitated the breakdown, organisation, and storage of the significant amount of data that was generated, as well as the comparison, analysis, and classification of those data (Walker & Myrick, 2006). Data were grouped into comparable categories, while new categories were formed from data that had not previously been categorised together. This strategy was used to organise the data into distinct categories (line by line coding).

Charmaz believes that coding line by line enables the identification of trends that could otherwise go undetected, since it allows for a more in-depth analysis of the events and observations of everyday reality. Researchers are advised to keep an open mind as they work through this procedure to uncover many new possibilities.

During the initial coding phase, the researcher works quickly through the transcripts by constantly comparing data with transcripts from the previous phase (Charmaz, 2014). Code words are used to reflect the actions or processes described in the data, referred to as 'Gerunds' or 'in vivo' codes, which are derived from the spoken words of participants (Glaser, 1978; Charmaz, 2006; 2014) and are used to represent the actions or processes mentioned in the data. Symbolic interactionism and GT both take the stance that words should be used to represent actions and processes, and this is consistent with their respective approaches.

Glaser (1978) encourages the use of gerunds in substantive coding as a means of identifying processes in written language (Birks and Mills, 2011). In some cases, in vivo codes were derived from the actual words of the participants. When data are collected in this manner, researchers are more likely than not to pay attention and return to an *in vivo* code that was previously used. This type of code is used to represent actions that took place while the data were being collected. When data are collected in this manner, researchers are encouraged to pay attention to them and if the researcher returns to an in vivo code, it is likely to be relevant.

Figure 5.5 an example of an interview transcript

Excerpt from interview with participant EXMEPP 002

57 So, what do you hope? What do you hope would have been more helpful during 58 this time?

59 Eh mmm, l think help from Mental Health Services has been really fantastic. Eh 60 mmm, l think before l was pregnant, there is a lot of waiting time and it's really
61 hard to access mental health services and since becoming pregnant the perinatal 62 mental health team has been really supportive, and so l think that experience has 63 been really good actually. And in terms of hope eh mmm, l hope to recover from 64 these things and have l don't know eh mmm l would say to have a normal
65 experiences but l don't know what normal is really, but eh mmm l think is probably 66 what l have to live with but eh mmm yeah just recover a bit, yeah to feel more
66 confident with her as well

Excerpt from interview with participant EXMEPP 009

91 So, what do you hope that would have been more helpful during this time?

> 92 Nothing really, cuz I cannot stop the services like the first GP appointment wasn’t 93 good. Like I say but after that from seeing the second GP that seems like the
> 94 plans to be in the mother and baby unit, having seen the CPN they’ve been 95 brilliants. They could not have been more supportive as they have.

While conducting the study analysis, a constant comparative approach was employed to enhance the overall quality of coding. Codes and categories that had been previously recognised were clarified, and new ones were discovered by using continuous reporting to confirm a similar group of codes and initial categories, as well as by identifying those that were hard to determine (Charmaz, 2014). As more data were collected, the technique of continuous comparative analysis was proven to be effective for comparison of data incidents and of categories (Glaser and Strauss, 1967). During this process, it was vital to focus on data that had demonstrated unique constructive ideas of experience as a technique to help create emergent grounded theory (Charmaz, 2006). It is through these ongoing processes that the researcher can develop a theory, which in turn improves analytical skills (Charmaz, 2014), as reflexivity becomes an essential process in contemplating the wider context of what the data might represent.

To analyse the data, a constant comparison method was employed. Coding forces the consideration of data in different ways, which may differ from the research participants' ideas and interpretations. It is therefore a powerful tool for data analysis. The professional expertise and analytical approach of the researcher have had an impact on the data gathered in this study by revealing some underlying beliefs, which resulted in a deeper understanding of the subject matter (Charmaz, 2006).

Table 4.2 Different authors Coding Categories in Grounded Theory

Initial coding	Focused coding	Theoretical coding	Charmaz, (2014)
Coding and comparing incidents	Integrating categories and properties	Delimiting theory	Glaser and Strauss (1967)

Open coding	Axial coding	Selective coding	Strauss and Corbin (1990, 1998)
Open coding	Selective coding	Theoretical coding	Glaser (1978)
Initial coding	Intermediate coding	Advanced coding	Birks and Mills (2015)

5.21 Focused Coding

After the initial coding, all transcripts were subjected to focused coding to further refine the results. Focused coding is a more targeted and specific strategy than initial coding, which is more common (Glaser, 1978). The stages of coding are described sequentially for comparison, employing an interactive and iterative approach throughout the analysis. To be more specific, focused coding refers to the process of sorting and selecting a large volume of data by using the most frequent codes. Choosing which initial codes make the most analytic sense in analysing data is one of the decisions to be made in this process (Charmaz, 2014) and by so doing, it became more apparent that the key concept had been recognised. A more focused, narrow, and conceptual approach was taken by separating the recurring codes from the relevant and meaningful ones (Charmaz, 2006). Interactivity and the ability to move across data were therefore very necessary. The initial codes were colour-coded in the transcript data and were then linked and integrated in the manner indicated above, allowing the tracking of the codes' lineage back to their original data sources. Initial codes can be organised into groups, and preliminary categories can then be developed.

To further elaborate and refine the findings, more theoretical sampling and data gathering was conducted. This process is illustrated in the table below. Afterward, more data were gathered using theoretical sampling.

Axial coding links categories to subcategories; thus, axial coding was utilised, and the quality and length of the code was acknowledged further. Fig 5.9 illustrates that the use of diagrammatic representation makes coding clearer. See table 4.2. For examples of axial coding (Strauss and Corbin, 1990).

Constant comparative analysis was performed to compare the data from the new transcripts to those from the initial ones. Examples of initial and focused codes are shown below.

Table 4.3 Coding example

Initial coding	**Focus coding**	**Axial Coding**	**Theoretical Coding**
You feel like you're **being judged** before you really have chance to be a mother. eh mmm I was **worried**, eh mmm she will be going to **focus on my mental health**	Discrimination Discrimination	Discrimination Stigma, labelling	Social context Stigma, labelling
I really **struggled**. Like I said I just **didn't want to do anything with the baby**. I think that the **difficult delivery contributed to it**. I think that the fact that there was one of my aunties that were staying with us when I gave birth actually, she was there for **the last week of my pregnancy, and she had like depression** she had like lots of mental health issues	Bond and attachment Trauma Self believes	Bond and attachment Trauma Perception and attitude	Childbirth experience Childbirth experience Socio (negative thought) Cognitive
I think **I probably should have told somebody a little bit earlier**. I don't think, if it was to happen again, I'd probably tell my husband a lot earlier when it did happen. **I think what would have helped is having early support**. I think **asking for help** is really important, whether that is from family or	Delay in access Support Coping mechanism,	Access Support Social context	Service engagement Service engagement Cognitive

partner and trying to understand that asking for help isn’t eh mmm is not deteriorating l guess and l think you can’t really do all that by yourself or you can ask help from **Mental health professionals**. I think it's really important. It just tries to connect with eh mmm other people not isolating yourself.	Personal resilience	Positive thought Cognitive	Service engagement

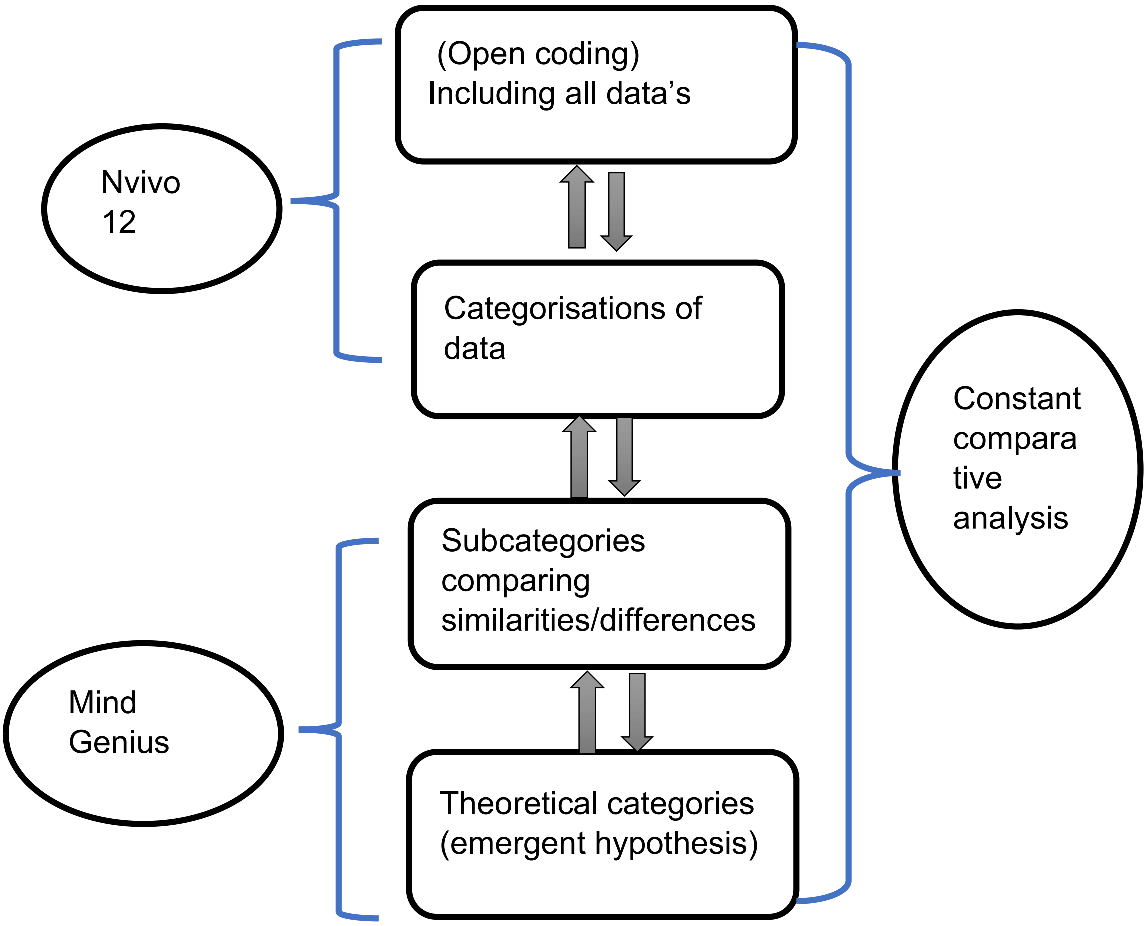
It was only feasible to reach the theoretical level, by asking significant and logical questions, such as:

- What is the participant saying?
- Who is involved in this?
- In what location and context is this taking place?
- How does this impact the topic under investigation?

Initial categories were first developed, as mentioned earlier, by constantly comparing and engaging with the data to generate focused codes. This technique requires the researcher to continue comparing and shifting between data that represent a shared position among the participants. Thus, women and their SMHI during the postnatal period were the primary focus at this point. The categories were subsequently developed and evaluated but remained rooted in the data through further data collection and analysis.

Number lining and colour coding in Microsoft Word were also utilised. The coding process throughout was an iterative process between the three levels of coding, which required constant comparison. Upon reaching this level of coding, the data were once again rerecorded and reconstructed, resulting in an even higher level of categorisation and conceptualisation, which aided in the development of theories that could explain what was happening, and which could also be capable of explaining certain dimensions of the participants' experience of motherhood in the post-natal period with SMHI. Figure 5.6 presents an example of practical coding activity.

Figure 5.6: Data analysis steps (sort out format)



The ongoing comparative approach and process add significantly in terms of 'best practice' to the research and make a significant contribution to methodological rigour (Cooney, 2011); it is, therefore, used extensively in the field (Fossey et al., 2002). Theoretical sensitivity is the ability to perceive and interpret phenomena in broad terms to establish relationships between them (Charmaz, 2014). To understand the concept of theoretical sensitivity, Gibson and Hartman (2013) say that it is important for researchers to have an open mind. 'Openness' is demonstrated in this study by using comparisons and the detailed information provided in the theoretical maps. Being open and practising theoretical sensitivity in a constructivist GT methodology requires the ability to be a reflective researcher who is better able to relate to and write about the subjects of the study (Charmaz, 2014). The researcher displays personal views whenever and wherever opportunities for this are presented; therefore, reflexivity is intrinsic throughout this study.

Reflexivity was undertaken during the supervision procedure in terms of researcher validation within the generated codes. To prevent them from being purely at the discretion of the researcher, codes and reflections were discussed during supervision sessions. In addition, all the research-generated codes were substantiated and compared to the information included in the transcript data. However, the data coding became onerous and at one point became more of a concern than the data itself. Following constructivist GT, categories and subcategories were established which demonstrated the connections between them as they emerged, rather than applying a predetermined framework to the data, as previously outlined. Researchers use theoretical sampling when they decide whom to interview based on their data analysis. As a result, the researcher can keep track of any differences or gaps in the data. This could be thought of as "searching and collecting relevant data to elaborate and improve categories in a growing hypothesis." To ensure the development of reliable categories, the researcher collects and analyses data at the same time. Additional methods, such as memo-writing and the use of diagrams, can also help the process of developing a GT, as can recruiting additional participants into the study, returning to initial participants, or exploring recurring categories (Charmaz 2006; 2014). Examples of memos can be found in Appendix 2.

Rigour and quality

In qualitative research, reflexivity is often considered best practice and an essential instrument for enhancing the research quality (Holloway & Freshwater, 2007).

This study presents a critical and honest appraisal of the research methodology in light of the researcher's role and personal values, which may have influenced the data collection, analysis and interpretation processes (Polit & Beck, 2010; Walker et al., 2013). To establish rigour and trustworthiness (Patton, 1999; 2002), this chapter begins with a critical appraisal of the research method and concludes with methodological reflections. Chapter four begins with a self-reflective account of the study methodology. Several issues concerning the validity of qualitative approaches, such as GT, arise as a result of the majority of qualitative research adopting a non-objectivist perspective (Seale, 1999).

The study's symbolic social interaction with the study subjects during the interviews, as well as the researcher's personal and professional interpretation of the data during analysis, have the potential to alter the study's influence (Silverman, 2020).

Quantitative research requires the systematic and objective collection of data on a phenomenon using numbers, with specific attention paid to minimising bias. This is because the researcher assumes the position of an impartial and external observer (as with bracketing) (Burns & Grove, 2005). This contributes to the study's validity. Burns and Gove's (2005) rigorous control approach lays the groundwork for the validity of quantitative inquiries. This could be affected by the process of including reflexivity in quantitative studies (Ryan and Golden, 2006), as objectivity is a fundamental tenet of quantitative researchers. The importance of qualitative and quantitative research, the nature of knowledge, and the criteria for evaluating qualitative research have been widely debated (Charmaz, 2011; Mays and Pope, 2000). The quantitative concepts of reliability and validity, as well as the qualitative concept of validity, are presented in the table below;

Table 5 Quality criteria (Rolfe, 2006; Charmaz, 2014)

Quantitative (positivist)	**Qualitative (Naturalistic)**
Internal validity: the degree to which the independent variable is confidently responsible for the variance in the dependent variable.	Credibility (see 8.5.1)
Trustworthiness/reliability of the study's conclusions in other areas.	Originality (see 8.5.2)
External validity: Is it generalisable outside of the context in which it was developed? Is the outcome transportable to a different setting?	Resonance (see 8.5.3)
Objectivity: the extent to which a researcher's work has an impact.	Confirmability/usefulness (see 8.5.4)

Several methods were used to assess the validity and reliability of this qualitative research study. The following criteria do not define the quality of research; rather, they prepare the researcher for the quality issues that must be addressed in a given research study.

5.22 Theoretical Memos, diagrams and aiding abstraction

During data analysis, there were many categories that needed to be condensed so that the data's value would not be lost. In facilitating data abstraction, and for theoretical development, the use of theoretical memos and diagrams is useful. Charmaz (2014) cautioned against the dangers of this process, as researchers frequently rely on discipline expertise and incorporate language which deconstructs that of the participants. Verifying that the coding corresponds to the incident or described experience and noting the clear linkages between data and codes alleviates this risk. This was difficult and can be time-consuming. Diagrammatic representations and a study of the theoretical framework were used to facilitate the development of theoretical abstraction. The use of diagrams increases insight into the emergent theory, which was crucial to analytical progress in this study. As the researcher consistently engages with data, memo writing is utilised to provide insight and aid in the development of a grounded theory model.

Researchers may find that diagrams can serve as useful and diverse tools for a variety of objectives at all stages of the analytical process as they can help to visualise ideas more tangibly. The main advantage of diagrams, therefore, is that they provide a visual representation of categories and the relationships between them, as described in the works of Clarke (2005), and Strauss and Corbin (1998). Engaging in self-reflection and capturing ideas from theoretical notes to make sense of the data consumed a lot of time and thought during the process. However, for a GT to develop, it is believed that this level of immersion in the analytical process is necessary (Stern, 2007). Using the data extracted in Table 4.3 as an example of initial and focused coding, the analysis is carried forward to demonstrate how theoretical memos can provide insight into thoughts and ideas.

5.23 Theoretical sorting and coding

Theoretical sorting refers to the act of modifying, organising, and classifying the theoretical memos and diagrams that have evolved. Theoretical sorting leads to theoretical coding and the formation of grounded theory (Charmaz, 2014). A reference to existing literature may also be useful, although the researcher cautions against cramming evidence into existing theory, which could limit the originality of the research. By becoming sensitive to data, the researcher remains receptive and reflexive to what emerges during the process to assist in the formation of an abstraction.

Theoretical abstraction and maps

Allowing for theoretical abstraction is the practice of reflexivity, category reduction through mapping, and constant comparison using an analytical tool. Implementing other analytic techniques, such as mapping, aided in this effort and enabled further construction of theory and interconnections across categories. The creation of maps, as detailed in situational analysis (Clarke, 2003), aided in the advancement of theory, category integration, and coding. Through the integration of memos, the map was linked to categories in addition to interconnections between categories and subcategories (Charmaz, 2014). See the appendix for examples of the initial map and memo. The coordinated procedures (in-depth data analysis, return to the literature, comparison of data to data, code to code, and category to category) enabled the development of the grounded theory (Charmaz, 2006).

5.24 Chapter conclusion

This chapter has explained in detail the data collection, analysis and research processes undertaken in the study. This includes the procedure for obtaining ethical approval, as well as considerations for the safety of the participants and the researcher. Data were collected in a semi-structured approach that allowed for the exploration of topics relevant to the study question and the clarification of participants' statements. It has been helpful to use GT coding approaches, such as memos and theoretical sampling, to create theory and improve the quality of this study.

In addition, reflexivity was used to improve rigour. The findings of the study, discussions and the rationale for using the constructivist GT methodology developed by Charmaz (2014) are presented in the following section. This methodology guides the construction of meaning from data, transforming the participants' lived experiences into coherent theoretical interpretations. Selecting the constructivist GT allows the construction of meaning from the data, as well as the theoretical interpretation of the participants' contributions.

A summary of the data analysis and findings, as well as the development of the Resilience-led Behavioural model will be discussed before moving on to present the findings from the data generated.

Summary of the data analysis/findings and the development of the 'Resilience-led Behavioural' Model

The data generated through coding using NVIVO and Mind Genius was detailed in chapter 5. A summary of the data analysis will be provided in this section, showing how the 'Resilience -led behavioural' model emerged. The model is presented in figure 5.8 from the discussion of the key findings discussed in chapter 7. A number of categories and sub-categories were identified in relation to women's experiences and the factors influencing participants' behaviour and coping strategies (open and axial coding). From the categories, subcategories were generated, which led to the development of the conceptual category (selective coding) of 'resilience and the development of the Resilience-led Behavioural Model.

Figure 5.8

Participants' coping paths

P2: I think asking for help is really, really important, whether that is from family or partner and trying to understand that asking for help isn't eh mmm is not deteriorating l guess and l think you can't really do all that by yourself or you can ask help from Mental health professionals. I think it's really, really important. It just tries to connect with eh mmm other people not isolating yourself (266-270).

P6: Ah great, the two don’t compare, l mean this has been so well planned, it’s been, eh mm, l had a C/section. So, I slept the night before sleep deprivation is the main trigger for my illness or one of physical trauma so having that pre plan C/section eh mm, and not giving birth eh mm, you know naturally, basically the two experience is worlds apart eh mm, we had a lovely time you know, coming home and having that experience at home while with G… I was at hospital for 8 weeks, you know. so, we have missed out on a lot of things (152-161).

P7: Ehhmm, I think I have, for me, probably let people in a little bit more……… So, we don't have a lot of friends still up here. So, we are a little bit isolated. And I think having other people around would have probably helped.
Ehhmm, so I definitely think Yeah, having people help (278-286).

The above table presents the approach with associated memo notes. This was helpful in allowing the researcher to follow the participant’s story, tracking and identifying the similarities and contrasts between each participant’s opinion on how to cope with motherhood and how this impacts their mental health issues. This culminated in the development of the Resilience-led Behavioural Model, and a theoretical sampling procedure based on a constant comparison of data. During the coding process, data were broken down into codes, or nodes, and the open coding method produced over 500 free nodes. These free nodes were developed by open coding and were linked to those participants’ responses deemed valuable and important for data analysis. The table below presents an example of Nvivo open coding:

EXMEEP 002

Well, it’s difficult at the moment with covid. So, I would normally have eh hmm a quite well lots of family support. Eh mmm, my husband is really good support, he is eh mmm he works with …… as a ……… eh mmm some days he works 12hours shift, (support issues) he has to drive over 40 miles, so eh mmm. Otherwise, l get to rely on family and friends so much for advice and help, but due to covid at the moment l can’t (Covid 19 impact). So, l do have support but due to covid l can’t access it as l normally at the moment. Eh mmm, yeah is kind of difficult.

EXMEPP 007

Ehhmm, I think I have, for me, probably let people in a little bit more, so, my family live in ….., so I don't have a lot of support (support issues and isolation), like l have from my partner family here. So, we don't have a lot of friends, so we are a little bit isolated. And I think having other people around would have probably helped.

Reference 2

Ehhmm, so I definitely think Yeah, having people help and maybe even the health visit (access to health care), was explaining that before call that they would have come in to see before you had the baby and on talk a little bit about what to expect things about feeding and sleeping and all of that. And obviously they weren't able to do that. And I think that would have helped. Ehhmm,

EXMEPP 008

I felt really isolated. Because nobody there had my problem. I mean, there were people with different problems, different backgrounds. But, I felt that I don't fit in the other people's, like none of the people that had child, like basically babies or like they, they didn't understand (access to mother and baby unit).

EXMEPP 004

At the time, I was exhausted. So, eh mm so I let my body just go on and my mind, go so. Eh mmm, So I was eh mm one day in the hospital, but because of covid the first night I spend it on my own, so I was a bit distressful and. Yeah, after two days, I didn't have any sleep like probably three days, so, I was absolutely tired, (sleep deprivation) so l was worried about the baby!
And people calling me like to see how I was and not be able to even pick the phone (culture) because I was like feeling like I didn't know how to do two things at the same time. And everybody kind of like just stressing me out, trying to check in a good way. But for me, it was kind of like the worst thing that they could be doing because I was having enough in my brain….

The free nodes were then split into further nodes. This is the moment at which Mind Genius was employed, and the codes were manually sorted using Microsoft Word for conceptualisation to happen.

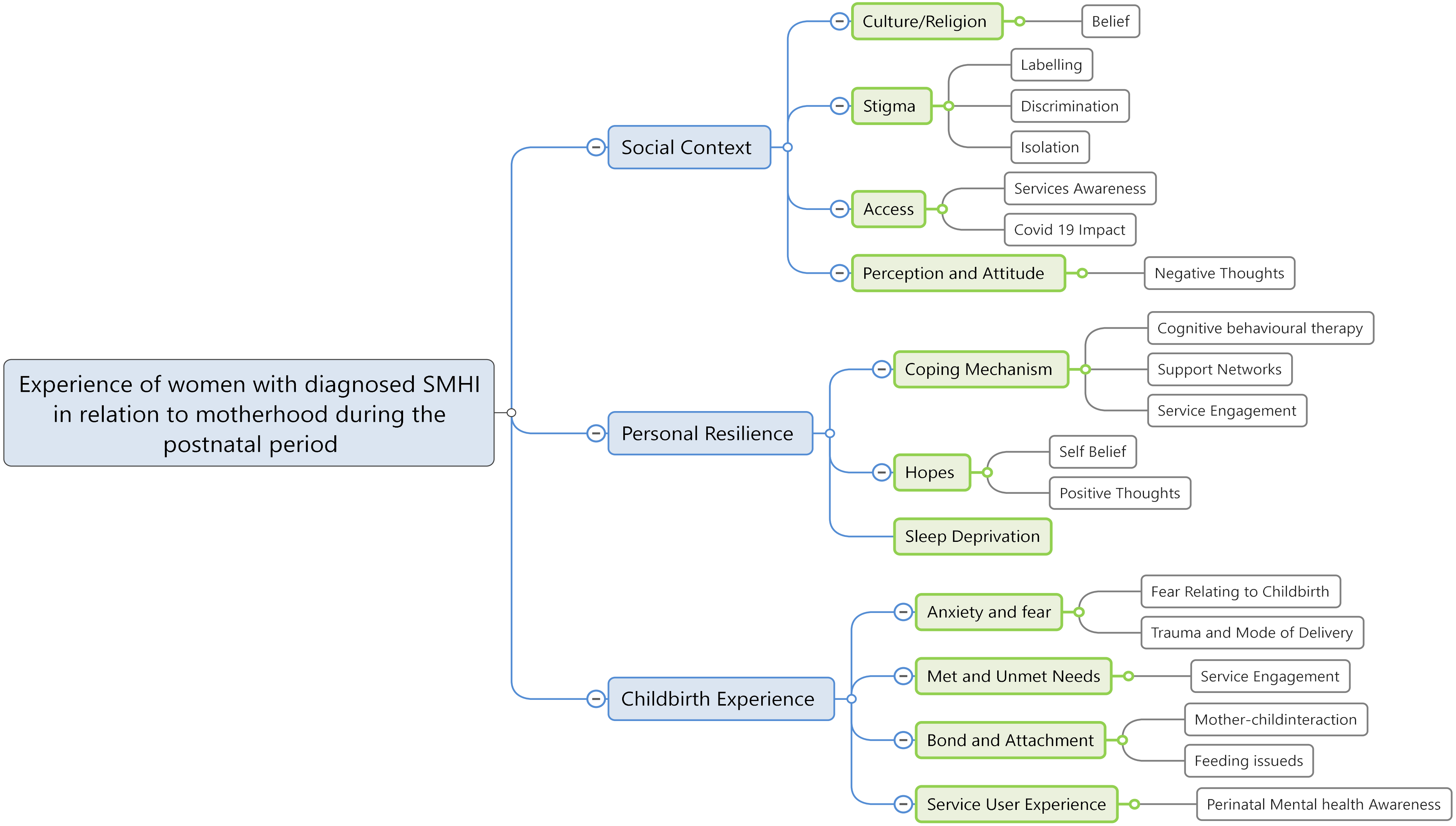
These activities helped with the conceptual analytical process, which is grounded in the data, allowing the researcher to see the links between the categories until the categories could be broken into smaller categories. The categories were then reconstructed into three main conceptual categories (between which the interactions constitute the study model) along with their sub-categories.

The findings are presented in the following way:

- The major categories are presented in light blue
- The minor categories are in light green
- Arrows point to the sub-categories, which are placed on a white background

All information may traced back to the initial interviews following Charmaz process of constructivist GT. There are notable similarities between participants throughout the journey and these are discussed when appropriate throughout the chapter. This relationship was drawn together using Nvivo nodes presented in map format, as shown, outlining the curves across the experience of women with SMHI in relation to the motherhood journey.

Figure 5.9 the three major categories and subcategories



The three major conceptual categories that were developed are: social context, personal resilience, and childbirth experience. The core category ‘resilience’ was derived from these. Resilience was considered the core category because it seemed to be pivotal for the participants in terms of recovering from their experiences and coping with motherhood challenges. This had a significant effect on other categories also; for instance, the participants’ accounts show that their social and psychological perceptions and beliefs are filled with or overcome by individual personal resilience. This was clear from the participants’ accounts and will be presented in subsequent chapters.

The emerging variables are strongly interlinked with resilience being the core component. This includes the social circumstances of the participants. ‘Resilience’ represents all the different mechanisms developed by the participants to cope with their overwhelming experiences, which may remove or respond to social behavioural issues. Childbirth experience also relates to the impact of interacting with different components of social context and personal resilience. Thus, the interactions and inter-relationships between the core categories (social context, personal resilience and childbirth) influence women’s experiences of EXMEPP, leading to the Resilience-led Behavioural Model shown in Figure 6.5.

Chapter 6

Chapter 6 - Research findings

6.1 introduction

The previous chapter provided an overview of the method of analysis used throughout the study, allowing for greater transparency and credibility. The data were individually analysed following Charmaz's (2014) method to gain insight into the language used and how feelings concerning postnatal SMHI in relation to motherhood are expressed. This chapter is structured in such a way that the findings are presented in chronological order. This is to demonstrate clarity on how the findings were generated. The data findings were completely grounded in the lived experiences of the participants as they were reported. The key findings were then arranged into major, minor and subcategories as they related to the aims, perceptions and factors that influenced the participants' experiences.

The three major conceptual categories and subcategories

Responses from participants were generated and presented as follows.

- social context
- personal resilience
- childbirth experience

Personal resilience is considered the core category because it seems to be crucial to the basic social processes that aid experience and also has an effect on the other categories. The social context also includes the social circumstances of the participants.

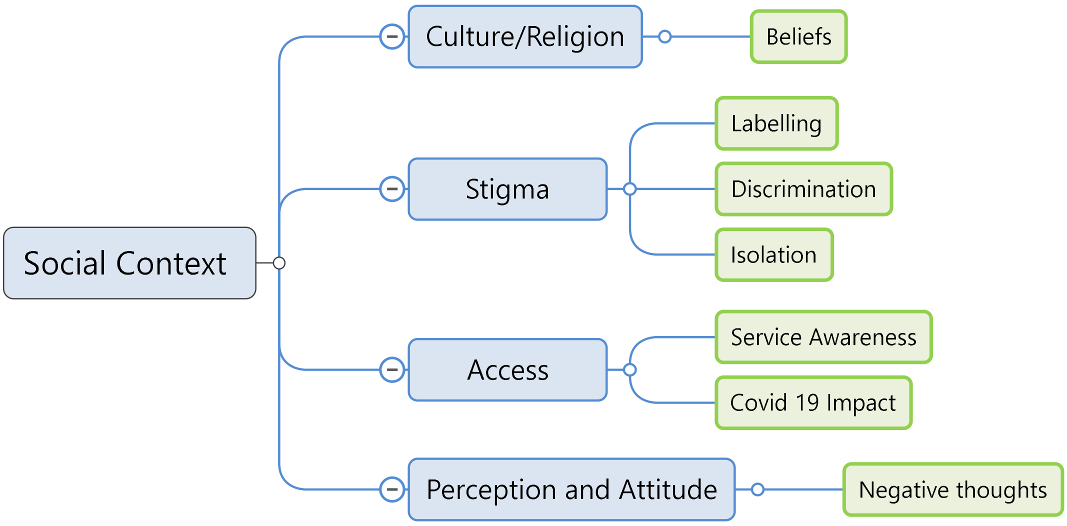
6.2 Social context

Social context includes all of the preconceived ideas, views and beliefs which individuals have, and may include:

- culture and religion
- stigma and access to services
- attitudes and wider social perception

The majority of the social context may act as a barriers to individuals. Figure 6.2 includes all of the preconceived ideas and beliefs the participants had formed before the interviews. These may be associated with culture, religion, stigma, access, perception and attitude.

Figure 6.1: Major Category 1: Social Context



6.2.1 Culture and Religion

Cultural sensitivity and awareness have become increasingly important as globalisation and multicultural societies have become more popular. Mental health experiences vary extensively across cultures and have been perceived or prescribed in some cultures and religions to have a direct impact on the individual's help-seeking and coping processes (Sihre et al., 2019). Bar Zaken's (2020) study shows that culture shapes the psychological pattern of motherhood, although the study did not say how. There appear to be cultural and religious beliefs around SMHI. As reported by some participants, their culture does not support the existence of mental illness. Their cultures and beliefs were not generally discussed openly among participants. It was also observed during data collection that people were able to correlate the impact culture and religion have on women with postnatal SMHI. Most of the participants mentioned that severe mental health issues are a subject that is not openly and generally discussed, as illustrated below.

‘’l think speaking about it openly should be advised we should be talking a bit more. Yeah, be honest with how you are feeling’’ (P6, 335; 77-82).

This indicates that health professionals rarely mention severe mental health disorders.

.. ***‘’*** *So, I think the biggest variable is that people just don’t understand and maybe they don't even believe it* **…** *For somebody to understand. Because every time I explain to my in-laws, you know, they’re just like oh it’s all psychosis, its psychosis, it's not real, it's not real. But I think for somebody to understand that, to me, this is real’’ (P3, 309; 272)*

These beliefs and assumptions are attributable to culture and religion.

‘*’Yeah, I don’t think, unless you’ve actually been through it, I don’t think you would ever fully understand it. And I think there's a lot of cultural issues as well for example my in-laws, I’m from ……, and they have come they think there’s nothing wrong with me and they said to me, oh, well, these things don’t happen in I…… and I was like, I’m sure they do, but you guys just tell them that they are crazy or I don’t know to lock them away or somewhere. I don’t know what they do’’ (P3, 285-290).*

The first response illustrates that the word ‘psychoses could be forbidden or a taboo in the context of mental illness for some cultures and is not yet acknowledged as an important issue. The second and the third quotes demonstrate the misconceptions and beliefs around SMHI. Interestingly, the last response pointed out the deep cultural issues around SMHI, and how the community feels and treats people with SMHI.

…….’’so l was worried about the baby, the baby crying, everything was just starting to build upon my mind and,…….And people calling me like to see how I ...And everybody kind of like just stressing me out, trying to check in a good way. But for me, it was ..... the worst thing that they could be doing because I was having enough in my brain. Eh mm, so that was …… mm it was fine that everybody trying to help, but I was getting more protective of the baby’’…. (P4, 85-93).

The above response was in relation to a checking culture, wherein people are constantly phoning or visiting the mother and her new baby. The above participant still recognises that it is part of her culture but was too tired and became overprotective of her child.

''So, then what happened is that lots and lots of visitors were coming and I do not know if it's the same in your culture but there's a lot of people that want to come to see the baby'' (P 03).

Some cultures have a particular way of receiving and celebrating the birth of a newborn baby. The participants could not comprehend the number of visits due to their SMHI and feelings. This could act as an influencing factor in terms of their experiences.

6.2.1 Religion

Religion has been a pillar that people rely on or turn to in times of need. For example, religion has been seen in one empirical study by Oman and Brown (2018) as one of the first resources that people and their loved ones turned to when faced with SMHI. In addition, it is claimed to be useful in coping mechanisms and reduces the severity of the symptoms of SMHI (Tepper et al., 2001). The participants in this study also reported that prayers sometimes helped them with their SMHI, although one participant was worried about finding time for prayers:

***…''** But there are some days I struggle with my prayers. Because I'm a …, I converted religion into ... Because I'm a …, I have to pray … times a day. Now that I've had my baby, I do struggle to pray on time. Say it's prayer time now, he'd be crying for a feed, he would cry and then I would feed him. It takes an hour. Then I go and pray. ………It's just my prayer that gets delayed'' (P5, 203-206).*

… ''I didn't seek help when I should've. I think because I had this realisation in my head that I had reached the spiritual state, and then I was a bit anxious initially because I thought is this what happened last time, or is it not? I did think it was just a spiritual experience. So, I thought I didn't need to tell anybody this time.

Spiritual experience, it doesn't need any treatment from the psychiatrist, I'll be absolutely fine but then when it got to day 14 l thought right, I need to tell somebody now (laughing)'' (P3, 210-218).

The above two quotes are an account of participants suffering from SMHI and relate to the following:
- Misconception of their SMHI and how they apply it to religion and use religion as a coping mechanism, and
- Dealing with religious delusions due to the experience of spiritual auras.

The implication of this is that faith is both a help and a hindrance to accessing help at the right time (Mohr et al., 2010).

Well, I wasn't coping at all. So, I, I probably had the luxury that my mom, she came from my country to support me for the birth (P8, 259-260).

To some women it is their culture that their mother will come and stay with them for some time after childbirth.

And also my mom and dad, so extended family, they come up and help as well and like when R…. in nursery nearly a full time. But they would come up (P10, 319-320).

6.2.2 Stigma

Motherhood and schizophrenia are gaining significant attention in mental health settings, although not in the broader public, except for stereotypes of the mentally ill, which are still prevalent (Fox, 2004). In addition to experiencing many negative emotions, participants who are stigmatised may also feel unwanted and stigmatised by others. Most of the participants in this study were subjected to different sorts of discrimination and all experienced stigma in some form including discrimination, isolation and labelling.

At one interview, a participant said….

….*''I think there's still such a big stigma around mental health and women talking about it. l think, even,.., if midwife having that experience around mental health, and…., understand and picking up early warning signs, you know, that's something isn't quite right with that lady'' (P6, 282-286).*

A major concern from hearing the above response was that professionals are not conversant with the signs and symptoms of early relapse in women with a diagnosis of SMHI. Identification of the early signs and symptoms of SMHI has been advocated by NICE (2014) as an issue that needs attention. Therefore, medical professionals require more training in the identification of the onset of relapse, to assist participants with SMHI gain early access to care management. This is demonstrated by the following quote from the participant:

…….'' *l think that makes you more stigmatised as well… because you feel like almost all GP are saying that am putting my baby at risk…. they were not thinking about my wellbeing as well……. l think that really didn't help with my mental health because that makes me feel like l wasn't being a very good……. you don't understand about the medications……that just makes you feel stigmatised, and you feel like you're being judged before you really gonna have chance to be a mother……. the assumption that if you get pregnant,.Should put the baby first straight away before they are even born….I think being made to feel like prioritising my mental health is a bad thing for the baby''…. (P2, 140-144).*

The above reflects the experience of participants with SMHI and the feeling of being stigmatised by healthcare professionals (institutionalised stigma), or the baby could have been at risk. This form of stigma may endanger patients, decrease the quality of care, or increase barriers to accessing good quality care. Glover et al. (2014) describe women as feeling judged by others, which may explain why women often tend to conceal their experiences and, in some cases, possibly create an image that all is well.
Most participants experience stigma in different forms.

…….''People have always told me "S… you're ill, you're going to find it very hard with babies. This is a baby no. …, you're going to find it really hard with your babies, you've just had a baby,…you've got a house to run, you've got to look after yourself, you've got to cook, clean' you've got a husband, you've got children, you've got a lot on your plate… The way people had said I am going to find it really hard coping (P5, 261-269).

The above statement is an example of social stigmatisation and demonstrates that women with SMHI may be viewed as unstable, although these women have a different individual attitude towards motherhood and SMHI.

''And it's only since gone into the hospital that I've felt okay about that. And I'm able to address it as an illness. Because before that, I thought that I was just weak because I wasn't coping,. So that being in hospital. I mean, it's helped in a lot of ways, but one of the most important things for me is that people (in hospital) do say, you know, you've been unwell, you know, and just because it's a mental illness, it doesn't mean it's any less important than if it was something physical'' (P 07).

The above response details the participant's experiences with healthcare experts' careful use of language in a mental hospital setting to mitigate the stigma associated with labelling (medicalisation). Labelling differences are a core pillar of stigma since they facilitate the identification of characteristics or behaviours that are then stereotyped and become grounds for discrimination. (Link and Phelan, 2013). In addition, this is also about the loss of identity and becoming invisible. For example, the person becomes invisible as soon as the baby is on its way, as all efforts are made to benefit the wellbeing of the baby.

''I had a lot of feelings to deal with around guilty and stuff and then l imaging a lot and my mind feel guilty, then the more l feels guilty the more l feels anxious'' (P 09).

In order words, the above quote is from someone blaming herself for her ill health. Additionally, it might be viewed as an internalised stigma. According to Sharaf et al. (2012) and Boyd et al. (2014), self-stigma occurs when patients embrace the stereotyped image of mental illness, anticipate public rejection, experience discrimination, and underestimate themselves as valued members of society.

P 006 went on to reassure herself by making the following comment.

‘’To have the confidence to ask for help, no one's gonna judge you…. not going to think of anything bad, no one's going to take your child of you’’ (P 06).

…’’ Yeah, when I was going through it, it wasn’t fine. The way I was feeling, nobody could understand that nobody could relate to me, and I was getting quite angry with people’’…. (P 07)

The first reaction (P 06) reflects how women with SMHI may self-stigmatise. Another kind of stigma is feeling excluded or isolated. In the second and third responses (P 03; 07), the participants described their encounters and how people with SMHI are perceived and treated differently from people with other illnesses. However, those with different health concerns face comparable stigma issues. For example, individuals with Type 1 diabetes, as well as those with other chronic illnesses such as cancer, also face stigma (Rose et al., 2021; Hamann et al., 2014). All of the above examples act as a barrier to care, hope and recovery.

6.2.3 Access

Some of the participants were concerned about awareness of understanding of perinatal mental health services (PNMH) and how these services might be accessed and made known to other women in their communities. The most frequently mentioned topic among the participants was access to information and care. During the discussion, one person was asked what she hoped would have been useful during this time.

….’’ if my original midwife have passed on kind of my record, but they should also marry up with mental health records, …….and I should have been under …. Psychiatric care and prevented it…., with G... just like we have now…. l think that come on leaps and bounds the mental health side of it, because that l was put into a clinic with CPN and …. The gynaecology work together. So,., this time around has been Worlds Apart……. but the main thing that could have been improved was the care that was given’’…. (P6, 117-127).

This statement represents the importance of information sharing, which facilitates effective and timely access to care. The participant also compared the previous and current experiences of care received, which was of importance to her. Another participant discusses hard-to-access mental health services:

….'' there is a lot of waiting time and it's really hard to access mental health services…… since becoming pregnant the perinatal mental health team has been really……. supportive, and so l think that experience has been really good actually'' (P2, 60-63).

….''It's like hope like it helps…. to know who you have to reach. I think is the difficult part''…. (P 004)

The fear may have come from previous experience of being unable to access PNMH care and from not knowing whom to contact. Not having access to services may worsen the condition for which help is required, other factors may be considered in impacting on the availability of access. It gives patients hope to know that they can access care when it is required. Another participant who faced difficulty accessing mental health services stated:

….''I was lucky to get a bed not everybody has, l cannot imagine being on a different ward''….(P 009)

The above response described how accessing the mother and baby unit (MBU) may be difficult and that this can mean being admitted instead into a general mental hospital. The MBU is an essential part of the continuum of service for women with SMHI. Most participants in this study had experienced both the general mental ward and MBU and recognised the differences between and the impact of both on their hope and recovery.

but I'm so grateful that actually such a service exist because it was like they saved me. And I didn't see any light at the end of the tunnel (P8, 96-97). Having people help and maybe even the health visit, was explaining that before call that they would have come in to see (P7, 284-285)

The above expression was a positive experience as the participant recognises that sometime there may be no beds available for admission following relapse. She was able to access services and was pleased.

6.2.4 Covid 19 impact

The Covid 19 epidemic had an extensive impact on access to hospitals, which was especially restricted for visiting loved ones to provide support and connection. All of the participants in this study experienced some level of impact on their mental health, access to services and support. A few examples are below:

Covid 19 impact

The Covid 19 epidemic had an extensive impact on access to hospitals, which was especially restricted for visiting loved ones to provide support and connection. All of the participants in this study experienced some level of impact on their mental health, access to services and support.
When the interviewer asked the questions, the following answers were received:

In terms of your worrying ….do you have support? [Interviewer]

……''Well, it's difficult at the moment with covid… I would normally have eh …. quite well, lots of family support……. it makes…. you feel like you have missed out a lot… from having normal experiences of having my F. baby…… l feels like if there is more thing in place around covid and…… motherhood. I don't think there has been a lot of taught going to how isolated…. new mums can feel eh mmm if there is a lot of things into the roles''… (P2, 33, 35, 47, 127-129).

The effect of Covid 19 is isolation, limiting the majority of women's access to support.

…..'' There's not really anywhere I can go, I can't go to anybody's house because of the lockdown. And then my husband wasn't allowed on the ward. I wasn't allowed any visitors on the ward''…… (P3, 409-411).

The impact of Covid 19 which resulted in isolation for most participants, restricting partners from staying with women and their baby in hospital.

….''I think as well if my partner would have been allowed on the ward, although near the end like he was allowed in but like at the start of my stay though……And I think that would have been good to kind of settle me in more.''' (P 10).

The above comments refer to hospital restrictions that were made mandatory following government rules on Covid 19. This means that only one birthing partner was allowed to visit the hospital.

….'' I think anxiety at the moment going out to places makes it worse. I think is….because of covid''… (P2, 376).

These Covid 19 restrictions impacted the participants in different ways and created a barrier to timely care.

..Have those extend kind of make sure that those services are available for other women and eh mm, if wouldn't for my partner… (P6 306-307).

6.2.5 Perception and attitude

Women have different views of their mental health issues regarding motherhood, including both positive and negative views which could affect attitudes to motherhood. There were various perceptions and attitudes held among the participants concerning how they were coping and what was happening around them.

….. **'***'feeling. ... like kind of fear of responsibility, that kind of trips me off. Like…. knowing that he depends totally on me is like it's a little person that you have to look after and yeah like yeah. (P4, 99-102).*

Some participants experienced challenges related to motherhood which caused them concern; indeed, most were afraid of the responsibilities of becoming a mother. The distress of trying to adjust to the motherhood role was therefore difficult to cope with.

….'' *with this baby, we work very closely with doctor ……, and psychiatrist was called and… a plan was put in place….so, the two times I've been unwell…. that's my…. reality, Yeah, so, if l hadn't had a baby l wouldn't have been unwell. Yeah, l think that there's an element of that''……. (P6, 67-69).*

The above quoted participant believes that working with professional improved her experience, but also had the perception that childbirth had contributed to her SMHI.

……. *It's like feeling…. if I was drinking, I was like a failure…. is like that… feeling starts to build up…. was noticing my body almost…. protecting the baby, and I kind of like working like a ROBOT (P4, 154-156, 164).*

Having negative thoughts as a result of SMHI could affect the way the participants behave and think about themselves and the world around them. Some participants continued with their activities despite their perceptions and attitudes toward motherhood, as seen in the following responses:

''……I struggle with my time…. he stays away quite often, speaking with other people that their babies sleep through made me…. kind of like…. really bad, I wish my baby would sleep a bit made me frustrated''…. (P4)

……*Yeah,…… it definitely makes things harder since I have given birth is just a worry about whether l will be able to have support***…….***Some days, l just feel l can't do it at all, eh mmm l think like l wish eh mmm…..it sounds awful but some days you feel like l wish l never have baby l can't do this (P2, 56, 223-224,).*

The challenges of having a baby have resulted in both negative and positive thoughts. Participant presents her baby's sleeping pattern as making her feel frustrated, which impacted her motherhood experiences, and P2’s perception of her struggles shows that childbirth has made her situation harder in terms of her motherhood role.

…….’’so, after l had her, I've had a bit of a breakdown, and l have gotten more and…. more anxious. And then, said that I couldn't do it. I didn't feel like I could… do it’’…. (P9, 20-22).

The above response is how the participants express their challenges of having a baby while coping with SMHI.

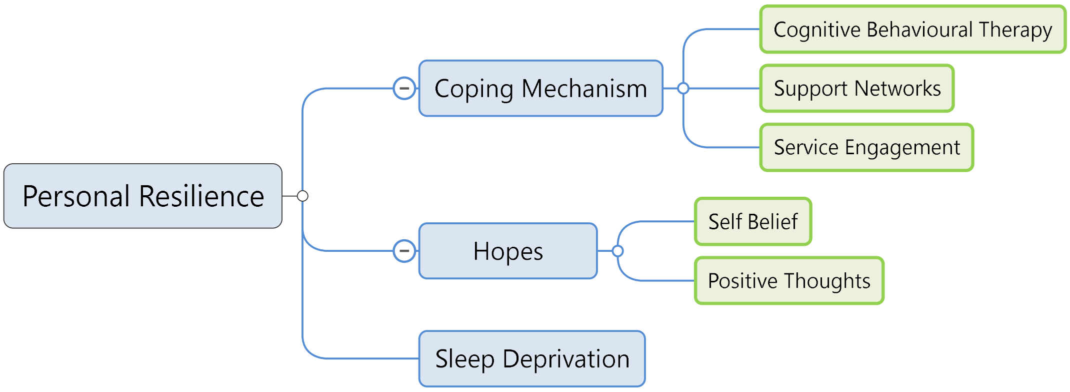
……’’And then that slowly started to turn into just fear, but fear of I just didn't want to do it anymore. I didn't want to exist anymore. And I was really scared that I had that feeling so strongly, because and I couldn't imagine ending things, but I knew I just didn't want to be here, so I felt trapped’’….(P7).

This is one of the stronger negative perceptions, which possibly influenced the motherhood experience and acted as a barrier to seeking help.

….’’I just wanted to be gone because I couldn't provide anything to…. I'm like, why, she's gonna, going to be better with somebody else……it comes up to the point I couldn't sleep. And then at that stage, I was adamant, I should give up my baby for adoption because I couldn't look after her. Then somebody else it's going to be better to look after her, either have to give her for adoption or have to like basically kill myself’’…. (P8).

The above response was a strong negative perception during a participant’s breakdown. Her experience, thoughts and perceptions could act as a barrier to care or help-seeking.

Figure 6.3: Major Category 2: Personal Resilience



6.3 Personal Resilience

Personal resilience in this study is the true account of the lived experiences of women with a diagnosis of postnatal SMHI in motherhood. Motherhood gives women a sense of self, particularly self-esteem, and judgment of one's worth (Liu et al., 2020).
These are demonstrated below:

6.3.1 Coping mechanisms

The coping mechanisms in women with a diagnosis of postnatal SMHI are those strategies employed to help manage SMHI and motherhood. The further subcategories under coping mechanisms are cognitive behavioural therapy, support network and service engagement. Several coping mechanisms were adopted by participants in this study such as seeking support from family and friends, services including the use of therapy such as CBT, and self-support methods such as walking, and listening to music. Some of the statements of the participants are below.

…. In terms of coping…… is there anything else you do to help you cope? [Interviewer] …….''So, I'm using the CBT techniques that I learned the first time…. So,….. I know some mindfulness, like deep breathing and meditation…….

when I get really angry or really anxious, I try to just take a few steps back, you know, do some breathing exercises, use my CBT techniques and that really helps me calm down''... (P3, 355-359).

When the following question was asked, these were the answers:

……. What do you think must have helped you cope? [Interviewer]

…… calm down like a warm bath. And like listen to music and sometimes if I repeat the song over and over again, I won't feel poorly again really'' (P1, 90-92).

..... With all ……how does this help with your emotions and feelings? [Interviewer]
……'' the work l have been doing with the psychologist has been really useful and that really helped eh mmm my confidence…. but More recently I have been doing… cooking just hobby craft''...(P2, 104-106, 120).

Most of the participants were using whichever form of coping mechanism therapy worked best for them. All participants also had a support network. Thus, it has been shown that women with a diagnosis of postnatal SMHI use different coping mechanisms, such as CBT, mindfulness, and other therapies such as warm baths and listening to music, among others. Therefore, coping mechanisms have been demonstrated to have a positive effect and to help with the recovery process.

6.3.2 Support networks

Most participants report receiving support from family and close relatives because they are close to them and understand how they feel. Other support from services such as the PMHT were positively viewed by the participants, who demonstrated that having a good support network helped in their motherhood journey during the postnatal period.

...'' Yeah, you see, I've got a good supportive network....I've got a husband. I've got my mam and dad. I've got my nana. I've got my brother and like my in-laws. They are all supportive so like if I need to talk to someone, I've got them to chat to. I have got my CPN nurse''.... (P1, 84-88).

participants in this study have a support network that works for them. Another participant quotes that.

.....'' I've got very good network around just so me and my partner now''.... (P6, 173).

The participants articulated their great need for a good support network during the postnatal period due to having SMHI, as demonstrated in the following:

....'' during the lockdown, my brother, my sister, grandparent and my parents were dropping off shopping things like that''.... (P2, 118-120).
The above participant was able to make use of her wider support network despite the covid 19 restrictions and was able to receive maximum support.

Some women received help from family during Covid 19 while maintaining their support network.

.......'' support from my husband. Support from family.... the two main things: medication and support....... Yeah, My sisters, do support me. My mum does support me. And when I say support, what they give me is listening to me. Like if I were to feel down or something or if I feel like I'm falling ill, I talk to them. They listen. That is what I get. I don't get any physical support from them like coming to my house and cooking any food, I don't mean that type of support'' (P5).

The above quotes clearly state the type of support participants received from wider family during their motherhood journeys. This support for the mother role was not physical; rather, it included emotional and listening support, including reminder to take medications.

6.3.3 Service engagement

Service engagement is a process that may impact the level of patient care and developmental factors. Not all participants continue to engage with the service after treatment.

This applied to some of the participants, as discussed below:

…….''the mother and baby unit, having seen the CPN they've been brilliant. They could not have been more supportive as they have. **…..** *Traumatic, traumatic but positive in terms of the service I've received was absolutely fantastic'' (P9, 166-167).*

The above perception and attitude represent how individual participants respond to their experiences of service engagement. Despite the trauma and experience, the quote expresses the positive support received from professional input following engagement.

…….''*Since having psychosis……. what has helped is having the nurses there that I felt comfortable with? And so, I've actually been able, to be honest about how I've been feeling and what thoughts I've been having'' (P10, 280-282).*

………'' *eh mmm l have done some work with some psychologist with the PNMHT.. So, we've done some…., where she's recorded me interacting with (baby)……. and then we have looked at the positive aspect of that, that is really, really helpful because is just nice to see it'' (P2, 71-74).*

Service engagement requires trust to build confidence, as in the case above.
These quotes show positive experiences which give hope to the participants and increase positive outcomes.

…….''I'm trying to apply the things that the psychologist told me, would before I wasn't listening, but she said is okay, like'' (P8).

This comment also represents the participant’s engagement with the services, her perception thereof, and the encouragement she received. This demonstrates that services can be most helpful to women diagnosed with SMHI in the postnatal period and motherhood.

……… ‘’l think is kind of having those all conversations in and if you build that rapport with that lady over time, you know she will share, those honest feeling that you though kind of building that rapport from the beginning and having that relationship with the woman because you did see them from 6 weeks right the away through’’…. (P6).

This comment may be understood as reflecting a positive outcome of the participant’s experience of engaging with services, where a rapport is established between the service provider and the participants.

When the following question was asked about services users’ engagement, these were the answers:

so…. asking whether you have heard about them, the services [interviewer].

…. ‘’I didn’t know about the perinatal mental health team; my health visitor was not ……, she didn’t ask how I was feeling afterward’’ (P9).

Some of the participants were not aware of the services which were provided or available during pregnancy and in the postnatal period, as demonstrated above.

…..’’Probably for all other women, you know, who have had psychosis in the past may be worried throughout their pregnancy, Oh my God, what’s going to happen? Try not to worry and just keep a positive mindset and engage with services, be honest with your feelings and I think honesty is the key. I think a lot of women will shy away from it because they are ashamed or embarrassed by it, l think speaking about it openly should be advised; we should be talking a bit more. Yeah, be honest with how you are feeling’’ (P6).

The above quotes indicate a positive experience of utilising the service when needed. Why some participants are unaware of the service and, therefore, whom to contact should be addressed.

.... ''It's like hope as it helps. It's just to know who you have to reach. I think is the difficult part'' (P4).

...''l thinks help from Mental Health Services has been fantastic. Eh mmm, l think before l was pregnant, there is a lot of waiting time and it's really hard to access mental health services……. there is always somebody who is on to speak to, or the reception is just, brilliant'' (P2).

Access to mental health care empowers and brings hope to women.

....''because I was feeling just so low, we spoke to the mental health crisis team. And I just feel and then we saw my GP and I just feel like, along the way, there were so many people that we were in contact with. But I felt that if, if I were if my partner and mother-in-law weren't, they push me the.... like to push further for extra support. And to get that meeting with Dr.... And I do worry that I may never have the support that I needed'' (P7).

The above experience was a near miss, a situation which arose due to poor communication between professionals and poor identification of the previous episode, resulting in inadequate support from the service providers.

''And literally like they gave me hope back. So that was amazing that that service existed…… I built it up confident, and then with those systems of. like doctors and staff there, for the first time, I felt that a moment, I can actually look after her, and like, slowly rebuild a bond, and then I've tried to, basically rely as minimum as possible on the staff just to build up that confidence.... but I'm so grateful that such a service because it was like they saved me. And I didn't see any light at the end of the tunnel, I am mad like completely mad like nobody else is going through the same'' (P8).

The above-cited quotes express the restoration of hope, confidence, and recommencement of the mother role, which was the result of service engagement.

6.3.4 Hope

Hope is part of the second category, which focuses on self-belief and positive thoughts as the cornerstones of hope.

……’’.l hope to recover from these things and have l don’t know eh mmm l would…… say to have a normal experience but l don’t know what normal is really, but eh ...mmm l think is probably what l have to live with but eh mmm yeah just recover a .....bit, yeah to feel more confident’’…… (P2, 63-66).

Some participants had experienced recovery, accepted their diagnosis and were positively reassured hoping to get back to the way things used to be.

....’’so, then..... women who actually tell their stories, the amount you have in common with it is just, it's unbelievable, but it's so important. .... you think Well, yeah, it's an illness that people have, and you can live with it and you can get through the tough times’’... (P2, 399-402).

Is there anything that ….say to other women who have the same problem? [Interviewer]

……‘’I would just say it is going to get better and there is light at the end of the tunnel. So, it may seem like, you're in this horrible, horrible position and like you’re never going to get out and it's all dark and gloomy, but I would just say to other women that there is light at the end of the tunnel, and you do get better’’ ....(P3, 431-436).

6.3.5 Self-belief

Self-belief is a positive attitude towards oneself. Some of the participants believed in themselves during their recovery process.

..... ‘have the confidence to ask for help, no one's gonna judge, you're not going to think of anything bad, no one's going to take your child off you’’. (P9)

Self-belief gives hope and encourages people to ask for help, as reflected in the above response.

‘’....and I couldn't picture myself as a mother, couldn't adapt or probably like the shock so what the psychologist was saying probably you were just stressed, and at that stage, everything to me was a big problem even like the smallest things that l can see people like small challenges during the day everything seems a massive problem that I cannot handle’’. (P8).

The above quote represents a contradiction of hope, a feeling shared by some of the participants. Other participants who had recovered felt much more strongly.

When the following question was asked, these were the answers:
What are your strengths there? [Interviewer]

‘’*....., I mean I think postpartum psychosis, makes you stronger. Like going through all that, if you’re able to go through all of that then you know, with your baby as well, with looking after your baby, it means that you've done a lot more than any of the mothers could have ever done. You know, it's such a difficult time. It’s a traumatic experience actually, to be honest with you. To be able to do that and manage a child I think you should just be very proud of yourself’’ (P3, 450-455).*

6.3.6 Positive Thought

Most participants had some positive thoughts which motivated them.

‘’....so engage with... services which l didn’t in continuity…..... Just kind of kept that positive mindset that I will be okay……. but absolutely over the years it has been stock ... . l tries not to worry too much about, and l haven’t worry throughout you’’ (P6, 136-141,186-187)

''.....yeah but the work l have been doing with the psychologist has been really useful and that really helped eh mmm my confidence'' (P2).

Some positive thoughts from participants occurred because they continued to engage with the services.

''…….To be honest, I'm enjoying being a mother and she's a really like, cute and content baby, so I have no reason to''... (P8).

Participants were pleased with their new-borns, which was bringing joy and giving them hope.

6.3.7 Sleep deprivation

Almost all the participants were worried about poor sleep and its effect on their SMHI and motherhood challenges.

….''sleep deprivation and by day four l was really, really unwell,.. l had a C/section. So, I slept the night before; sleep deprivation is the main trigger for my illness'' (P6, 93, 156-157).

……How do you think things have been going? [Interviewer].

…'' *l thinks the lack of sleep……. sometimes doesn't help my mood, l just feel generally exhausted……. eh mmm I try to get as much sleep as l can'' (P2, 230,-232, 254)*

Most of the participants considered sleep deprivation the main trigger of their SMHI in the postnatal period.

''*That was really tiring, I wasn't getting any sleep. I was sleeping about maybe 2-3 hours a day'' (P3).*

Tell me about the experience you have had since you gave birth? [Interviewer]

''So yeah, the sleep deprivation was a big, a big problem…. I just couldn't sort of see the difference between the days and the nights; we were just trying to grab sleep where we called it that just felt I wasn't getting any, any sort of house jobs done, and things would just build up''(P7).

Some participants have mentioned sleep deprivation as one of their difficulties, which may prompt hospitalisation.

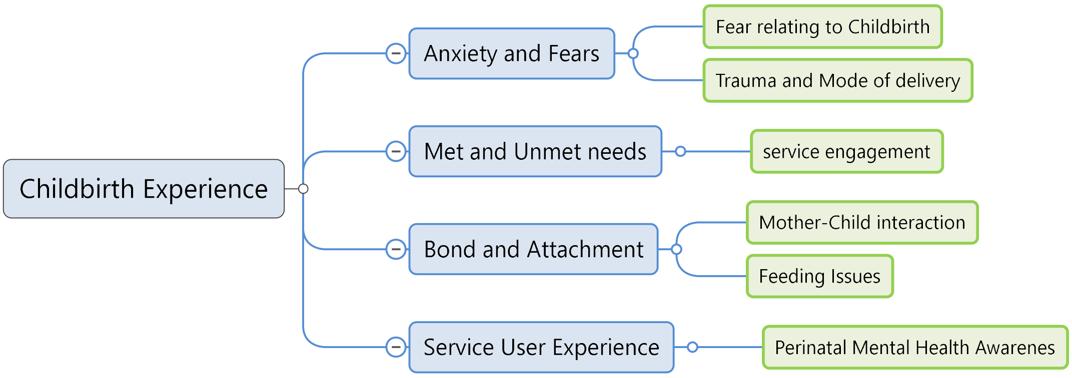
''coupled with giving birth naturally and sleep deprivation… by day four l was really, really unwell. At home is a burden along with my sleep deprivation and l assumed absolutely that contributed me having postpartum psychosis'' (P6).

Most participants experiencing sleep deprivation and its impacts tied getting rest whenever they could.

….''l am level headed on how l cope, eh mm you know, by understanding the….. illness kind of being aware that if I've had a bad night, or if I've had broken sleep …… that I had to go to sleep. I have to have a nap'' (P6, 189-191).

6.4 Childbirth experience

Figure 6.4: Major Category 3: Childbirth Experience



6.4.1 Anxiety and fear

Anxiety and fear following childbirth could relate to childbirth, trauma and the mode of delivery.

…''Well, it's like the feeling that I was having, all the worries and things it's like…. is what triggered my feeling of being unwell because it was a lot of emotions…. in there, that was difficult to handle, a lot of anxiety, a lot of worry of new things…. Realising that l have a new baby, a lot of its responsibility…. Instead of……just relaxing. Somebody has to do it, from pregnancy. It is scary'' (P4, 230-234).

The fear of care responsibilities and being unwell increases anxiety and fear.

…''so now I feel like all though l think, things don't just disappear, and mental illnesses don't just get better overnight. And then some days, I do feel, I feel it's like a black cloud, that's how I describe the depression, I feel like, it's got the potential to overtake and to be stronger than I am sometimes'' (P7).

….''so, I slept the night before sleep deprivation is the main trigger for my illness or one of physical trauma so having that pre-plan C/section eh mm, and not giving birth eh mm, you know naturally basically the two experience is worlds apart eh mm, we had a lovely time you know, coming home and having that experience at home'' (P6).

The above quotes illustrate two experiences wherein the participants are fully aware of how to manage their situations, such as how having a planned operation was helpful.

What do you think makes the feeling worse? What do you think may have contributed to these experiences? [Interviewer].

… ''I guess I was unprepared for the C/section… well that C/S was really bad, I don't know that that was like really bad. I know why they have to do……the fact that l had emergency C/section contributed to my anxiety and being anxious'' (P4, 173, 273-274)

Trauma following childbirth has been shown to be a trigger to worsen mental health issues (Sharma, 2018; Sharma et al., 2022).

6.4.2 Unmet needs

Some of the participants expressed their unmet needs as anxiety and fear related to childbirth, in terms of what would happen during and after delivery; how the professional would see them; whether they would be judged and how they would be able to cope with their babies.

…‘‘*First time when l had G…eh mm, the part of need that was not met is the.....care the continuity care, that they took it down as neurology instead of a psychiatrist as well….. and then this time, ... with G… not getting the right medical care, so, eh mm, that's a huge thing in failing in information sharing'' (P6, 315-316).*

The above response identifies the negative and poor experience of unmet hospital needs. Other participants stated the following:

‘‘l worried sometimes if l am asking for the help am failing and you know admitting you need help eh mmm l feel like is failing almost'' (P2).

What do you think makes the feeling worse? [Interviewer]

…‘‘*well, that C/Section was really bad, I don't know that that was really bad. I know that was what they have to do…..but is gone on like instead to have… the joyful moment of him arriving. I was too stressed with my mind somewhere else now; l wish l will… have to... not a great way to start with……The postpartum time was a little bit…. more difficult more like you have to crack on with your stuff…. is like you just sign up for this though… which is fine'' (P4).*

6.4.3 Met needs

One woman's needs were met including receiving support from family and professionals, expediting recovery while building confidence to assume the responsibilities of motherhood.

''… *I've got very good network around just so me and my partner now…..so, yeah, kind of having that support networking, being a team kind of and…..eh mm, doing together'' (P6, 173-177).*

Working with the professionals also proved helpful in restoring confidence and meeting the needs of the participant quoted below:

''The mother and baby unit, having seen the CPN they've been brilliant. They could not have been more supportive as they have''. (P9)

''So, l have done some work with some psychologist with the perinatal mental health team…, we've done some ……., where she's recorded me interacting with (baby)……. and then we have looked at the positive aspect of that, that is really … helpful because is just nice to see it'' (P2).

The above response indicates one of the met needs for fulfilment of the motherhood role by engaging with professionals.

''having a session with a psychologist still from the ward'' (P8).

It was also found by P8 that engaging with professionals helped them.

…'' So, we thought this is brilliant because we've got that care this time so, eh mm quite unfortunately that our record wasn't shared so'' (P6).

6.4.4 Bond and attachment

‘‘l will be doing…. kind of things that l expected the team there was kind of encouraging me like l do things to... like bonding with baby and they kind of taking video of me’’ (P8).

The idea of video recording mentioned above by the participant, was intended to help women interact with their babies and proven to be helpful with the emotional wellbeing of women diagnosed with SMHI in their motherhood journey.

‘‘So, l have done some work with some psychologist with the perinatal mental health team. So, we’ve done some eh mmm …., where she’s recorded me interacting with (baby)……. and then we have looked at the positive aspect of that that is helpful because is just nice to see it’’ (P2).

Here, the video recording of mother and baby interactions was also commented on by (P8) as having a positive effect.

‘‘Didn't get to bond properly with him with me being poorly until he was older’’ (P1).

The above indicates that bonding could be a problem following relapse.

‘‘…. But then I was trying breastfeeding as well at that time. So even with all of that l did find those first few weeks easier than how they got…., even though everything was new, and it was quite …. Obviously stressful in a lot of ways’’ (P7).

The above quotation expresses some of the challenges coping with the situation.

….. ‘‘so, we have missed out on a lot of things. I think… you know, looking back within one sense you know if somebody says you won’t be unwell ……..of course, that isn’t you would chase how G…bond have been affected. But yeah, it was traumatic’’. (P6, 161-165).

The above again highlights the delays in child bonding and attachment although the participant was ultimately able to adjust to motherhood issues or challenges.

‘‘the fact that my baby was losing weight and I couldn’t breastfeed because of pressure from my mum to exclusively breastfeed so l thought that contributed towards it as well, and the lack of sleep as well. But to be honest with you, this time, I don't know what contributed to it because everything was going so well. I didn’t expect it’’ (P3).

The above quote describes the breastfeeding issues that can be experienced by some women, as well as the influence and or pressure that can be exerted by family and relatives.

Data saturation

The saturation of data can be affected by a number of elements, including investment of time and resources (O'Reilly and Parker, 2013). In contrast to a larger study, a smaller study can reach saturation more easily. Thus, it is important to maintain a sense of flexibility and be pragmatic while accounting for all categories to verify the similarities and connections between data through analysis. This means that, after the data have been repeatedly transcribed and analysed following the GT analysis method, no new data are produced. The criterion for determining when to stop sampling relevant to a particular category is the category’s theoretical saturation, which means that no new data emerged from the data, while the categories have been identified. Although the postnatal experiences of women with SMHI could be similar altogether, there will always be some degree of variation in how those experiences are interpreted.

This study is based on data from different ethnic backgrounds, guided by similarities and contrasts (Dey 1999), and saturation was deemed to have been reached when the same comments were heard repeatedly. According to Bryman (2012), data collection and analysis are combined based on a grounded theory perspective, as opposed to being considered separately as a sequential process. Therefore, data saturation is defined as the point at which no new codes were generated throughout the coding process (Urquhart, 2013; Birks and Mills 2015; Olshansky, 2015). In contrast, Urquhart, (2013) and Birks and Mills (2015) define saturation as the end of the analysis, not the accumulation of fresh data. The data saturation is depicted in appendix 5, which illustrates how it was achieved through interviews and the probing of interview questions. Figure 6.5 illustrates how saturation occurred in this study. Each code indicates an individual’s interview responses, where the data were the same or similar.

Each category corresponds to a participant (P), while the number refers to the coded data. The second category (personal resilience) is the main category that forms the model of the study. This is because each numbered data point represents the perspective of the participants. The ten participants' opinions are similar to those in each code, meaning that no new information was generated because the data provided by each participant reached saturation. Motherhood and severe mental health issues (SMHI) require a distinctive concept to build confidence. This concept is usually ambiguous and may confirm the status quo. This thesis suggests that a new approach to motherhood and SMHI is necessary to create the fundamental components of daily social life in response to resilience-led behaviour. This constructed model thus facilitates future research. The process of developing the model presented in the study took into consideration the specific reality of each participant.

Conclusion

This study suggests that the experiences of women with SMHI during the postnatal period constitute a resilience-led behavioural process that was employed by the majority of women in this study in order to maintain social control (particularly through the acceptance and evaluation of their progress or by not falling ill). This was achieved by developing resilience in new concepts, maintaining a positive attitude, and recognising one's own capability in any given situation.

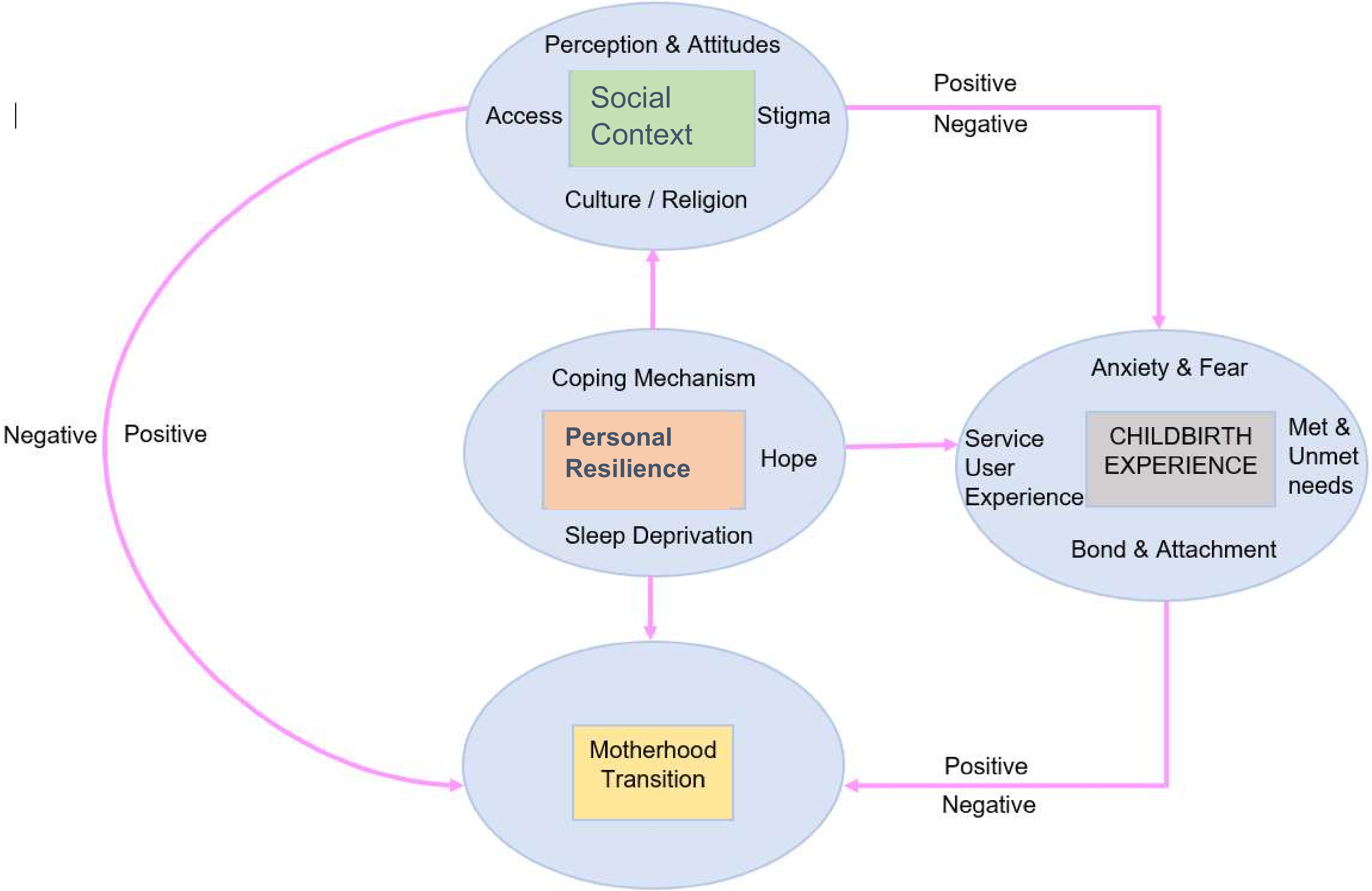
In light of the study's analysis, the dynamics of developing resilience appear similar to the concepts of coping which allows the individuals/participants to move into motherhood spaces. The participants in this study used resilience as a tool for regaining control over the motherhood transition by utilising their support network, education and available resources to reduce hurdles, such as isolation, that could be a hinderance to regaining the motherhood role.

The 'Resilience-led Behavioural model'

The findings from this study have created new and original knowledge by proposing a framework for modelling personal resilience. This theoretical framework was used to obtain information on women's postnatal experiences with SMHIs in relation to motherhood.

The purpose of the model is to bring structure and clarity to the context around mothers with SMHI that may appear ambiguous in the real world (Griffith et al., 2013). Theory assists in the practical recognition of what works by giving time to apply flexibility, as each woman with SMHIs' resilience is based on her strength, how she copes with her motherhood role, and her support networks, as well as how she interprets and responds to the things around her. Theories are used in studies as an approach to influence the consideration, planning and development of activities that will influence complex behaviour. Progression then occurs as a result of the construction and testing processes. However, theory is not always applicable, necessitating the use of flexibility and initiatives. The main objective of grounded theory methodology is to generate theory around a set of fundamental emergent categories that capture the essence of occurrences, as well as their similarities and differences in the data (Corbin and Strauss, 2008). The current study demonstrates that enhancing support during the postnatal period helps in the management of women with SMHIs.

Figure 6.5: Resilience-led behavioural model (RLBM)



6.5 Theoretical model

It is important to summarise the research findings and expand the argument to create a model for women with SMHI in relation to motherhood during the postnatal period. Stigma creates fear and doubt in those participants who experience it as well as institutional and personal labelling. Participants in this study also have fears associated with childbirth and trauma in relation to the mode of delivery, which might result in unmet needs, including poor bonding and attachment with their babies. The study's participants described both supportive aspects and difficult challenges as influencing their experiences and impacting their mental health in both positive and negative ways.

The participants in this study believe that SMHI have social effect; however, their attitudes and mindsets, including what is believed and valued are more significant. Thus, it is necessary to support them by focusing on their interests and not their expectations during the motherhood transition. For example, one of the participant's views on SMHI is that; ‘‘P1: it does get better, like, the situation always get better no matter how hard you think it is at the time, it will get better (148-149)’’. This model reveals that there are practical steps that may be taken to improve the postnatal experience of women with SMHI during their transition into motherhood. This RLBM, therefore, hopes to provide individuals with SMHI during the postnatal period with guidance based on their needs and values; by providing continuing support and engagement based on contact with the mother, thereby enhancing their daily functioning, social participation, and quality of life.

Participants view the social context as presenting multiple challenges, including stigma and discrimination at various levels. Stigma can lead to reduced access to services. It can also affect the individual participants' perspectives and attitudes, as well as their mental health, which may prolong recovery. Understanding the social and environmental risks such as discrimination, stigma, labelling and the worry this may cause, may aid the individual in developing and utilising a coping mechanism effectively. Culture and religious beliefs have both beneficial and negative effects on people. Some participants believed that prayer helped them cope with the pain of mental illness.

The majority of women engaged in CBT to control their feelings and emotions, and this helped them to accept their feelings and to counteract risk factors for illness such as trauma. Indeed, one participant stated during the interview that SMHI "makes you stronger after postpartum psychosis" (P3, 450). Participants in this study developed resilience, optimism, and self-belief while relying on their established support networks.

The adaptability of these networks in times of stress is dependent on individual coping mechanisms. Some participants who had previously experienced triggers were able to recognise their experiences and adapt to their challenges, whereas this had taken longer initially. Despite these challenges, the participants employed alternative coping strategies to enable effective management of their mental illness; as a result, they became extremely hopeful. According to Feder et al. (2009), schizophrenic patients display adaptive responses to unpleasant circumstances or experiences, which involve the application of positive coping mechanisms, resulting in a better outcome (Holubova et al., 2016). Additionally, Boschi et al. (2000) supports the hypothesis that adaptive coping is the most effective strategy for improving functional results in schizophrenic patients.

The American Psychological Association (APA) defines resilience as the process and effect of adjusting to adversity and difficulties in one's life. Participants who were hospitalised reported poor mother-child interactions, and resilience was not observed until the participants began to recover.

The study’s findings suggest that increased support improves women’s experiences of motherhood challenges; the study data also revealed that there are additional issues, such as stigma and labelling, which impact women's mental health.

Thus, by addressing some of the study's findings, such as the practicality of personal resilience, it may be possible to assist women experiencing difficulties during the transition to motherhood.

The conceptual model utilised in this work establishes a new link between well-researched SMHI characteristics and motherhood such as social factors and childbirth experiences.

The three key categories were used to illustrate women’s experiences of the transition to motherhood during the postnatal period. Figure 5.9 demonstrates the uneasy experiences that women with SMHI undergo throughout their transition, along with each of the minor components.

All of the subcategories under the heading ‘social contexts' in figure 6.1 share the same features and are intended to represent participants' social surroundings and circumstances in terms of their SMHI and motherhood experiences.

The relationship between the three components (social, personal resilience and childbirth) and their interactions in influencing women’s experience with SMHI is represented in the theory as the resilience-led behavioural model (RLBM) figure 6.5.

Subcategories under ‘personal’ illustrate many sources of individual experience models that are utilised to ease the transition and enhance the motherhood experience, although ‘childbirth’ is considered the real EXMEPP difficulty (transition to motherhood). The social context and childbirth experiences contribute to a better understanding of women’s experiences in relation to the study.

Personal resilience (the key category) demonstrates the ability and strength to recover from an overwhelming experience. The key categories appear to have a significant influence on women’s perceptions of their experience throughout the transition to motherhood, resulting in the development of the ‘resilience-led behavioural model’ (RLBM). This concept applies to a variety of behaviours, those linked with SMHI are illustrated in figure 6.5.

Resilience within the model framework shows some strong tools developed by the participants to protect against overwhelming experiences and help them in overcoming challenges.

6.6 Concept of Resilience

Fletcher and Sarkar (2013) define resilience as a constructive response to adversity. Resilience requires diverse responses to various adversities posed by significant life events, and the positive adaptation must be appropriate to the specific adversity (Fletcher and Sarkar, 2013). The idea of resilience is too restrictive and constrained for an individual with disabilities (Hutcheon and Lashewicz, 2014). In this study, the women present positivism as their source of hope in motherhood. Positive adaptation has been characterised as “behaviourally manifested social competence, or achievement of meeting stage-specific developmental tasks” (Luthar and Cicchetti, 2000). How a person's social competency is expressed reflects his or her sociocultural background (Clauss-Ehlers, 2008).

The main idea of the social constructionist model is that positive or negative behaviour arises from an individual’s environment and is facilitated by perception and coping processes, resulting in positive or negative responses. This continuous process is facilitated by various personal and social factors, including positive effects (Manyena, 2006). Since it is often considered that resilience emerges from the activities of fundamental human adaptational processes (Masten, 2001), the concept has frequently been associated with coping. Thus, Richardson (2002) states that resilience is ‘‘the process of coping with stressors, adversity, or opportunity in a manner that results in the identification and enrichment of robust qualities. Resilience is therefore characterised by its impact on an individual’s appraisal before emotional and coping responses and by its positive, protective effect.

Resilience is comprised of various variables that promote personal assets and protect individuals from the negative evaluation of stressors. It influences the stress process at different levels, including an individual’s evaluation of stressors, in response to perceived emotions and choice of coping mechanisms.

Accepting one's condition is an important factor in the ability to tolerate stressful situations and develop resilience to improve outcomes. These ability rely on the SMHI trajectory, for example (Wambua et al., 2020). Accepting the reality of a situation, although it is unpleasant and uncomfortable, is a crucial component of cognitive flexibility. However, the ability of an individual with SMHI to reclaim their sense of self is measured by how well they can overcome challenges and setbacks. Indeed, in this study, most demonstrated resilience more often in their challenges and setbacks, which include emotional pain and stress.

According to Torgalsben et al. (2018), resilience is something that can be learnt through a change in behaviour, attitude, and mindset that enables an individual to recover from stressful or traumatic experiences. Developing resilience can help women with SMHI during the postnatal period to cope adaptively and recover from setbacks (Torgalsboen et al., 2018; Wambua et al., 2020). According to Torgalsboen et al. (2018), individuals experience the activation of resilience in different ways which are related to greater personal recovery chances. For example, the outcomes of the study demonstrate that the individuals had varying responses to traumatic stress and stressful situations.

The participants showed new coping strategies, as seen in the categories, which are interconnected; therefore, it is clear that participants learned what worked for them in terms of developing resilience, hope, self-belief, and altering their behaviour while adopting a positive mindset.

Resilience enabled women with SMHI to respond more favourably to stress during the postnatal period, which was reflected in the development of natural resilience. This is represented most in the second category, which discusses how individual resilience can be naturally built up and how this helps with coping skills.

Having a strong social network was shown to boost the resilience of the research participants in terms of coping with their new-borns and their mental health difficulties, by demonstrating a variety of resiliency traits, including commitment level, support engagement, control or choice, tolerance, and optimism (Conner and Davidson, 2003).

However, all of the aforementioned resiliency traits can be utilised in different contexts, depending on the individual's abilities and capabilities.

Resiliency in the face of adversity can be linked to a participant's social context, in which she adjusts to adverse environmental events. The third category can be linked to the participants' acquired resilience, which can also be learnt since the participants with SMHI adapted to their new mother roles over the postnatal period. According to resilience theory, it is not the form of adversity that matters most, but how we respond to it. When confronted with adversity, or frustration, resilience helps us recover. It helps us survive, recuperate, and even thrive in the face and aftermath of adversity. The resilience model by Kumpfer (1999) illustrates that the interplay between the individual’s resilience process and her environment (societal stigma, social support, cultural difficulties) is active in shaping her environment.

Resilience is considered an ongoing notion that aids individuals in constructing or reconstructing the relationship between family, society, and external support networks (Gooding et al., 2019).

It is widely accepted that resilience can favourably affect real-world functioning and is regarded as a protective factor that ensures a favourable outcome, particularly for people with SMHI (Poloni et al., 2018). In recent years, psychiatry has acknowledged resilience as a crucial human quality and clinical tool (Aburn et al., 2016; Deng et al., 2018).

However, the questions of whether positive coping and resilience are independent conceptions, whether positive coping is associated with resilience in individuals with schizophrenia, and how these qualities interact with one another in the context of disability have not been well explored.

Most of the study participants have healthy relationships with their loved ones, who were able to offer them appropriate assistance whenever it was needed (P1 to P10).

Regardless of their SMHI status or the difficulties associated with motherhood, all participants expressed how satisfied they were with their babies. With positive perspectives and attitudes, participants were able to control their mental health issues while engaging with programs to reduce relapse and enhance the motherhood experience.

Personal resilience within the model setting reflects the unique conditions that contribute to women's postnatal SMHI experiences during their transition into motherhood. Individual perceptions of their encounters may be favourable or unpleasant, although, the majority of the study participants reported positive experiences as a result of their recovery journey and support networks. Personal resilience is important to the model's concept, as it demonstrates the model's influence on the social setting and childbirth experience, hence altering individual behaviour during the motherhood transition.

The models are connected with arrows in figure 6.5, representing the relationship between each category.

The model's left-hand side highlights the positive and negative contexts that may have impacted the participants' perspectives and experiences during the transition to motherhood. The majority of social circumstances and childbearing hurdles were improved as a consequence of personal resilience, which resulted in acceptance. Thus, the outcomes of the activities, such as self-belief and positive thoughts, can continue to have a direct effect on reducing the barriers created by the social setting, such as discrimination and isolation. Mothers with SMHI should believe that the benefits of developing positive thoughts and having self-belief outweigh the disadvantages of discrimination. This inculcates hope in the majority of the participants. Participants in this study increased their resilience by adhering to a routine, performing one task at a time, and adjusting their mindset and approach to coping and adaptation.

Therefore, the model advocates that resilience information be incorporated into a postnatal care plan for early intervention and care navigation based on elements detected through screening processes and according to individual needs. Edward et al. (2009) state that resilience information should be incorporated into both the academic and practical aspects of nursing education. Some studies (Newton et al., 2014; Tansey et al., 2017) have also indicated that resilience and self-efficacy are useful for those with chronic pain or impairment. Increased resilience has been proven to be connected with reduced anxiety and sadness (Ordway et al., 2020).

A number of hypotheses could be generated from the illustrative model:

1. Personal resilience is more likely to lead to adopting positive concepts which will then enhance positive thoughts and hope.
2. Where personal resilience in the model is combined with elements in the social context, this enhances a positive childbirth experience. These hypotheses are intertwined and lead to a positive motherhood transition.
3. Challenges associated with childbirth and social context with no personal resilience are more likely to result in a negative perception of the motherhood transition, as shown with the continuous arrows connecting social context to childbirth experience.

It is possible to assume and develop the three possible hypotheses. However, there are further instances that contradict them. For example, participants who express a desire to engage with services may enhance their experience by minimising one of the social context variables (stigma). Although the small sample size constrains this untested hypothesis (10 participants), larger sample size and geographical area may be used in the future for better understanding.

Furthermore, accepting the reality of a given situation, even if it is unpleasant or uncomfortable, is a crucial component of cognitive flexibility. This is because accepting one's condition continues to be an important factor in the ability to tolerate stressful situations and in developing resilience to improve outcomes, both of which can be explained differently depending on the illness trajectory outcome, such as in schizophrenia, where it is under-researched and poorly understood (Wambua et al., 2020).

However, the ability of an individual with SMHI to reclaim their sense of self is measured by how well they can overcome challenges and setbacks.

For example, the outcomes of the study demonstrate that the individuals had varying responses to traumatic stress and stressful situations. The participants in this study have shown new ways of coping strategies as seen in the categories. The categories are interconnected; therefore, participants learn what works for them in terms of developing resilience, hope, self-belief, and altering their behaviour while adopting a positive mindset. Most of the study participants have healthy relationships with their loved ones who were able to offer them appropriate assistance whenever it was needed (P1 to P10). Regardless of their SMHI status or the difficulties associated with motherhood, all participants expressed how satisfied they were with their babies.

Resilience enabled women with SMHI to respond more favourably to stress during the postnatal period which reflected the development of the following resilience such as natural resilience; the resilience you are born with. This is represented most in the second category, which discusses how individual resilience can be naturally built up and how this helps with their coping skills.

6.7 Conceptual model

Women can utilise their strength, which is primarily present in their resilience, to improve their mental well-being while also enhancing their motherhood experience (Hine et al., 2018; Egeland et al., 1993). The conceptual model in this study illustrates the current notions that influence women's resilience to SMHI, as well as the positive and negative impacts on their mental illness. Resilience enables women with SMHI to continue functioning despite their obstacles by reaching out for support.

An experience or behaviour does not occur in isolation, but within a situational context that comprises other experiences and behaviours. Thus, comprehending such experiences and behaviour provides information about them. This model offers insight into the relationship between experience and behaviour in the context of a positive healthcare system. According to Haddadi and Besharat (2010), resilience can relate positively to an individual’s experience of well-being.

The concept of personal resilience is centred on how one strength can positively affect mental health. This is apparent in people with schizophrenia, according to Bozikas et al. (2016), who found that patients with more resilience had the better functioning capability.

Thus, more resilience may protect against the onset or long-term effects of mental health issues, although, some people may still have a good memory of their previous experiences as they relate to resilience. The findings of this study suggest that the resilience-led behavioural model could partially shape individual behaviour towards adopting a positive attitude to health or having good help-seeking behaviour. Depending on individual values and social artefacts, the cognitive preferences of individuals and impulsive motivation can jointly focus or impact behaviour.

Social artefacts could influence experience, which may impact behaviour either positively or negatively. Each claim on adopting positive or negative behaviour, (such as a claim on culture and religious beliefs) cannot gain enough strength unless it is tested based on other social contexts, such as personal resilience and experience of stigmatisation, as per this study's findings.

Women with SMHI can adopt positive behavioural change, although, with an additional phenomenon such as childbirth, the new experience will have a different effect on shaping their behaviour. Participants' positive perceptions of their behaviour require understanding their patterns and how this will lead to behavioural change during the transition to motherhood. For a positive behavioural change, there is a need to identify the negative experience that required change to promote good behaviour. There is a relation between a positive experience and a negative experience of a particular behaviour.

This study's findings illustrated how participants' adaption of positive experiences such as new coping mechanisms and hope, promoted confidence in the participants. For instance, this study's findings show that some participants felt motivated and compelled to adopt positive behaviour in their transition to motherhood due to previous experiences with childbirth. However, there are issues, such as culture and religion, which may influence experiences which lead to negative resilience-led behaviour.

In this study, by embracing positive perceptions and attitudes, participants were able to manage their conditions while engaging with the services to minimise relapse and improve the motherhood experience.

6.8 Limitations

The study was conducted on women with SMHI in the Northeast; thus, the generalisability of the research findings may be limited to other women with SMHI in other areas in relation to motherhood during the postnatal period. This indicates that the analysis of the study focused on women with SMHI during the postnatal period. To discover coping strategies, future research should focus on and include women from different regions. In addition to studying women who have given birth within the past year, the study may also analyse women who have given birth over five years.

Summary

The theoretical model checklist developed in appendix 12 will help in the construction of a care plan based on awareness, highlighting possible changes that may occur during the postnatal period and providing access to relevant information and resources. The model was designed to assist in influencing women's perspectives of care needs, such as early engagement with professionals and awareness of open information access. The model can be used as a guide to support clinical care for women with SMHI by staff and family members. This theoretical model is built on the core categories; the process of women obtaining support, comprehending challenges following childbirth, and engaging with care providers improves and put women in better position of the situation. Understanding the need for sleep, breastfeeding challenges, and substitutes, and adapting to these needs can reduce triggers and improve coping mechanisms.

Therefore, the outcome must be viewed as a guideline for healthcare professionals in maternity to support women and their families prior to hospital discharge to community care, and as an ongoing process in the community that focuses on building support and resilience (see model check list in appendix 12). The model can be utilised in conjunction with other models or programmes until the individual recovers, i.e., when she is capable of coping and implementing health intervention between health care providers. The perception of being a mother and being able to cope with challenges is necessary for health recovery.

Recovery in this study refers to women regaining personal strength, developing coping mechanisms, and the RLBM provide women and their families with resources and competencies. This model supports women with SMHI in collaboration with a mental health lead/care coordinator. It is important to conduct additional research on the relationship between resilience, coping, and motherhood.

6.9 Chapter Conclusion

This chapter has discussed the three major categories of experiences of women with formally diagnosed SMHI in relation to motherhood during the postnatal period by following a grounded theory methodology. It has become clear that the social context around culture and religion, stigma, perceptions, and attitudes may contribute to women's experience of SMHI in the postnatal period. The effects of social perceptions may be either positive or negative however, participants' perception of SMHI in relation to the motherhood role may be influenced by previous experience, family, culture and religion. The data analysis shows that women's experiences of SMHI in relation to motherhood roles include both negative and positive experiences. Women's perceptions of negative thoughts, stigma and discrimination evolve as a source of or impediment to their experiences. All participants appear to be positive about motherhood with support from professionals, extended family and friends. All participants expressed confidence and knowledge about their motherhood role and how to manage it. The participants in this study had a positive perception of motherhood as bonding with their baby superseded their negative experiences as they assumed their motherhood responsibilities. Having lived the SMHI experience in relation to motherhood, the participants have proposed strategies to improve other women's postnatal experiences. The next chapter will discuss the results of the findings. The interpretation of the findings and the discussion were done separately since the finding part allows for additional analysis while the discussion section interprets the findings in a clear format.

Chapter 7 - Discussion

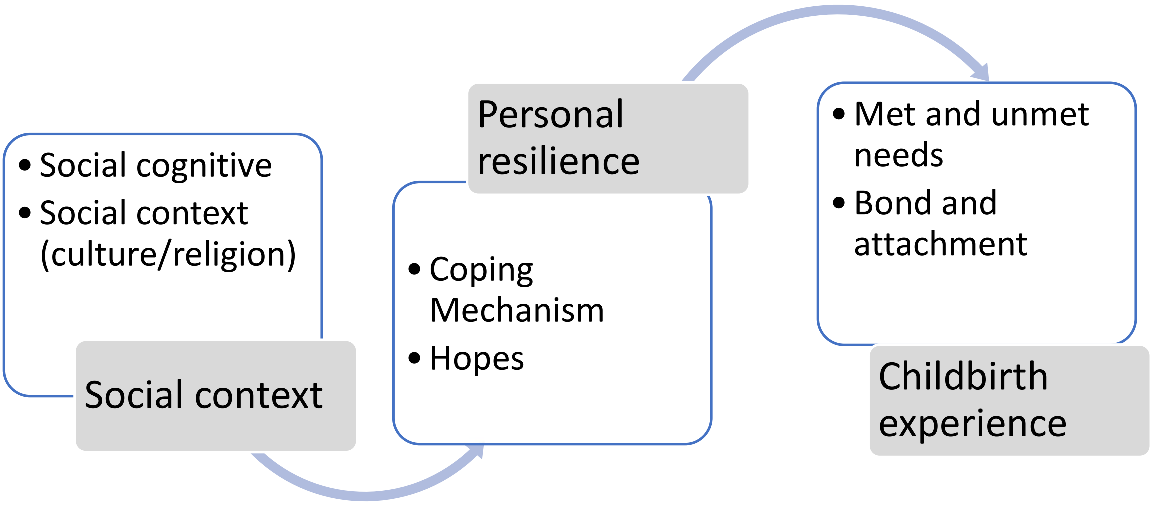
Chapter 7

7.1 Discussion of the findings

This chapter discusses the findings and any strengths and limitations of the study while referring to the aims and objectives and how they were achieved. The study aimed to explore and develop an understanding of the experiences of women with severe mental health issues in relation to motherhood during the postnatal period. From the study findings, the categories highlight that women's perceptions of their experiences of the transition into motherhood are rooted in a continuous process, in which these experiences play either a positive or negative role, based on factors related to social context, personal resilience and childbirth. The study used grounded theoretical approaches to develop understanding of the experiences and feelings expressed by women with a diagnosis of SMHI, as well as the factors that influence these experiences. The choice of methodology was to ensure that the conclusion of the study were derived from the data and not from the existing literature.

The review of the literature (in chapter two) for this study shows that very few studies have been conducted in the United Kingdom and the United State of America on this subject. This qualitative study has explored the experiences of the participants in the EXMEPP study. The study analysis thus made sense of their experiences. The study findings were presented in chapter 6, in line with each of the three evolving major categories in the study. The discussion of this study will be based on the three categories of the study. Each theme will be appraised below in a broader theoretical literature in relation to the participants' experiences, thoughts and attitudes towards their transition to motherhood, as in figure 7.1 below. Additionally, there is a critical appraisal of the methodological approaches. The chapter concludes with a summary. Below is a summary of the key findings.

Figure 7.1: Summary of key findings



The purpose of this study was to explore and develop an understanding of the experiences of women with severe mental health issues in relation to motherhood during the postpartum period. The study objectives were to

- Explore the factors that influence the experiences of women with SMHI in relation to motherhood during the postnatal period.
- Examine how women with a diagnosis of SMHI perceive motherhood in the postnatal period.
- Gain an understanding of women’s concerns about SMHI and what they hope to gain from services in relation to motherhood in the postnatal period, and
- Identify the met and unmet needs of women with SMHI concerning motherhood.

The study's key findings, as shown in figure 7.1, suggest that social factors such as culture and religion, stigma, perception and attitude are among those reported by the participants as influencing their experiences during this period. These findings addressed the study’s first and second objectives, while the findings related to their resilience addressed the third objective, and the findings on their childbirth experiences addressed all four objectives. This shows the interlinked nature of and relationships between the three main categories explored in this study.

The findings also indicate that an individual understanding of postnatal SMHI, its interpretation and the impact on motherhood experience is not only influenced by personal social factors such as cognition but is also rooted in the wider socio-cultural context.

7.2 Social Context

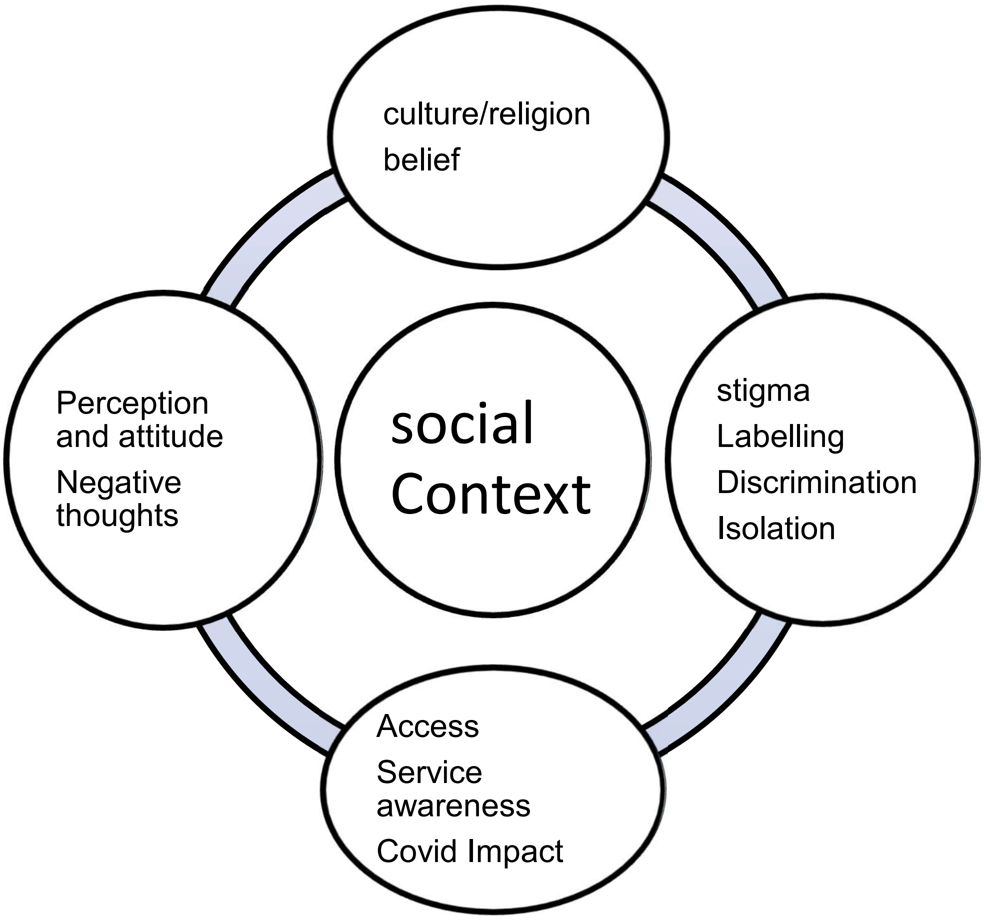
Sociological perspective on mental illness is that our social backgrounds influence our views, behaviour, and lifestyle choices. In this way, we are not merely individuals, but rather profoundly entwined social beings. The sociological perspective emphasises that mental illness is a result of the social and behavioural factors that are attributed to the individual through labelling. In contrast, the biomedical concept views mental illness as a disease.

A number of social cognitive concepts emerged from the study as factors that could influence women's experience of SMHI in the postnatal period.

The most frequently reported experiences encountered by these women were influenced by or related to their beliefs. Indeed, most of the study participants reported that their beliefs (based on their culture and religion) influenced their individual experiences. This could be because of the way in which each individual sees themselves or how the environment in which they live is socially represented (this will be discussed later in this section). Social representation theory is used by psychologists to understand the nature and interactions of social beliefs (Marks, 2005). The theory deals with how the social systems shape the understanding of an individual and the world around them. In other words, the sociological perspectives are that mental illness is a response to severe environmental stress, such as sleep deprivation and trauma.

The use of interventions was reported (by the study participants) to be mostly influenced by their beliefs in their culture and religion. The findings suggest that postnatal SMHI and motherhood experiences are surrounded by many socio-cultural perceptions and beliefs, which could affect these women's experiences in different ways, either as motivators or possible barriers. However, research on mental health has regarded psychiatry a biomedical concept, in the absence of social and cultural determinants (Babalola et al., 2017; Engel, 2012), although some authors consider social factors while dealing with mental health issues (Jafari et al., 2010). Figure 7.3 shows the social context and its subcategories, which are explained below.

Figure 7.3. Social Context



This study highlights multiple interrelated social contexts which influence mothers' experiences of SMHI during the postnatal period. The participants, especially the first-time mothers were anxious about childbirth and motherhood but were happy to discuss their feelings for the first time. They felt that participating in the study and sharing their experiences would help other mothers with SMHI, as well as professionals in an academic environment, to understand the weight of their experiences. Some of the social contexts which influenced women's experiences were culture/religion, stigma, access, perceptions and attitude. These will be explored further in the following sections,

7.3 Culture and religion

Culture and religious beliefs have a significant impact and greatly influenced the experiences and behaviour of the individual participants. Religion is regarded by the participants in this study as a key social and spiritual resource, and a source of strength.

As noted by Wesselmann and Graziano (2010), some religious teachings relate mental health issues to spiritual challenges, although there have been few studies that demonstrate why specific religious and cultural beliefs are associated with stigmatisation (Wesselmann and Graziano, 2010; Abdullah & Brown, 2011).

Religiosity is the practice of following a system of structured beliefs that serves to improve the relationship between the cultural context and the sense of moral obligation (Ventriglio et al., 2018). This study has used participants from different ethnic groups, since there is greater social diversity in the 21st century in the UK concerning minority groups from Asia. This means that individuals originate from different countries and ethnicities, which include heterogeneous cultures, religions and languages (Phillimore, 2015).

7.3.1 Culture

Culture can influence how individuals feel about themselves and their health symptoms and can affect how the individual recognises and makes decisions. This study shows that culture affected participants' experiences and perceptions during their transition to motherhood. Participants (P3, 285-291) emphasise their family's cultural perspectives on mental health concerns by relating information about belief, locking away, and stigmatisation. This could inhibit or delay the individual from seeking help or support at the right time. However, different ethnic groups have different cultural perspectives on mental health issues. For example, the issue in participant 4’s culture (P4, 86-88) of individual persistent visiting or constant telephone calls was perceived as a nuisance. The participants found this to be positive but also disturbing and upsetting, which impacted the transition into motherhood. Culture plays an important role in most women's adjustment to motherhood, according to Dankner et al. (2000), and some cultures have traditional practices that encourage maternal role transition.

Hence, culture can be defined as a system of thoughts and beliefs that individuals use in social networks and communication to create meaning in interactions (Littlewood, 2001). However, such meanings are not self-evident; instead, they originate from mutual knowledge and experience, as well as shared ideas and beliefs.

The variables observed in this study show that some participants perceived culture as a stressor in terms of having many people visiting to see the baby without helping in any way, as seen in P3…66-65, 309.

The quote indicates that culture could be associated with poor access to health care facilities and could impact the individual’s health-seeking behaviour. For instance, the cultural norms of a particular place and time may have an impact on the care and support that an individual receives, which might be hindered by their cultural practice. This is shown by P3, where the relatives did not believe that mental illness exists.

During encounters with patients, health professionals may therefore be completely unaware of the impact of their interactions and assumptions. Cultural identities are formed by the environment in which people live (Rogers-Sirin and Gupta 2012).

However, it is important to remember that cultural differences in understanding and reporting mental illness affect everyone, not just those who are ill themselves (Hwang et al., 2008)

Many studies have discussed the issues and connections between culture and mental health issues within countries. For instance, the idea that cultural traditions and practices act as a supportive tool is stated in various studies (Lee et al., 2004) among Chinese women in Hong Kong (Chien et al., 2014) among Vietnamese women and in Ho Chi Minh City in Vietnam, bearing in mind cultural variations (Fisher et al., 2004). This, in most situations, leads to self-isolation, which might result in stress, anxiety and exhaustion (Hung and Chung, 2001; Huang and Mathers, 2001), although it should be acknowledged that a study reviewed by Klainin and Arthur (2009) among Asian societies did not reveal the same result, finding that cultural practices did not provide relevant psychological benefits for women. However, the significance of cultural beliefs and practices is relevant in the context of mental health diagnosis and treatment; for example, services might be inaccessible to potential users and their families if they have difficulties in accessing service culture due to language barriers. Furthermore, some healthcare practitioners may have difficulties comprehending the cultural norms of patients from other ethnic minorities. This can impede effective care delivery and lead to patient dissatisfaction with the care delivered.

For clinical contact to be engaging and useful, Venkatapuram (2003) found that it is important to understand the cultural diversity of professionals, as having specific ways of thinking and reporting SMHI that are distinct from others (Lipsedge and Littlewood, 2006). For example, some have argued that higher rates of mental illness in women may more accurately reflect the process of identification and diagnosis than the presence of illness (McMullen and Stoppard, 2006).

This gains particular salience when dealing with women from minority backgrounds. From a social construction perspective, a diagnosis of SMHI results from encounters between health professionals and patients, in which what counts as mental illness is negotiated within a wider social context (Rogers-Sirin and Gupta et al., 2012). This means that what is regarded as a mental illness in any particular place or period is neither constant nor fixed, but rather is influenced by socio-political factors (Morrow and Weisser, 2012), were not evaluated in this study. Services providers must acknowledge the cultural varieties in postnatal SMHI presentation and needs and should continue to move towards cultural awareness and development of the skills and confidence to ask culturally relevant questions. They should work with different cultural communities to inform or educate them on their responsibilities for managing their SMHI and motherhood challenges.

7.3.2 Religion

A key concern in the context of this study is the role of spirituality and religion, which may inform or introduce strange religious delusions, some of which can be challenging to differentiate from normal religion or cultural beliefs. Religion is defined as a set of beliefs and practices shared by a community concerning the sacred, where spirituality, although complex, can be traced down to a form of religion but is not limited to a particular set of beliefs or community (Das et al., 2018; Koenig, 2009). Religion is related to positive psychology and good mental health, such as peace, inner self, or strength (Koenig, 2009), and as a social resource for coping with stress. This may often become ‘pathologised’ within mainstream mental health services (Koenig, 2009).

The findings of this study, however, have shown that religion could be used negatively in terms of hindering accessing help or delaying access to intervention. For example, in this study, religious belief was seen as a factor that could delay seeking medical attention. Moreover, the feelings encountered by the participants could have been constructed as relating to religion, but were in fact hallucinations (P3, 210-218) (Cook, 2015). Based on the findings of this study, religious involvement was also used to find peace or to spend time with God to cope with stress. Hence, religion could also be used to destress or ease emotional pressure, as seen in the study (P5, 182-184).

Ethnic minority communities in western societies tend to have higher rates of religious adherence, which may result in reduced help-seeking behaviour. Koenig's (2009) study reports that religious beliefs and practices are normalising and may lower the rate of isolation, fear and loss of control among people with diagnosed postnatal SMHI.

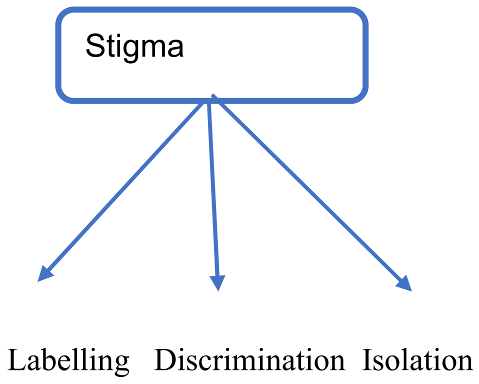
Religious support and spiritual struggle, both positive and negative, are viewed as a source of social interaction or as indicators of social isolation (Mohr et al., 2006). This indicates that a person's religious beliefs may affect their behaviour, experience, or recovery. For example, while some participants viewed their religious belief as a protective factor against suicide, others described it as an expression of their resentment toward God, as reported by Mohr et al. (2006). Similarly, the participants in this study (P3, 67-74) regarded religion as a source for maintaining feelings of self-worth and the value of life, despite the difficulties associated with religious stress, which resulted in delays in help-seeking.

Spiritual stress may occur when the degree of a particular stressor exceeds the religion's tendency to retain its normative direction, as indicated in the above quote. Moreover, this religious belief exposes people to external forces, such as sleep deprivations, which affects their motherhood experience. This has been found to promote adaptive coping skills in patients with schizophrenia during remission (Das et al., 2018). Stigma was also perceived in this study as one of the social contexts and is discussed below.

Belief

One's belief significantly influences one's perception affecting the way he/she response to the world around her which affects some aspect of her life from making decision to wellbeing (Moses and Shoham, 1993). Belief has different cognitions formed by knowledge and experience including attitude and mind-sets. A number of studies has reported that belief can influence behaviour of the individual (Kube and Rozenkrantz, 2021; Ibrahim et al., 2019).

Stigma



7.4 Social contexts

Concept of Stigmatisation

Postpartum women with SMHI often complain of being associated with labelling following diagnosis, feelings of not being a good mother, and a reluctance to express their emotions to their loved ones or healthcare providers (Seidman, 2014).

Stigmatisation is the process by which a culturally devalued and discrediting mark or attribute is assigned to a person or group of individuals by another more powerful group. Typically, stigma by a member of the majority group can result in labelling, stereotyping, isolation, status loss, and discrimination (Link and Phelan, 2001).

Stigma is caused by consistent attribution of blame (Corrigan and Wassel, 2008), discrimination and negative stereotypes (Corrigan, 2004; 2005). Therefore, stigma is associated with the amount of control an individual has over his or her condition (Corrigan and Wassel, 2008).

Labeling and stereotyping involve the recognition of differences and the attribution of social significance to those differences. Labelling concerns those words to which we tie ourselves, primarily after being diagnosed with a mental condition and learning how to cope with it.

Labelling is personal, while stigma is societal. For instance, we may refer to ourselves as being bipolar rather than as having bipolar disorder (Corrigan et al., 2014), which may potentially contribute to discrimination. The stigmatising effect of labelling then results in discrimination, and an individual may be affected by isolating him or herself as a result (Corrigan et al., 2014).

Discrimination is the act of making unjustified, prejudiced distinctions between people based on the groups, classes, or other categories to which they belong or are perceived to belong (Williams et al., 2019). It may be based on race, age, gender, religion, disability, or sexual orientation, as well as other categories. In other words, discrimination occurs when individuals are unfairly treated in a manner that is worse than that which other people experience. A discriminating attitude is an action that emerges from stigmatising attitudes and beliefs (APA, 2013).

7.4.1 Stigma

Stigma is present when discrimination, stereotyping and isolation occur (Link and Phelan, 2001), inhibiting access to treatment and prolonging its duration (Monteiro and Balogun, 2013b). This study reports high levels of self-stigmatisation as seen in P3 (162). This idea may be supported by Corrigan and Penn's (1999) findings that members of stigmatised groups self-stigmatise as a result of public stigma. Participants in this study (P2, P3, P5 and P8) made similar comments, contributing to their feelings of isolation. Thus, the stigma associated with mental health has a number of negative consequences for people with SMHI, including poor recovery outcomes, low self-esteem and poor social interaction, and this may inhibit help-seeking behaviour (Chan et al., 2019).

Stigma is a broad and complex term that people encounter regularly in their lives. It is believed to be rooted in the lives of the individual as a social construct and has been defined as when a person is given a separate label (Schreiber and Hartrick 2002). Each society establishes which personal features are socially acceptable and which are unacceptable or subject to stigmatisation (Hinshaw, 2005). Self-stigmatisation may result in a variety of restrictions, including reduced hope, less self-esteem and poorer quality of life (Lien et al., 2016; Schrank et al., 2013). However, stigma resistance may alleviate self-stigmatisation and improve self-esteem, hope, reflective ability and coping skills (Lien et al., 2016). Indeed, this study found that some participants with a strong understanding and knowledge of their illness had more effective coping mechanisms.

This study revealed that all the participants experienced stigmatisation in some way, such as labelling, discrimination and isolation.

This impacted their perceptions of, and attitudes and behaviour towards the transition to motherhood. Stigma has been defined as a form of discrimination against an individual (Rusch et al., 2005; Thornicroft et al., 2007) that is caused by repeated blame (Reupert et al., 2021), discrimination, and or negative thoughts (Corrigan, 2004; 2005). Goffman (1963) defined stigma as a shameful characteristic frequently encountered in a person associated with a stereotype that is not desired by the group norm. As a result, to be stigmatised is directly related to how much power and control one has over his or her condition (Reupert et al., 2021). Most participants in this study encountered stigma, particularly internalised stigma which manifested as self-blame, guilt and shame (Clement et al., 2015). Women with SMHI described a vast range of experiences indicative of stigma (such as labelling, discrimination and isolation), which was observed and indicated as a significant social context affecting women with SMHI as a result of how people saw them (Thomas et al., 2013).

Stigmatisation is a term that refers to a negative attitude and preconceptions held towards a group of people with mental health issues (Corrigan, 2000). The societal myth is that women are supposed to be happy following childbirth, which is promoted by the global media demonstrating a happy time in which women are blooming and accepting of the pressures and demands of motherhood (Morrissey, 2007), whereas women with SMHI often may express concerns of being associated with labels, creating a sense of inadequacy as a mother and anxiety around communicating feelings (Dennis, 2006). Hope is also negatively impacted as a result of this (Corrigan et al., 2011).

Thus, there is a need to have positive hope for women with SMHI. The concept of hope in this study acts as a source of strength (changes in participants' attitudes, values and feelings) that benefit the participants’ well-being and recovery.

Stigma comes in different forms; this study demonstrated the breakdown of stigmatisation as follows:

- stigma directed towards oneself (internalised stigma),
- stigma from health professionals (institutionalised), and
- societal sigma (Corrigan et al., 2011).

Self-stigmas are characterised as internalised forms of public stigma (Link and Phelan, 2014; Arboleda-Florez and Sartorius, 2008; Phelan et al., 2014; Link, 1987) that involve the fear of rejection by others (Corrigan et al., 2004). This fear of rejection or abandonment by others may lower one's self-esteem, sense of empowerment and optimism, contributing to delays in treatment and an increase in hospitalisation (Tsang et al., 2016; Corrigan et al., 2006). Self-stigma may result in individuals not seeking treatment on time as a result of low self-esteem and self-efficacy, but it may also reduce the need for assistance (Tsang et al., 2010). Based on the findings of this study, most women with higher levels of education may find it easier to address or seek help due to their awareness and perception of the stigma associated with SMHI during the postnatal period. There may be a correlation between educational attainment and stigma awareness and women’s perceptions of their postnatal SMHI experiences. The educational level of an individual may therefore influence their ability to comprehend their stigma symptoms.

Experiences of stigma can be quite different, since women may have positive or negative feelings about their postnatal periods or their infant for a variety of reasons, and this should be considered. Almost every participant in this study encountered stigma in a variety of ways, including labelling, discrimination, and isolation (P2, P3, P6, P7 and P9). The stigma associated with SMHI is widespread (Link and Phelan, 2014; Angermeyer and Maatschinger, 2003); thus, this study's findings indicate that discrimination, labelling, and isolation all fit well into the aforementioned forms of stigmatisation.

Self-stigma, as one of the forms of stigmatisation, was expressed in the form of guilt, whereby the participant may blame herself for circumstances beyond her control. The quotes (in the study findings) indicating that the participants' mental health was not initially considered during a consultation with their GP, and not necessarily prioritised by their midwives are good examples of institutional stigmatisation. Women diagnosed with SMHI during the postnatal period are labelled high risk and require a higher standard of care management, which may result in stigma, discrimination, and social exclusion. Participants observed that some general practitioners (GPs) more frequently stigmatise their patients than psychiatrists when it comes to treating people with SMHI insensitively (Thornicroft et al., 2010). The negative attitudes against people with SMHI held by society are extensively documented (Razali and Ismail 2014; Loch et al., 2013; Crabtree et al., 2010).

Among study participants, societal stigma is often reported as having had an effect on women with SMHIs ability to seek support during the postnatal period (Watson et al., 2019). This is largely and consistently determined by their cultural ideas, religion, and conceptions of SMHI, although this study is unable to comment extensively on social stigma due to the pandemic (Covid 19). During the postnatal period, the majority of women with SMHI respond to this negative reputation by rejecting the use of mental health services (Karidi et al., 2015); thus, this was the case with this study. The effect of institutional stigma is connected with the reasons why women with SMHIs are reluctant to seek help (Clement et al., 2015). This study (P2, 52-53) has shown that any kind of stigma, whether social, internalised, or institutionalised, can result in labelling, discrimination, and isolation. Positive knowledge of SMHI management and processing contributes significantly to knowledge of the symptoms of stigma for certain groups in society. In other words, more knowledge and awareness of SMHI may help to reduce social stigma (Amsalem et al., 2022). Stigma among healthcare workers might also act as a barrier to treatment and access (Penn and Wykes, 2003). Thus, reduced stigma may promote help-seeking behaviour and treatment, as well as lower barriers to care. In addition, most people diagnosed with SMHI experience discrimination, withdrawing behaviour, and labelling in the form of isolation from their loved ones (Hamilton et al., 2016), making it difficult to seek support (Clement et al., 2015), and thus affecting the standard of care provided to people with SMHI at various levels.

7.4.2 Labelling

Labelling is viewed as a means of identifying individuals in a manner distinct from classification, and of distinguishing oneself from another (Paul and Nadkarni, 2017). Individuals who are labelled fear loss of status and discrimination (Link and Phelan, 2001, p 365). Labelling individuals with mental health problems has an effect on public perceptions of those with schizophrenia.

According to Angermeyer and Matschinger (2003), one of the negative effects of labelling is that it promotes the stereotype, which affects how people react to someone with SMHI and is associated with social isolation. Another benefit of labelling is that patients with SMHI are viewed as severely affected, which provides them more rights in terms of receiving and accessing care (Hamilton et al., 2016).

Unfortunately, the fact that those with SMHI are classified as psychiatric patients affects their identity by defining who they are and what they do (Yanos et al., 2010), as in this study's findings (P1, P2, P6, P7). Labelling also affects how people with SMHIs are perceived socially, such as expecting that they are harmful and unpredictable (Angermeyer and Matschinger, 2005), and associating people with SMHI with anger and fear, which results in limited access to facilities (Corrigan, 2000). Ahern and Fisher (2001) acknowledge that such assumptions may act as a barrier to recovery and may be interpreted as contributing to relapse. This is consistent with Thornicroft et al. (2010) observation that people regard the SMHI diagnosis as a form of reality. Some participants in this study accepted their SMHI as a reality and something they had to live with (P2; P3).

7.4.3 Discrimination

Some evidence suggests that service users of mental health institutions experience unpleasant levels of discrimination in the majority of care centres, including the way that they are spoken to and excluded from important decisions (Thornicroft et al., 2010; Corrigan et al., 2006). The evidence asserts that discrimination of any kind has an impact on an individual’s mental health (Penn and Wykes, 2003). Indeed, Farrelly et al. (2014) demonstrated a link between discrimination and an individual’s behavioural actions, which may result in lack of access to different aspects of life (such as employment, education and healthcare). For example, service users described the professional approach towards them as a type of stigmatisation. Similarly, Janssen et al. (2003) indicated that people who were discriminated against had a higher incidence of delusional thoughts than the general population, particularly when the impact of discrimination appeared to be severe. In the findings of this study, the majority of women experienced discrimination as a result of their SMHI, which resulted in them not receiving care at the right time, possibly leading to relapse and hospitalisation. Thus, discrimination due to labelling can be viewed as a form of stigma (Paul and Nadkarni 2017), which can have a serious impact, especially on women with SMHI.

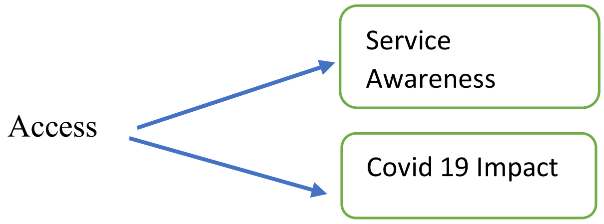
7.4.4 Isolation

Social connections and relationships are crucial for emotional and cognitive development in society (Shankar et al., 2013). Social isolation is a term that refers to the low quantity, quality and structure of social connectivity that a person has with others in society. This suggests that, while isolation does not necessarily result in loneliness (Peplau, 1997), social isolation can. Social isolation and loneliness both serve as significant risk factors for morbidity and mortality (Steptoe et al., 2013; Holt-Lunstad et al., 2015). Social withdrawal and isolation are characterised in the early stages of SMHI (Bucci et al., 2018; Michalska da Rocha et al., 2018). Indeed, in people with SMHI a lack of social connection is frequently seen; an isolated person feels lonely.

However, this is not always the case (Perissinotto and Covinsky 2014; Holt-Lunstad et al., 2015). Participants in this study experienced some degree of isolation, the majority of which was a result of the Covid 19 global pandemic. The pandemic caused a substantial level of psychological stress, leading the majority of women with SMHI to feel excluded during the postnatal period. The impacts of Covid 19 on participants will be discussed later in further detail.

7.4.5 Access

Figure 7.3



A substantial proportion of participants in this study reported that accessing mental health services before pregnancy was extremely difficult but became much easier throughout the perinatal period (for example, each participant was affected by Covid, which restricted their access to support and services; P2, 60-61, 39-40; P6, 117-112).

Access to health care represents the level at which health care is available when required, although individuals in need may frequently have access to resources but have difficulty utilising them. Service availability is a relatively limited measure of access to basic health care. Access to healthcare services has been a significant issue in recent years, despite the ongoing effort to meet the demand of individuals in need.

Access to health care requires an appropriate supply of health services. Thus, access implies that the individual recognises and accepts their need for services and is willing to utilise them. However, individual social and cultural activities may affect both access and the environmental constraints that surround it. Access to specialised mental health care has been a concern during pregnancy and in the postnatal period (Smith et al., 2019), as women with SMHI have many challenges to service access throughout this period, which may occur at any point along their care pathway. Such barriers occur for different reasons such as knowledge, women's attitudes, and their family relationships (including support, cultural attitude, and social network) (Reid, 2005). Poor access could be linked to inadequate knowledge of SMHI (Wan et al., 2008;), resulting in a stigmatising attitude which may in turn result in a delay accessing care (Megnin-Viggars et al., 2015).

There is evidence that women with mental health issues, for example, have poorer access to the health care system as a result of the stigma associated with this. It was demonstrated by Knaak et al. (2017) in a Canadian study that stigma associated with mental illness exists among professionals and can be a barrier to people accessing care. This study's findings reveal that professionals were often unable to initiate discussions about SMHI during the postnatal period. This may be due to stigmatising attitudes toward women with a severe mental health issue which may emerge from how mentally ill women are perceived (Abbey et al. 2011; Stuart et al., 2011).

Some participants were not even aware of perinatal mental health services. Furthermore, recent study has reported that accessing services is a problem for BAME society and is a public health concern in the UK (Simkhada et al., 2021), although Lewis-Fernandez et al. (2019) discovered that BAME communities are themselves less likely to engage with mental health services. This was not the case with this study and was not reported by the participants from an ethnic minority group, although other participants reported the same stigmatisation attitude that exists among healthcare professionals.

Different authors have emphasised the fear of discrimination and mistrust among professionals as one of the main reasons for poor access to services (Henderson et al., 2013; Shi et al., 2020). Other concerns include unequal access to care (Kapke and Gerdes 2016) and lack of information regarding cultural beliefs and stigma (McHugh et al., 2013). Managing cultural diversity in BAME communities requires a sensitive approach that includes cultural awareness and understanding of this minority's mental health concerns in the UK (Vahdaninia et al., 2020). This is in line with several research studies, indicating that access constraints are connected to individual awareness of available services and a lack of information about perinatal mental health services (PNMHSs) (Edge, 2011).

7.4.6 Service awareness

Participants in this study were already known to services or were aware of service delivery prior to pregnancy as they were connected with the mental health team in the North East of England. However, one concern raised was the lack of availability of beds in the mother and baby units during admission, which resulted in being admitted onto general wards.

This might need to be explored further. Women with a history or symptoms of SMHI are more likely to be referred to MH services. However, most of the study findings reveal that some were already aware of the services due to previous involvement with them. The findings report that women would prefer a system wherein health professionals understand their situation and facilitate a relationship within which they could disclose their distress.

There are some delays in referring participants from primary to secondary care services. This makes it more difficult for women to access timely care and management at appropriate times. One of the recurrent categories in this study was that women desired information about the perinatal mental health services and the possible changes that may occur in the postnatal period relating to SMHI (P3, P8).

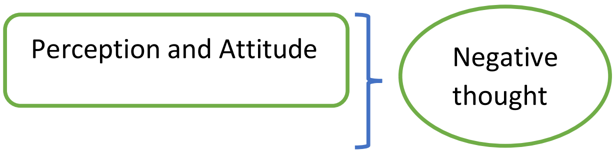
7.4.7 Covid 19 Impact

Coronavirus disease 2019 (Covid-19) is a novel coronavirus (SARS-CoV-2)-related acute respiratory infectious illness (Gorbaleny et al., 2020). Covid 19 was discovered in 2019 and labelled a global pandemic by the World Health Organisation in 2020 (Sohrabi et al., 2020), and countries worldwide limited the virus's spread by enacting social distancing policies and isolating sick individuals until vaccines and particular antibodies became available (Rahimi and Abadi, 2020).

Governments worldwide responded by instituting a range of steps to aid in the disease's containment, including masking, social distancing, and lockdown measures, as well as amending and adopting legislation and policies to reduce the pandemic's effects. Covid 19 has had a detrimental effect on a variety of factors, including mental health and access to healthcare services, resulting in increased difficulty accessing care facilities (Masters et al., 2021). Daily changes resulted in a significant issue when face-to-face appointments were restricted. The majority of countries imposed varying degrees of 'lockdown'. However, this had unintended consequences for the majority of people with chronic health issues, including those with SMHI, who felt alone and socially isolated (Flint et al., 2020). In the UK, there was a dramatic shift in individual circumstances following the coronavirus disease pandemic of 2020 whereby many individuals experienced job loss, increased financial strain, reduced personal support systems and professional services, physical isolation, loneliness and illness. The impact of Covid 19 may have been particularly significant for mothers during pregnancy and the first year following childbirth (Sergio et al., 2021). The study findings revealed that most participants were affected by Covid 19 in many ways, such as restrictions to face-to-face communication, and the reduction of interaction between individuals. Additionally, facial coverings (masks) became a requirement in healthcare settings as a result of the pandemic, placing women in an awkward position when receiving care. However, the majority of care was received online or via telephone discussion. The findings of this study indicate that Covid 19 affected women's postnatal mental health by reducing connections to family and relatives who typically might have provided support to them.

7.4.8 Perception and Attitude

Figure 7.3.4.



Participants shared a common understanding and perception of their own mental health. Some of the participants exhibited confidence and felt in control of their mental health, making them more likely to seek treatment on their own if they needed it. They characterised having insight into their own mental health needs as knowing what support they would need if they became ill again, and how to access that support. Motherhood perceptions have changed within a post-feminist paradigm that gives women the option of having children or not. Whereas the majority of women are believed to become mothers of their own choice or decision (Donath, 2015a), this idea does not apply to all cultures. Although women's perceptions of motherhood vary considerably by cultural and geographical area, there is one aspect of motherhood that all women share: having a child provide some form of emotional security for a woman (Blumenthal and Dielman, 1975), and motherhood may be associated with desired motherhood (Bernard, 2017; 1989). For some women, the purpose is to provide for their children (Chodorow, 2003). Motherhood mythology has been attributed to idealised views of motherhood in women, making it challenging for women to voice their challenges (Shloim et al., 2020). According to Lev-Wiesel and Al-Krenawi, (1999), the majority of women would choose motherhood over other identities. Culture is multifaceted and dynamic (Valibhoy et al., 2017), and it plays a crucial part in moulding women's perceptions regarding postnatal access to mental health services or resources (Abrams et al., 2019; Ahmed et al., 2017; VIgod et al., 2016). This study reveals that some women wish to reinforce the image of a good mother, while others believe they were made to believe they were poor mothers long before their children were born as a result of their mental health issues. Women's perceptions and attitudes of motherhood are shaped by their experiences of sleep deprivation and feeding issues (breastfeeding or bottle feeding). However, women rarely express this as a burden; rather, they are happy to see the baby thrive.

According to this study's findings, an infant's weight loss during the first postnatal week added to motherhood stress and was perceived as in some way neglecting the baby.

There was also some conflict for women who believed that their emotions were a normal aspect of being a mother but who also felt distressed. The findings reveal that one participant attempted to complete all tasks independently, assuming that this was part of the new mother's job to get things done (P4). Women in this study describe their perceptions and attitudes towards motherhood, childbirth and their SMHI as frightening; some report feeling agitated and anxious, particularly first-time mothers, while this apparently lessened with a second or third child. One participant recalls her hallucinations and spiritual experiences and how she battled to determine when to seek help. Overall, perceptions were focused primarily on the difficulties associated with bonding with their infant and obtaining the necessary assistance or support from family members.

Certain perceptions were formed mostly as a result of abrupt and large changes in their lives, not as a result of the transition to motherhood per se. As they adjusted to life with their new-borns, many first-time mothers felt vulnerable and dependent. On the other hand, several participants expressed general weariness, despite believing that having a baby was the best thing that had ever happened to them and was something to focus on to distract their attention away from their mental health issues, as well as something to look forward to. Further research is necessary to determine whether motherhood is a genuine decision, as opposed to being simply influenced by societal, cultural and religious perspectives which maintain the image of the self-sacrificing mother (Douglas and Michaels, 2004). Some of the participants in this study expressed feelings of guilt, shame and stigma, as well as a sense of not disclosing their concerns or seeking help at the right time to avoid being labelled as a bad mother or upsetting other family members (P2, P4, P9).

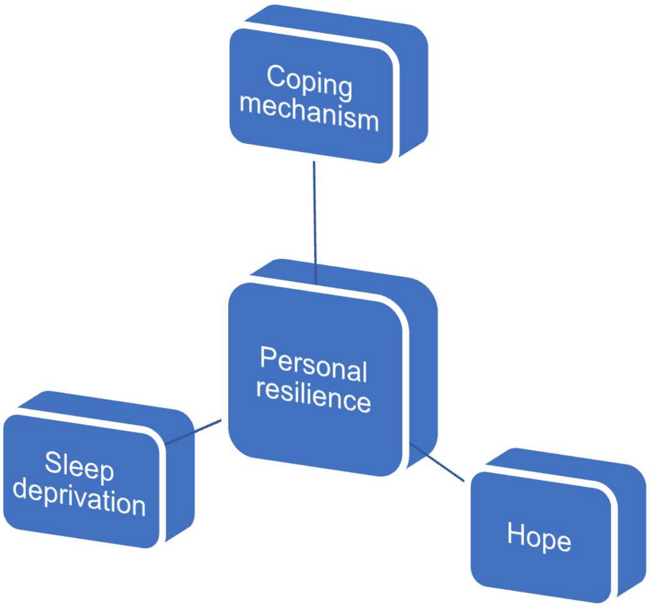
7.4.9 Negative Thoughts

Negative thoughts may arise as a result of previous and present experiences, or due to the onset of relapse in individuals diagnosed with SMHI, as observed in this study. For example, one of this study's participants reported that she was hallucinating with religious thoughts of reaching a spiritual place which was misinterpreted as the onset of relapse. In this study, negative thoughts about motherhood were prevalent among women with SMHI which is problematic because distress caused by negative emotions and thoughts can act as a barrier to SMHI management.

According to some women, SMHI perceptions reflect a negative attitude to emotions (Thornicroft et al., 2007). Attitudes concerning mental illness that are negative, or that include stigma, guilt and shame are associated with receiving a mental health issue diagnosis (Jomeen et al., 2013; Glover et al., 2014). Negative opinions regarding treatments for schizophrenia patients also play a role in non-adherent and self-stigmatisation behaviours (Boyd et al., 2014). In this context, concerns about being labelled a bad mother (Wyatt et al., 2015; McGrath et al., 2013), or not wanting to upset other family members, were frequently expressed (Wyatt et al., 2015). This study’s findings indicate that a significant majority of women have had unfavourable thoughts about new-born care and sleep deprivation. Furthermore, most women with SMHI experience negative thoughts. Some believe it is too much and that they would be incapable of caring for their baby, wishing they had never had one.

7.5 Personal resilience

Figure 7.4: Personal resilience



Individuals are not passive recipients of events; rather, they analyse their experiences based on their personal history and social surroundings, so affecting their ability to adapt to events, and adjusting how they interact with their environment to select and shape future experiences

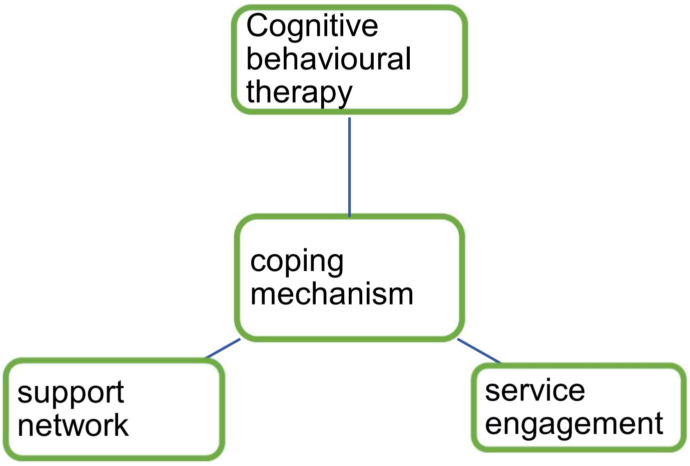
(Rutter at al., 1997). Family intervention and other measures that foster individual resilience may be useful in enhancing outcomes.

Pregnancy and childbirth are complex events in the human experience (Tuteja et al., 2016) and can predispose women to developing general psychiatric disorders (Meltzer-Brody et al., 2018). Personal resilience is the practicality of the participant's actions throughout the postnatal period in relation to her SMHI and her motherhood responsibilities. This also involves the characteristics that participants possess which assist them during the transition to motherhood, including:

- sleep deprivation
- learning and adjusting to a new role
- coping mechanisms
- what forms of support are employed to assist women in their new roles and responsibilities, and
- hope, in terms of what helps them to carry on adjusting to motherhood roles.

Psychiatry has recognised resilience as a significant personal resource and a therapeutic component. Therefore, resilience refers to the capacity to regain or preserve mental health and to positively adjust to adversity and difficulties (Aburn et al., 2016; Deng et al., 2018). Resilience can significantly affect real-life functioning and is therefore seen as a protective feature associated with a favourable prognosis for psychosis patients (Poloni et al., 2018). Therefore, resilience may be viewed as a complex and dynamic construct that facilitates the link between an individuals' social and external support systema as opposed to a singular concept (Gooding et al., 2019).

Figure 7.4.1. Coping mechanism



7.5.1 Coping Mechanism

Coping is a means of coping or a behavioural technique an individual employs to deal with stressful situations that are demanding, challenging and potentially harmful (Folkman, 1984). Coping is a way of solving problematic situations by either addressing the source of the stress or avoiding it (Folkman 1984; Carver et al., 1989). Meyer (2001) identified two distinct types of coping: the first is maladaptive coping, which entails self-distraction, self-blame, denial and behavioural disengagement, while the second is adaptive or positive coping, which includes planning, obtaining social support, and utilising emotional and instrumental support, acceptance and religion. With sufficient support from a network of family and friends, the participants in this study experienced both positive and negative coping mechanisms. Additionally, they utilised techniques such as cognitive behavioural therapy and service engagement. Individuals and cultures have different coping mechanisms (Wong, 2002; See also Essau, 2010). The choice of coping strategies is contingent upon the individual's perception and experience of stress, particularly the resources available for coping and the effectiveness of the method adopted (Folkman, 1984). The findings from this study indicate that women utilise a variety of coping mechanisms to manage their SMHI during the postnatal period. Alternatively, a coping approach is a complicated interaction between the individual and the environment with a focus on the problem; this is also referred to as positive coping (Taylor and Stanton, 2007). Positive coping and resilience are crucial personal resources for schizophrenia patients and can successfully mitigate the negative effects of symptoms.

Although, coping and resilience are sometimes used interchangeably, they are different but interconnected notions that have not been thoroughly examined (Gloria and Steinhardt, 2016). Resilience is the capacity to recover from stressful or painful life experience rather than submitting to the situation. In this study, participants exhibited their ability to regain control following relapse or hospitalisation to enjoy motherhood while fulfilling their motherly roles. Some reported that they had tried not to worry excessively, to avoid feeling incapable of doing anything or caring for their baby (P2 221-222). This helped them to build self-confidence. In this study, the majority of women benefited from utilising cognitive behavioural therapy (CBT), which will be discussed in the following section.

7.5.2 Cognitive behavioural therapy (CBT)

CBT is effective in reducing post-traumatic stress disorder following childbirth (Nieminen et al., 2016). CBT is a type of psychotherapy that focuses on assisting individuals in making practical changes. It can be used for addressing problem in a different setting and is often used by psychotherapists. Most participants in this study found CBT to be helpful in their situations and changed the way they dealt with the positive or negative symptoms they may have experienced or were experiencing. CBT acts as a support mechanism for changing one's thoughts by building more positive than negative thoughts and behaviours, especially, when thoughts wandered, inflicting negative emotions, unhealthy thoughts and pain (P2, P4, P6). Thus, using a CBT approach may aid in identifying and reducing symptoms in women with severe mental health issues during the postnatal period.

7.5.3 Support network

A variety of perspectives were expressed by participants regarding their support networks. A support network is a crucial coping mechanism for people with SMHI during the postnatal period in relation to motherhood. The majority of participants in this study utilised support from their extended families throughout the postnatal period. According to those participants with severe illness, after delivery of their babies, care providers seemed to feel that the mother's needs were no longer relevant and that their attention and focus should be dedicated to the baby's physical needs (P3).

Women are regularly seen by their midwives and health visitors at the community care level during the postnatal period. A six-week appointment is often fixed for a visit to the GP. However, some participants in the study expressed concern with the type of support they received from non-mental health practitioners during the postnatal period in relation to their SMHI and motherhood needs (P3). Some women also found it difficult to proactively seek assistance from healthcare professionals and these women were afraid or reluctant to talk about their mental health issues. Participants in this study who had access to the mother and baby unit throughout the postnatal period described it as helpful and supportive. It was also believed that there is a need for more specialised community perinatal mental health services as well as improved access to PNMH Services (P2, P3).

7.5.4 Service engagement

According to NICE (2014; 2018), health care professionals should ask about a woman's well-being during pregnancy and in the postnatal period in order to identify possible areas of concern. Some women expressed their concerns about addressing their mental health issues with their midwives and health visitors at every visit because of having repeat the history of past events (Russell and Chamberlain, 2017).

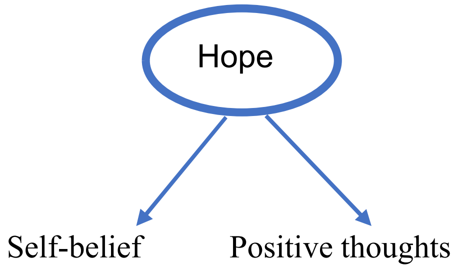
Participants in the study also expressed concerns regarding the continuity of care: for example, they worried about the fact that they were not able to see the same healthcare professional throughout their care, thereby diminishing their ability to develop relationships or to confide in the professional (Russell and Chamberlain, 2017). There is certainly a need for more continuity of care for individuals with SMHI. Another aspect that might contribute to poor service engagement in women with SMHI is the minimal consultation time these women spend with the healthcare professional during their appointment, making it difficult to disclose their mental health state. Due to time restrictions, insufficient relationships are developed. It is obvious in this study that the participants were concerned that the consultation time was inadequate to build a relationship with their healthcare professionals or to disclose how they were feeling about the state of their mental health (P8, P3, and P4). For example, they reported that they were not asked about their mental health issues or feelings of stigmatisation, which left them feeling that their experiences with their MH were normal (P2) and that they were unsure what was wrong (P5).

They also worried about not wanting to take up the consultation time (P8), and that the focus was only on the baby (P3). However, this study did not examine whether the women were concerned about their babies being taken from them by social services. Women might refuse to interact with healthcare professionals during the postnatal period by denying having SMHI symptoms. The study did not explore the reasons for this. It may be that some women are uncomfortable speaking with various professionals about their mental health concerns (Russel et al., 2017). Moreover, the chances of engaging with services are mostly dependent on individuals' perceptions of their needs, beliefs, religion, culture, and previous support experiences with the health services (RCOG, 2017).

Personal resilience

7.5.5 Hopes

Figure 7.4.2 Hope



Hope was defined by Colla et al. (2022) as the human capacity that enables individuals to utilise the resources available in their immediate surroundings to help in their journey towards healthy achievement. Through an increase in positivity, hope is thought to assist individuals in navigating through difficult and challenging situations and recover more rapidly from hurdles (Snyder et al., 2002**.** On the other hand, Werner (2012) and Synder (2002) define hope as a motivating intuition that inspires a person to pursue a goal and has been associated with a better quality of life (Werner, 2012; Synder, 2002). One could argue that an individual's expectation of a condition is dependent on his or her understanding of the circumstance and the significance of the condition to the individual. This could imply that a situation's negative or low expectation, desire, or belief may influence a positive outcome. Hope has also been linked to a decrease in self-stigma in people with SMHI (Mashiach-Eizenberg et al., 2013).

Having hope is important for people living with SMHI (Hayes et al., 2017; Resnick et al., 2005). Therefore, for women with SMHI, developing hope might be a vital step toward recovery (Anthony, 1993). The compelling personal stories from people of different cultural backgrounds give insight into the contextual variables of women who have experienced SMHI and the role that negative and positive hope play in their motherhood issues. Despite the fear and stigma that surround these women, the participants in this study demonstrated the crucial nature of trust, confidence or belief in oneself and others. They recognised the benefit of having a positive self-image in developing and sustaining one's uniqueness, which in turn helps in the recovery processes. SMHIs have been associated with a lack of hope (Lysaker et al., 2004; 2008), particularly in relation to postnatal motherhood responsibilities and challenges. Hope is significantly associated with psychological development and health (Song et al., 2011) and is explained as a multidimensional, dynamic life force defined by anticipation of a better tomorrow, with possibilities within the framework of interpersonal relationships that provide life purpose and meaning and that enable the individual to transcend present obstacles (Stephenson, 1991; Adams and Partee, 1988). This is crucial to the recovery of individuals with SMHI (Roe et al., 2004; Anthony, 2003). Indeed, Anthony (2003) emphasises the significance of hope as a positive expectation of change in the recovery process, while Deegan (1994) compares hope to a touch to symbolise the darkness of despair in schizophrenia recovery. In this study, three participants define hope as a glimmer of light at the end of the tunnel, as something that has not yet been accomplished but which may be realised in the future. They have confidence in themselves. The majority of participants want to get better and to do what they must without relapse, as an expectation of a better tomorrow; this is essential for overcoming mental illness and creating positive changes in the lives of people with SMHI (Roe et al., 2004).

Almost every woman in this study acknowledged or expressed their desire for their circumstances to improve, while others anticipated when their circumstances would improve sufficiently for them to fulfill their motherhood role. Since family also plays a significant part in the lives of people with SMHI, this can also impact how hope is conceptualised and utilised (Hernandez et al., 2019). This study's findings indicate that the majority of women believe that having a positive relationship with their family enhances their view on life and provides them with hope. (P1, P2, P3). In contrast, hopelessness (a lack of hope) has been identified as a risk factor for the majority of suicide attempts (Johnson et al., 2010).

7.5.6 Self-belief

In this study, participants' perceptions of self-belief and hope were highly connected to their religious and spiritual beliefs, implying that faith instils hope in the participants (Tuck and Anderson et al., 2014), although there may be a conflict between individual autonomy and reliance on others. Beliefs are interpretations of events that individuals accept as true based on their faith (Shapira-Berman, 2021). Participants are motivated to achieve symptom stabilisation and have defined goals, such as being able to care for their babies and families. It is understood that beliefs are developed as a result of one's experiences and reflections, or as a result of exposure to events. This study's findings suggest that the majority of participants' beliefs or self-thoughts are a crucial focus for treatment and support during postnatal SMHI recovery (P3, P5). Hope and self-belief coincide but not the same. Self-confidence is the capacity to finish tasks and reach one's objective, whereas hope is the expectation that things will go one's way.

7.5.7 Positive thoughts

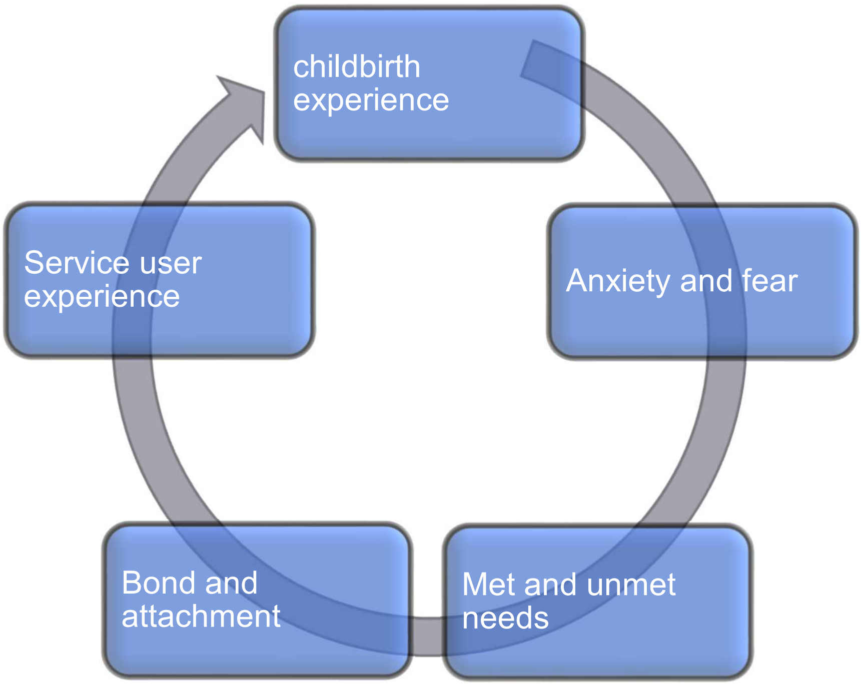
Individuals with SMHI are reported to have the most distorted thoughts, such as predicting that things will turn out badly or hallucinating. According to studies, people with SMHI tend to have more negative thoughts (Takeda et al., 2019). Positive self-thought is necessary during the postnatal recovery period of women with SMHI. Positive thoughts have been reported by women with SMHI as a way to keep their hopes up and aid their recovery. However, people with SMHI are known to experience a range of thoughts, both positive and negative. Not every thought disorder is associated with the same outcome. Positive forms of cognitive disorder (stress talk) lack values and power, whereas negative thought disorder (lack of speech and content) is typically connected with a longer, more chronic course of illness.

7.5.8 Sleep deprivation

Healthy sleep patterns and regular physical activities have a positive effect on an individual's mental health and well-being (Taliercio et al., 2020). Moreover, certain forms of psychotherapy reduce sleep deprivation, which may be worsened by antipsychotic withdrawal, resulting in a shorter or longer sleep pattern in some individuals (Chan et al., 2017). Since frequent sleep deprivation is obvious during the first few months following childbirth predominantly in first-time mothers (Karacan et al., 1969). The difference between first-time mothers and those who have already experienced motherhood is that the former struggle to adjust to their new role, whereas second- or third-time mothers have previously experienced this and have implemented measures (such as visitor restrictions) during the postnatal period to avoid sleep deprivation and relapse. Sleep deprivation has been reported to trigger relapse in those with SMHI and should be avoided. Study data indicate that insomnia is the most common cause of sleep deprivation in individuals with SMHI (Manoach and Stickgold, 2009). According to Shinkoda et al. (1999), women who had more than one child been unable to obtain restorative sleep due to frequent awakenings at night (Sharma and Mazmanian, 2003). This is consistent with the findings in this study, wherein the participants reported disturbed or lost sleep, which resulted in them spending the majority of their time awake at night. This demonstrates that sleep deprivation may act as a trigger of SMHI. Individuals with SMHI who are sleep deprived are likely to present with hallucinations and delusions as a result of their sleep loss (Waters et al., 2018; Mulligan et al., 2016). This study found that practically all participants were aware of the negative impact that sleep deprivation had on their SMHI and thus continually sought to minimise the situation with the support of their partners or families. The findings of this study indicate that the source of their sleep deprivation was having a new-born or being a new mother. For instance, one participant describes enduring sleep deprivation as a result of her baby's unsettled night. Other participants attribute their sleep deprivation due to visitors and a high number of phone calls from relatives congratulating them on the births of their children.

7.6 Childbirth experience

Figure 7.5

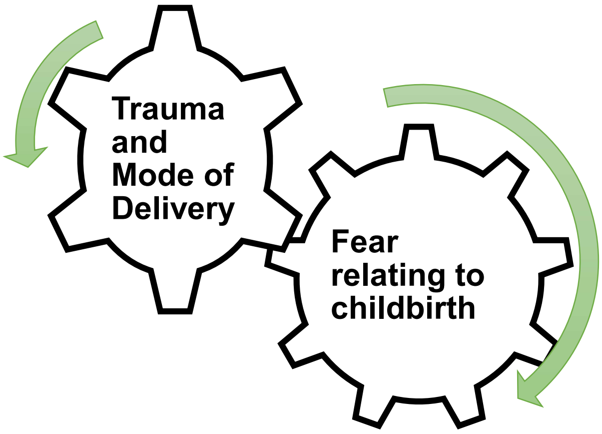


The fear of childbirth has been linked to a propensity for general anxiety that may be acquired by traumatic experience or by observing other frightened responses (Rachman, 1977). For example, women might recall the specifics of delivery years after the event (Simkin, 1992). Anxiety can be connected with posttraumatic stress disorder and difficulties with infant attachment, which may in turn result in the avoidance of future pregnancies. This may be a result of social and psychological factors. Having an emergency caesarean section or instrumental delivery increases following pregnancy anxiety of labour (Areskog et al., 1983). Thus, mode of delivery affects the psychological status of women following childbirth (Ryding et al., 1998). Indeed, women who had had an emergency caesarean section or instrumental delivery had a more negative psychological reaction than women who had a planned caesarean section or vaginal delivery (Ryding et al., 1998). For some women, the fear of suffering endures for many years.During the postnatal period, women with SMHI have a range of experiences on their path to motherhood.

Their childbirth experiences are mostly determined and influenced by the following: childbirth trauma, mode of delivery, met and unmet needs, and bonding and attachment with regards to the mother-child relationship, including feeding issues. All these variables contribute to the development of their positive or negative experiences (P3, P5). In the postnatal period, the most commonly reported childbirth experiences of women with SMHI were centred or based on fear and anxiety. Childbirth experiences have been reported to have an impact on women with SMHI throughout the postnatal period as a result of birth trauma, fear and anxiety, stigma, labelling and coping with motherhood roles, as described in theme one/ the first categories of the study. According to the study findings, women with SMHI childbirth experiences, and the changes associated with motherhood, had an impact on their lives, including their everyday activities and social duties. They felt and assumed that they were prevented from meeting their own needs in order to satisfy those of their children.

7.6.1 Anxiety and fears

Figure 7.5.1



The findings in this study indicate that women with SMHI had traumatic, frightening and overwhelming experiences during the postnatal period in relation to childbirth and motherhood roles. Different perspectives have been generated around childbirth and motherhood, and the majority of women with SMHI experience significant anxiety and depression during this time.

This could be a result of the stigma associated with being labelled a mental health patient, or of the fear of being judged as a bad mother for not being capable of looking after herself, the baby and the family (Nagle and Farrelly, 2018). Fear of childbirth may also precipitate relapse in women with SMHI during the postnatal period. Women in this study expressed feelings of guilt and disappointment as a result of the high level of unmet needs. Fear, loneliness and a sense of being left out were identified as significant and prevalent symptoms observed in women with SMHI during the postnatal period. This study's findings support what the participants had previously stated about the difficulties and delays associated with bonding with their infants (Forde et al., 2020; Brockington, I., 2017; Engqvist et al., 2011), insofar as the study participants reported that their anxiety was exacerbated by uncertainty about the future, while they also expressed fear of being locked up (indoors) until they recovered from this setback. Women with SMHI are also concerned about having additional children in the future due to the fear of recurrence of their mental health events or relapse.

7.6.2 Fear relating to childbirth

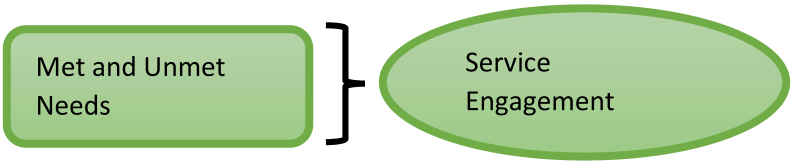
Fear of childbirth has been shown to have an adverse effect on a woman's psychological well-being, during both pregnancy and the postnatal period (Slade et al., 2019). It can also impact women's experiences in terms of birth outcomes (Junge et al., 2018; Haines et al., 2012), leading to a higher rate of Caesarean sections (Dweik et al., 2014). Not only in the UK, but throughout the world, fear of childbirth has been widespread, affecting women (Ayers, 2014; O'Connell et al., 2021). According to Slade et al. (2020), this could be due to multiple factors, although there has been no consensus on what constitutes fear of childbirth (Nilsson et al., 2018). Participants in this EXMEPP study expressed concerns about childbirth, particularly the first-time mothers and those with previous negative experiences of childbirth. The participants' fear, as well as their experiences, led to delays in trying for another child or an unwillingness to have further babies. This is demonstrated in reports from this study, such as by P3, who stated that ''difficult delivery has contributed to fear''. The study findings refer to instances in which childbirth was difficult and resulted in relapse. It is reported that increased anxiety during pregnancy can influence a woman's postnatal wellbeing (Storksen et al., 2012). Therefore, fear of childbirth (P3) could be a trigger to postnatal relapse for women with SMHI.

7.6.3 Trauma and Mode of Delivery

Mode of delivery and trauma during the postnatal period may precipitate a recurrence or relapse in women with SMHI (Badaoui et al., 2019; Dekel et al., 2019). The mode of delivery is connected with the rate of trauma (Priddis et al., 2013; Perry et al., 2021; Taylor et al., 2019). Vaginal birth, for example, is known to have a significant effect on the pelvic floor and weakens the bladder in some deliveries (Peschers et al., 1996), which can have a long-term effect on the individual in the form of stress urinary incontinence (SUI) (Tahtinen et al., 2016). SUI is an involuntary loss of urine in response to sneezing or coughing (Haylen et al., 2010) that is connected with the long-term effect of the delivery mode (Tahinen et al., 2016). In contrast, Caesarean birth is believed to protect against such pelvic trauma although assisted vaginal delivery with instruments such as vacuum and forceps, also increases the risk of trauma, including pelvic organ prolapse (Volloyhaug et al., 2015). Planned Caesarean section delivery was not shown to be associated with an increased incidence of relapse in schizophrenic patients (Cannon et al., 2002). However, relapse is also evident following an unexpected Caesarean section, which has a significant impact on women's mental health (Dekel et al., 2019).

7.6.4 Met and Unmet needs

Figure 7.5.2:



An effective transition to motherhood requires identification and support of the postnatal needs of women (Fahey and Shenassa, 2013). Motherhood comes with its challenges, such as maintaining day-to-day parenting skills and abilities, caring for the infant, managing mental health issues, and overcoming the stigma associated with mental illness (Howard & Hunt, 2008; Mowbray et al., 2000; Nicholson et al., 1998a; Karidi et al., 2015).

In terms of the met and unmet postnatal needs of women with SMHI, this study focused on their childbirth experiences and transition to motherhood. Megnin-Viggars et al.’s (2015) study identified some of the unmet needs of postnatal women that are similar to those of this EXMEPP study’s participants in the following ways:

- women require a collaborative and integrated service system that supports their needs and can direct them to mother and baby units when required (Chandra et al., 2019)
- healthcare professionals are unable to meet women’s psychological needs. This study finds that professionals focus on their baby’s needs
- all women with SMHI who are hospitalised during the postnatal period need to be admitted into mother and baby units.

Women also experience lack of information and peer support, lack of continuity of care and some unmet needs, including the provision of childcare, particularly in times of crisis (Dolman et al., 2013). According to the majority of research, women encounter a number of hurdles to accessing primary care, such as trouble obtaining GP appointments, or a health care professional that prioritises the baby’s needs over the mother’s (Wittkowski et al., 2011; Chew-Graham et al., 2009; Edge, 2009; Edge, 2008). Other unmet needs relate to women’s reluctance to confess mental discomfort for fear of losing custody of their babies (Cooke et al., 2012). Additionally, women are dissatisfied that they cannot receive services unless they are in crisis (Cooke et al., 2012).

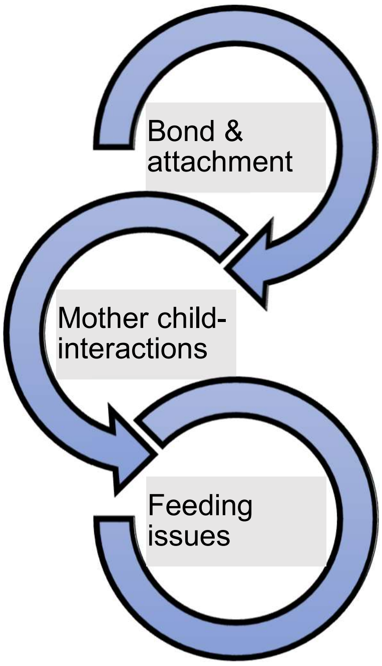
Breastfeeding issues and sleep deprivation were the primary sources of unmet needs mentioned by the participants in this study. Friction between relatives, beliefs, religion and cultural values can also influence their feelings and emotions (Russo et al., 2015). Failure to reach an agreement on the best way to cope can also cause distress, shame and lack of confidence, all of which can worsen mental illness (Dolman et al., 2013). Due to the fact that the global Covid-19 pandemic restricted face-to-face interactions among people (as documented by various studies), this study identified isolation as a source of unmet needs.

This study’s findings demonstrate the importance of professionals having SMHI awareness, and handling and management ability in order to support these women. According to this study, more than 30% of women were admitted to general wards when they required hospitalisation. Another issue reported was not having enough time during appointments with healthcare professionals due to their workloads. This time constraint prevented women from discussing their emotional needs in detail with professionals (Higgins et al., 2017; Darwin et al., 2015).

However, there are also many met needs in the study findings relating to women with SMHI's experiences of motherhood. The findings indicate that self-empowerment, recovery and hope were all included in the participant's met needs. Women were able to articulate their strength, while family members were described as a significant source of support in terms of ensuring their psychological well-being during the postnatal period as they came to terms with SMHI. This study finds that some women prefer to work independently, as evidenced by participants' refusal to ask for help, particularly following childbirth.

7.6.5 Bond and attachment

Figure 7.5.3: Bond and Attachment



Pregnancy and childbirth are seen as significant life events for a woman. The nine-month gestation period is required not only for the physical growth of the foetus, but also women to acclimatise to their motherly role (Cranley, 1981). Maternal-infant attachment is the process by which an expectant mother engages in behaviours that indicate affiliation with the unborn child (Cranley, 1981). It is the emotional connection with an unborn foetus, whereas bonding relates to the interaction between mother-infant and raises the likelihood of psychological, social and cognitive issues (Tetley et al., 2014).

Women develop bonds and attachments to their babies during pregnancy; this process is termed 'prenatal attachment' (Condon and Corkindale, 1998). The maternal responsive temperament is expressed in terms of protecting, meeting needs and avoiding loss through acting and performing a defensive role towards the foetus (Walsh et al., 2014). This relationship is maintained throughout pregnancy and the postnatal period (Maas et al., 2016) and it has been shown to facilitate the transition to motherhood (Mazzeschi et al., 2015). Positive prenatal maternal attachment enhances the potential of the mother to adopt a positive response behaviour following childbirth and sensitivity to the child's needs (Walsh et al., 2014). The level of bonding and attachment between a woman with a SMHI and her infant during the postnatal period can influence her mental health and behaviour throughout the transition to motherhood (P2, P3).

7.6.6 Mother-child interaction

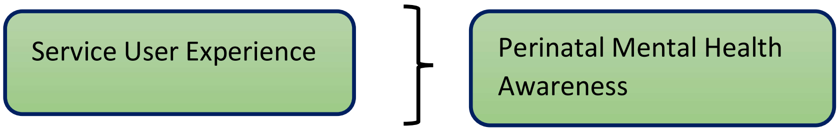
To become a mother, a woman must restructure herself by realigning her goals and roles to fulfil her motherhood responsibilities. The ability of a woman to build an attachment and care for each of her children is based upon her ability to perform the developmental goals involved with this process (Fahey and Shenassa, 2013). Poor mother-child bonding or interaction can impair mother functioning and well-being (Dekel et al., 2019), as well as child development (Cicchetti et al., 1998). As Holt et al., (2018) point out, trauma can result in a poor relationship with the baby. Mental health issues can also have a negative effect on the mother-child relationship (Perera et al., 2014). This study identified severe instances of poor bonding and mother-child interaction following relapse or hospitalisation, although most of the participants re-established their interactions following their recovery and some women reported having a different experience with their second child with regards to interaction and bonding. Positive mother-child interactions are necessary to enhance participants' recovery process.

7.6.7 Feeding issues

This study's findings indicate that, even though the majority of women with SMHI breastfed their babies, some experienced difficulty with this. While the majority of participants expressed a desire to breastfeed, some women with SMHI felt that it needed all of their time and resources. Due to the fact that newborn babies require frequent feeding, this feeling may occur intermittently during the day and night, perhaps resulting in sleep deprivation. The pressure to breastfeed, as reported in this study, can compound the postnatal stress levels of women with SMHI. Indeed, it was reported by the participants that breastfeeding took priority over every other part of their everyday lives. Women feels that exclusive breastfeeding takes too much of their time and hinders or prevents them from performing housework. The women described their feeding experiences as anxiety-inducing, stressful and frustrating. One of the participants reported having an issue with baby weight loss despite breastfeeding. This prompted her to discontinue breastfeeding her baby. Breastfeeding also takes a lot of physical strength and can lead to sleep loss; thus, many of those who braved breastfeeding felt overwhelmed.

7.6.8 Service user experience

Figure 7.5.4: Service User Experience.



The experience of women during childbirth can have an impact on their mental health and decision-making with regard to accessing services. Women who have had a poor or unfavourable experience with services may find it difficult to seek assistance when it is needed. In this study, individuals' narratives about their experiences utilising services were interwoven with their mental illness labelling (P2, P3).

Women with SMHI who receive services fall into two categories:

- Those who are initially admitted to a general ward due to a lack of available beds in the mother and baby units, and
- Women who have been admitted directly to the mother and infant units.

Women who were separated from their babies while confined to a general psychiatry ward described the negative impact the separation had on their recovery journey (Powell et al., 2020).

During the study interviews, one of the participants described the impact of her admission to the general ward on her recovery, arguing that she might not have recovered had she not been transferred to the mother and baby unit. Women admitted to the general ward with SMHI required additional support throughout their separation from their new-borns to minimise the negative impact on their recovery process. However, women with SMHI who were admitted directly to the mother and baby unit during the postnatal period had a different experience that was filled with support and encouragement and therefore helped in their recovery process. Women with SMHI have unique childbirth experiences. This experience differs significantly among women, as seen in the study findings. Women also experience a range of emotions surrounding labour, including fear of childbirth. The fear of childbirth is perceived as a common psychological phenomenon that occurs before, during and after childbirth (Hofberg and Ward, 2003); this was also discovered in a study conducted by Qiu et al. (2020) on nulliparous women in China. It is this fear that can increase the risk of women developing additional postnatal issues such as post-traumatic stress disorder (Soderquist et al., 2009).

This in turn frequently results in women having doubts about their ability to cope with childbirth and motherhood. The current study found different views on childbirth experiences, which were both positive (empowering women) and negative (traumatising experience) (P5). The childbirth experience can indeed be physically or emotionally stressful. This indicates the need for creating awareness of Perinatal Mental Health Services. However, some women who were referred for SMHI services were recommended to continue taking their medication (P3, P4). The study's participants recounted continually being referred to as lacking the capacity to be accountable for their own lives (Thornicroft et al., 2010). They felt they lacked sufficient knowledge about their condition to make educated pregnancy and postnatal decisions.

The majority of maternity hospitals have established specialist perinatal mental health units with a well-defined referral pathway: however, there remain some hospitals lack the resources necessary to treat women with SMHI during the postnatal period. Mother and baby units provide care for the mother and infant(s) to facilitate mother-baby interaction (P2), which benefits the mental health and wellbeing of both the mother and the child.

7.8 Conclusion

Chapter seven has presented the major categories and sub categories of elements influencing women's experiences of severe mental health issues, which may be positive or negative, but appear to be more positive in terms of recovery and motherhood. It has demonstrated how social context around culture and belief perceptions could influence women's experiences and help-seeking behaviour. Data analysis revealed different perceptions towards severe mental issues and motherhood, with most of the participants striving to identify coping mechanisms that work for them, as well as the best ways to manage their new responsibilities and severe mental health issues. While self-blame appears to be prevalent among some women, internal stigma is also common. All interviewees felt that having a baby was the best thing that had ever happened to them as they had something positive to keep them occupied.

Personal resilience is the core category of the study and determined by an individual's self- or inborn resilience, which helps them to withstand challenging situations. Due to the discovery of a positive interaction between condition and motherhood, all of the negative elements in categories 1 and 3 can be reduced, resulting in strong resilience. Resilience can assist an individual in developing robust coping mechanisms for dealing with their SMHI, whereas coping difficulties can indirectly delay or inhibit the individual's natural resilience but can lead to learning or developing a new resilience approach or strategy. If participants lack a support network or a motivating aspect or concept with which to interact, for instance, they cannot engage in baby related activities and benefit from adopting a motherly role. The individual may therefore find the motherhood role challenging if they fail to recognise the connection between isolation and support, hence validating their position.

Social context or childbirth experience as referred to as category one or category three can only become positive or effective if category 2 is powerful in an individual who recognises their strength and coping skills. The motherhood activities highlighted in category 3 can thus become the most positive and inclusive of all childbirth-related activities.

Women who regain or develop resilience are less likely to experience postnatal depression or related SMHI. Therefore, by generating awareness and training programs, the Resilience-Led Behavioural Model can change practice. This model can be employed to inform mental health services and midwives about the problems faced by women with SMHI in the postnatal period and the necessity to begin educating them about the model. Understanding the experiences of women with SMHI is a major concern, as more women with SMHI are having children with the support of their families.

Chapter 8

Chapter 8: Summary

8.1 Researcher's Reflective Journey

The use of reflective practice in qualitative research has been well documented in research (Seale, 1999). Researchers have a responsibility to be honest, and critical of their influence on the study process (Porter, 1993; Robson, 2002). In addition to enhancing quality, reflective practice can be used for other applications and has served as a record of each step of the research process since this study began. Thus, this section will report on the incidences and reflections that were recorded during the research project. It is fair to say that the entire study process has been enlightening in many ways. As soon as the study framework was established to gather and analyse data from the participants, the first problem arose, which centred on ethics and convenience. Gaining clearance from the University of Northumbria's ethics board marked the start of the study. The ethics board gave their approval for the project and, due to the participation of service users, further clearance from a Regional Ethics Committee (REC) was also sought. Considerable care was given to this, and the current study was conducted in a hospital setting to ensure that the participants and researcher were in a safe environment throughout data collection.

This study complied with all applicable government and university policies concerning Covid 19, which implies that all data collection took place using visual electronic devices such as computers and tablets, rather than from face-to-face contact. Notes (memos) were taken, and reflections were recorded throughout the data gathering process, in line with the chosen methodology; a reflexive approach to data collection was used. Grounded theorists employ spontaneous note-writing to capture transient ideas about the code, which serves as an analytical tool (Charmaz, 2006). It has been debated how much reflexivity means to researchers and how they implement it (Rettke et al., 2018; Tobin and Begley, 2004).

Memos are used to increase the researcher's self-awareness in GT. For researchers, notes or memos are an invaluable tool because they help them detect and deal with data that goes against their own biases more easily (Hamberg and Johansson, 1999; McGhee et al., 2007). The possibility of beginning data collection after a long wait for ethical approval piqued my interest, and I was eagerly looking toward getting started. All of the necessary preparations were made, including doing practice interviews with my supervisors, and everything was set to go.

I was nervous and unsure of what to anticipate because of the importance of the task, and I wanted to make sure everything went smoothly. The team leader was assigned the job of contacting possible participants and so the research progress was halted until this task had been completed. The team leaders were also responsible for deciding how materials would be presented to attract participants. Once the participants were recruited and the introduction was complete, the study could begin. The following notes were taken after the first interview with a participant who had previously been diagnosed with serious mental health difficulties. "25th September 2020 – Overall, I was nervous, but the 40-minute recording session went well".

Throughout the interview, I was aware of the connections between theory and experience from my practice, which allowed me to see the issues stated by the participants more clearly. Excitement at having started to collect data and at hearing the language relevant to the study was also reflected – "relief that everything was working according to plan and producing high-quality data (although the duration was short)".

Thoughts – "keep the participants on track – (currently) allowing them to use their words and make too many suggestions". Seeing connections between theory and practice experience prompted other inquiries:

- ''Do I use the same questions for each interview?
- or do I tailor the questions to each individual?

Considerations for the next interviews

-Do not ask too many questions at once to the participants''

It is important to be as concise as possible while asking questions or making remarks and to avoid talking over individuals and attempting to cut off the beginning or conclusion of a participant's conversation. Only one person was unwilling to share additional information and expressed disappointment at not having been able to provide more information during the interview process. This was difficult because the interviews were not intended to make any of the participants feel uncomfortable or as though they were being scrutinised. In preparation for further data collection, the same feelings about recruiting potential participants returned; nonetheless, the team leaders and team employees proved to be beneficial in terms of the support needed to allay fears.

Before approaching the service user, I was reliant on the team leader, referred to as the Principal Investigator (PI), and the care coordinators to understand what was required to effectively communicate that knowledge to the service user. A few people refused to participate in the study, and not knowing what the care coordinator had said to the participants made it difficult to determine whether or not they should. Three of the participants had given consent but had declined to participate in the study, exercising their right to opt out, and two were difficult to reach despite repeated attempts: it was later discovered that they did not live within the study area. To address this, the team leader decided to involve the researcher in the recruitment process by asking the researcher to join the team leader online to participate via Microsoft Teams (before the interview process). This enabled an initial introduction between the researcher and the participants. The researcher was able to address questions that the participants had and provide an insight into the study in terms of their participation. Each participant was assigned a coded name and a number, which was unique to them. In the process of overcoming the voice of the researcher, new and interesting challenges arose. It was exciting to be working on a practical project, but the process of interviewing, transcribing, and attempting to make sense of the data all at the same time is difficult. I was trying to create categories and concepts as well as attempting to portray the discovery in a unique way that would pique the interest of readers (Mason, 2002).

In terms of displaying the data, I was looking for something different and unusual that would make the work stand out while maintaining the analytical rigour (Luciani et al., 2019). The transcription process is extremely time-consuming and lengthy, which can lead to frustration, especially when combined with the analysis. However, despite the usefulness of NVivo, it was necessary to try other software that would promote re-examination of the data collected; for this Mind Genius proved beneficial. Data collection was also somewhat laborious, and it was felt that the research should be progressing more quickly. Thus, it was necessary to seek the input and guidance of the research supervisors, who provided new perspectives on the data and findings and reinforced the notion that speed is less important than the quality of the work. Thereafter, the research process resumed. The transcripts were subjected to scrutiny for analysis. The participants in this research are representative of the population being studied because they have a diagnosis of SMHI such as schizophrenia or bipolar disorder during the postnatal period. They are currently involved with perinatal mental health services and have had a child within one year of the study's commencement.

Women who had been diagnosed with SMHI but were no longer in need of the services of a mental health professional were not included in this research study.

The appropriateness of an interview with SMHI patients, as well as the creation of rapport, was a potential area of difficulty (Cogan et al., 2019). However, there were some articulate responses to the questions asked during the interviews performed for this study, which allowed for a wide range of information to be collected. During the interviews, the participants expressed their thoughts and feelings openly.

As they related their stories, the people who were being questioned shed tears and smiled at appropriate times. This presented another possible barrier, and while it was not a major issue, it was something to keep in mind during the interview process. Effective communication techniques were employed during interactions with participants to establish a positive rapport and encourage a certain amount of openness on their behalf during interviews. The interview schedule was largely followed, and participants were not urged to say anything which made them uncomfortable or that may be interpreted as being off the subject or the point. This was communicated explicitly, and feedback was provided to the care coordinator when it was deemed appropriate.

8.2 Impact of Covid 19 on the Research

This research was affected by the global pandemic guidelines, resulting in disruption to many activities. The lockdown, which also involved restrictions on one-to-one contact meant that all non-Covid-related data collection was suspended. This made it very difficult for participants to be involved in a non-Covid study. The study required ethical clearance; however, the commitment to act following ethical principles meant that further permission was required before altering the study data collection method. As a result, the method of data collection was changed from face-to-face to telephone interviews or the use of Microsoft Teams or other online communication platforms. This adjustment was made to enable me to continue the study with minimal interruptions.

The restrictions imposed as a result of the pandemic resulted in delays in the research study. The study also experienced a more substantial reduction in enrolment than expected. The likely impact of this disruption on the study was still not clear because data collection was due to completed within the following few months with minimal impact on the study.

However, data collection might also have been delayed, which would have meant that the timeline for data collection would expire, requiring adjustment. The ethics committees at the University, REC and the NHS were contacted to ask for an extension, which extended the completion of the study by a few months. This means that the study milestone was also extended. The timeline for data collection was therefore affected and as a result, the completion date was delayed based on the continuing effect of the global pandemic Covid 19. These challenges could have affected the study findings and data collection as people felt overwhelmed by the pandemic and were less likely to participate fully in the research study, although the lived experience of women with postnatal SMHI might have had new meanings and concepts which have might impacted the research design.

8.3 Ethical Consideration

This study went well due to a supportive supervisory team. The main challenges of this study were gaining ethical clearance due to the nature of mental health needs and the perceived vulnerability of participants. Gaining ethical approval was a difficult and slow process. During this protracted period, I focused on both the literature review and gaining a deeper understanding of mental health theory and practice in general to expand my knowledge and comprehension.

This enabled me to develop a comprehensive literature review and to write a draft of chapter two. Ethical approval was eventually granted by Northumbria University and through IRAS on the 24th of February 2020 with minimal adjustments. Following some minor amendments, final approval was granted by REC/NHS in April 2020. The other major challenge was that, once both University and NHS ethics committees were satisfied that the study was safe to conduct, a global pandemic (Covid 19) suspended the collection of all research data apart from that of Covid 19 related study, as mentioned previously. The University followed the government guidelines on Covid 19, updated the school webpage and emailed students on what to do. Recruitment to research studies and data collection was suspended, meaning that data collection was no longer permissible, despite receiving ethical approval. However, as of September 2020, a participant was recruited and interviewed using an online platform (Microsoft Teams), as approved by the committees. The study continued to face the impact of Covid 19 throughout, which significantly interrupted the data collection process.

This study strictly followed research governance. A study invitation and participant information sheet were designed and given to each participant to gain informed consent during recruitment. Disclosure and Barring Service (DBS) clearance was also acquired by the researcher as the participants were deemed vulnerable adults due to their mental health needs.

All participants were interviewed using an audio-recorded, semi-structured format, though either an online platform or by telephone. Due to the CoVid -19 policy, and the restriction on face-to-face meetings, the study had to be modified to use an online platform (audio recording) and or telephone conversation for interviewing participants. This meant that previously arranged study sites were not used for the study. All recordings were digitally encrypted, password protected, and stored securely, following strict data protection guidelines. Quality assurance of the research is assured by adhering to ethical considerations to ensure that appropriate ethical procedures are maintained. This avoids unnecessary risk or unintentional harm and ensures the reliability and validity of the results, whilst avoiding unwanted bias.

8.5 Checks for Credibility and Confirmability

Credibility and confirmability have been achieved by giving a detailed description or documentation of the research process. Participants will be granted access to the data, or the report generated from the data collected.

8.5.1 Credibility

The credibility of this research study is supported by the participants' perspectives as they developed in response to the emergent theory. The description of women's experiences and the factors which influence them aims to provide diverse insight into the target audience (women who have given birth within one year) and is not intended to generate directly generalisable explanations (Strauss and Corbin, 1990). The relevance of a qualitative study is determined by measuring the study's significance and contribution to knowledge in its subject area (Bryman, 2016).

The relativist position taken in this study implies the existence of constructions of reality and knowledge that are time-bound and are constantly evolving in response to the study's findings, as illustrated in this RLBM model.

8.5.2 Originality

Social reality and perspective are dynamic and change over time, depending on the social and cultural context. The investigations of this study are guided by relativist perspectives and are critical for the investigation's unique local environment, time, and context; and thus, contribute to knowledge. Due to the subjective nature of qualitative research, the findings can be generalised and may apply to similar contexts in terms of postnatal women, time period, and background (Johnson et al., 2020). This is because the findings are based on the perspectives and lived experiences of those recruited for the EXMEPP study in the Northeast region. This may not be generalisable to other locations due to differences in cultural and social systems, time periods, and circumstances. Additionally, participants' characteristics may be regionally typical.

However, the use of GT provides additional support for the findings in a variety of ways. The purpose of GT in this study is to explore the experiences and perspectives of women with SMHI and their perceptions are valuable in representing diverse perspectives on the factors influencing women's experiences thereof. Additionally, GT emphasises theory generation over detailed description (Glaser & Strauss 1967; Glaser, 1978). Thus, the GT advantage is in the conceptualization of everyday empirical knowledge, which can then be translated into a practice development tool (Bryant, 2007). The grounded theory approach can be used to explain a related event that occurred in practice, thereby assisting in the formulation of relevant strategies for enhancing wellbeing. Nonetheless, grounded theory is rooted in data and remains true to them through systematic and rigorous processes such as coding and maintaining memos consistent with the GT methodology. This demonstrates that GT derived hypotheses can be generated and tested in a variety of contexts, meaning that others may arrive at similar conclusions using the same data.

To aid in the transferability of the research findings, it was determined that Chapter four should include information about the study participants, their backgrounds, data collection, and analysis, while maintaining anonymity and confidentiality. The sample size of the study may invite criticism that it is not representative of the entire target population invited to participate in the EXMEPP study. However, the likelihood of building several realities within a naturalist paradigm may be improved through selective sampling. Furthermore, the credibility of a study (in terms of truth, value and data interpretation) is not determined by the sample size but rather by the richness of the data obtained, by the depth rather than the breadth, as is the case with quantitative methodologies (Lincoln & Guba, 1985).

8.5.3 Resonance

Resonance is defined as the degree to which findings are accurate and reliable in relation to the underlying data. This study's significant strength is its use of theoretical sampling and a diverse sample of participants, which aided in the collection of sufficiently rich data that addressed the study's aims and objectives, as well as findings that are supported by research and empirical evidence.

Theoretical sensitivity was maintained by employing a continuous comparative method that involved concurrent data collection and processing. Theoretical sensitivity increases one's confidence in the findings being consistent with the data. The reliability of qualitative research is also determined by the researcher's ability to make appropriate data judgments. Keeping track of the research process, including iterative processes, interview transcripts, and memo writing (Appendix 2), all of which are provided as an audit trail, allows the researcher to remain receptive to the study findings, while monitoring factors that could potentially influence the research process to distinguish them from the voices of the participants. This was possible through a complete transcription of the interview, the use of Nvivo and Mind Genius software, in-vivo codes, and direct quotations from participants' remarks, all of which, according to Johnson (1997), increase dependability.

8.5.4 Confirmability/Usefulness

Lincoln and Guba (1985) examine the extent to which the researcher's theoretical predisposition influences the research. Keeping an audit trail and providing a critical methodological evaluation of oneself and the research approach aided in the confirmability of the current study. Qualitative researchers are unable to remain objective in their analysis of their study findings (Seale, 1999). However, the grounded theory procedures in this study, such as line-by-line coding aided by Nvivo, ongoing comparative analysis, theoretical sampling, and participant validation through interviews, confirmed that the emerging concepts remained true to the data (see chap 5). Comparing and contrasting data, as well as discussing negative situations with supervisors, aided in minimising the bias in this study. Despite the inherent limitations of qualitative research in terms of trustworthiness and reliability, this study provided some insights into the postnatal experiences of women with SMHI and the factors that influence their transition into motherhood.

8.6 Study Strengths and Limitations

To put some of the findings into context, a reflection is presented. The study's concluding remarks must reaffirm the overall process of the study. This methodology collects and connects information on the study in a strategic, strengths-based manner.

8.6.1 Reflection on the sampling limitations

The sampling strategy for this investigation has been covered in chapter 4. However, notable sample difficulties that developed during data collection and processing, which may constitute a concern to the credibility of the study, will be re-visited here. Initially, the study set out to explore the experiences of women with SMHI in the postnatal period. One limitation of the current study is the small number of non-responders in the sample (three). The three non-responders may not be considered as such because they had completed screening invitations at the time this study was conducted. However, they withdrew from the study for personal reasons. The ten remaining participants in the study were happy to be interviewed and all expressed how much they enjoyed the process. One could argue that the method of recruitment used attracted only the most dedicated participants. From the initial telephone contact (negotiating interview) to the actual interview, it was not difficult to establish a positive rapport with the participants. However, as previously stated in Chapter 4, there were very minor concerns about distractions and background noise during interviews. The sampling issue could have been resolved by conducting a theoretical sample of non-responders, but this proved difficult due to the study's time and resource constraints.

Additionally, constructing a suitable sampling technique to include non-responders would have required a new ethical approval application. Nonetheless, the participants in this study were willing to disclose information about their unwillingness to participate and what may have prevented them from doing so, which may aid in the planning and implementation of appropriate measures aimed at improving the women's experiences and perceptions in the EXMEPP study. The data were theoretically analysed through constant comparison, which gives the study additional credibility.

The study's findings include some ethnic minorities for maximum variation. Women suffering from anxiety or depression were excluded from the study since these conditions were not recognised as SMHI. Additionally, due to limited resources, people who do not understand and/or speak English were removed from the sampling. By offering interpreters, those who may have encountered language obstacles but were still interested in the study may have come forward. Due to the challenges in generating variation in the sample, data collection was continued even after theoretical saturation was attained to allow for the occurrence of additional non-responders.

8.6.2 Ethical Strengths

While the sampling issues were discussed in Chapter 4, Chapter 5 focused on the ethical issues that arose throughout this research study. These include the recruitment methods used, how consent was obtained, the data's confidentiality, data protection and management, and any potential harm to participants and how this would be addressed.

Because the research involves the participants' lived experiences, ethical concerns are unavoidable. The ethical ideal of 'benevolence,' which refers to doing good while avoiding harm, is a crucial aspect of this study. As discussed in Chapter 5, the first stage of this research was obtaining ethical approval from the proper authorities, (The University Ethics Committee, IRAS, and NHS Ethics Committees, Research Ethics Committee (REC) and the designated research sites and research and development departments (R&D). These steps are important, especially as the study participants were National Health Service (NHS) patients. This enabled an objective view of the study and the necessary adjustments to increase benevolence. Participants were also allowed to make informed decisions to be interviewed without being forced to do so and were given decision aids to assist them in making their choice, which included an information sheet, consent forms, contact details, and telephone numbers if they required additional clarification before deciding whether to participate in the study. Furthermore, telephone contacts were used to schedule interview dates. The participants were informed about the study's purpose, methodology, intended and possible uses, and their participation. Prior to the start of the interviews, participants were allowed to ask further questions during the verbal discussions about the information sheet and consent form. They were informed and assured that they were free to terminate or withdraw from the interview at any moment without any consequences. Throughout the interviews, the researcher checked with participants to ensure they were still willing to continue. This is because consent is a continuous process that extends beyond obtaining a participant's signature (Mandal and Parija, 2014).

Additionally, this provides an opportunity to build a positive rapport. Then, the participants were informed that, to maintain confidentiality, all personal identifiers and data would be anonymised, as discussed in Chapter 5. There were no major ethical incidents related to the study in retrospect. In the EXMEPP trial, all individuals were positive. Due to the restrictions imposed by Covid 19, no face-to-face interviews were conducted; all interviews were conducted via online software (Microsoft Teams) or telephone. All participants were interviewed in their homes, except one who was interviewed in the hospital; the individual acknowledged this during the interview but was willing to participate in the EXMEPP study. This participant had decision-making capacity and was preparing to be discharged from the hospital. The participants appeared engaging and positive about the EXMEPP study throughout the interviews.

8.6.3 Data collection strength and limitation

The data collection method was semi-structured, one-on-one interviews. This strategy was chosen due to the study's subject matter and the possibility that participants may require some privacy. It was regarded as a good technique, since participants in the EXMEPP study were free to discuss the positives and negatives of social and personal resilience of motherhood without fear of being observed, which can be an issue in a focus group.

The interview guide helped participants through the process by raising and discussing issues that were important to them. The researcher had never conducted a formal and methodical interview before but, as a midwife, had taken histories and cared for patients at the point of admission, which had helped to establish some confidence in the process. The first interview went well and developed into a more conversational-style discussion as it progressed. The confidence gained from this meant it was no longer necessary to consult the guide, and subsequent interviews were kept as informal as possible.

Some of the limitations to data collection included the loss of connection during online interviews, but this was resolved, and the interview continued. As a result, time was lost; however, the researcher maintained the audio recording's quality. Unless otherwise noted, participants were addressed using their preferred name out of respect. The participants tried to explain their experiential journeys into motherhood with SMHI and their accounts seemed honestly given.

The analysis of data occurred concurrently with the collection of data. Throughout data collection, the participants' views were constantly verified to confirm that their intended viewpoints had been captured. This facilitated the collection of extensive data on the topic of study, which helped in the construction of a GT.

Similarly, explanations were sought by posing comparable questions in a variety of ways at various stages to enable complete comprehension of the participants’ social interactions and to obtain accurate interpretations of actual meanings relating to the topic. The audio recordings were listened to numerous times ensure that my interpretations remained as close to the data as possible. As the chief investigator, I conducted all interviews myself, and the transcripts were repeatedly revisited for confirmation and to maintain focus. Interviews were conducted in participants' homes through an online platform such as Microsoft Teams and audio recordings were made to guarantee that participants' perspectives were accurately captured. As a result, the recorded interviews were transcribed verbatim, although this process was repetitive and slow. Flick (2018) recommended that data be analysed based on what participants say and how they say it seeing through the participants' eyes (G, 2020; Bryman, 2016). Concurrent data collection, coding, and analysis (continuous comparison) increased the time required for the process, but this constant comparison provided detailed interpretation of data, ensuring that the evolving hypothesis reflected the study participants' perspectives and experiences and was capable of addressing the study objectives. During the coding process, the use of Nvivo and mind genius software was very useful and made data administration significantly easier. The software was used primarily to organise, sort, and manage the data, while Microsoft Word was used to number the transcripts (line by line).

8.6.4 Data analysis reflections

A significant difficulty in qualitative research is the large amount of data generated by interviews, which can be quite overwhelming. Ten interviews were conducted in total, and as a result, a large number of transcripts were generated, as well as research diaries and notes. The benefit of using a GT approach is that data analysis can begin sooner due to the concurrent data collection and analysis processes. This means that once data are collected, they can be transcribed, and preliminary analysis can be conducted prior to the next interview. This was very helpful when dealing with accumulated transcripts to code, which was unavoidable at times.

A reasonable amount of time was allowed between interviews to ensure that the previous interview had been provisionally analysed before moving to the next. Additionally, there exists the possibility of over conceptualisation (Glaser, 1992). At this point, therefore, it was decided to employ Mind Genius, which helps researchers to visualise data by assisting them in approaching data analysis at a conceptual level (axial and selective coding), identifying emerging concepts rather than individual accounts. The tentative emergent category reflects individual experiences.

Although disagreements abound (Becker, 1993; Wuest, 2012) over the use of software in a qualitative research study (chapter 4), Corbin & Strauss (2008) admit that software considerably facilitates the tedious process of screening, shredding, and sorting through data. In this study, using Nvivo increased the expertise and audit trail of the data analysis process, thus enhancing rigour, and did not affect the researcher's sensitivity to the data. However, in the open coding stage (line-by-line coding), the volume of codes became overwhelming, and it became more difficult to retain focus and knowledge of all the codes. Following Yates (2003) suggestions, something far simpler was needed to manage the fractured parts of data, and a line-by-line numbering system was utilised to facilitate the identification of items classified in axial and selective coding. Yates advised that, as a result of coding, qualitative data may become decontextualised and disjointed (ibid). According to Corbin & Strauss (2008), a researcher is a translator of research participants' words and actions, which may never be entirely interpreted the way participants wish. Nevertheless, the inductive-deductive reasoning used during the data analysis process assisted in addressing the study's aims and objectives through the conceptual model generated.

8.7 Limitations of the Study

The methodology addressed the study's theoretical limitations. As a result, the limitations detailed above are important to the study's process.

It is considered that, in retrospect, a handful of categories indicated in participant interviews that became more obvious during data analysis could have been identified and examined further.

In particular, some participants discussed GP awareness, stigma, and delays in consultation waiting time, while others expressed concerns about being admitted to a general ward rather than the mother and baby unit. There is thus a need for additional funding to create more beds in the mother and baby unit. This is because those women who had encountered the general psychiatric ward rather than the mother and baby unit had different experiences during the initial stage of the interviews. The extended waiting time for consultations could be reduced by outsourcing services to an external organisation but this may warrant further investigation and exploration. Finally, the RLBM is for women with SMHI in relation to motherhood, although the findings may be used to explore other chronic health issues. Since the model is new and exploratory, there is limited scope for recruiting a higher number of participants with SMHI experience. Evaluating the model will benefit other studies that consider whether patient uptake of positive experiences will improve outcomes (behaviour).

8.8 Recommendations

The current study suggests that understanding the personal resilience of women with SMHI could improve their transition to motherhood during the postnatal period. This study recommends additional research initiatives and strategies for improving the understanding SMHI during this time in relation to this transition. Additional research should be undertaken by professionals from both primary and secondary care settings to ascertain how women with SMHI understand and view motherhood based on their experiences. This would include elements of the transitional process, as well as the challenges faced in motherhood to eliminate any previously documented relapse behaviours. Doing this would help determine and comprehend whether the components of this study are transferrable and applicable to both maternity and mother-baby units. This study's recommendations may therefore contribute to better perinatal management by reducing unnecessary stigma in primary and secondary care, thereby enhancing understanding of the transition between secondary mental health services and primary care in maternity services for women with SMHI.

Provision of direct or open access to prenatal mental health services for women with SMHI, as well as a mental health nurse or midwife lead in the perinatal period are also recommended. The study also suggests that more attention be given to the level of awareness of and education on SMHI for healthcare providers, including in the primary healthcare setting. Study participants suggested the need for more training that will create awareness and reduce stigmatisation. Therefore, an exploration of the experience and awareness of primary healthcare professionals in perinatal mental health services including the mother and baby unit, and how they could be fully involved in the management and referral of women with SMHI during the perinatal period is proposed as a starting point. A major practical hurdle to the transition into motherhood from the perspective of the current study analysis centres on stigmatisation in health care services and issues of isolation. Most participants were separated from their babies due to the unavailability of beds in the mother and baby units where they had been admitted. The study analysis suggests that it may be beneficial for NHS services to provide more beds in mother and baby units for women with SMHI, in order that they are not separated from their babies. This might speed recovery during relapse and shorten hospitalisation periods.

Most participants recalled their experiences of childbirth, including traumatic delivery. Some participants' previous and or current childbirth experiences required a specific mode of delivery to minimise the trauma associated with them. For example, some women requested a Caesarean section to avoid traumatic delivery. Therefore, the study finds that it is worth exploring and comparing the experiences of these women in terms of both vaginal deliveries and Caesarean sections. The conceptual model has illustrated the role of personal resilience as a mechanism for driving positive behavioural change, and the need for improving knowledge on the transition to motherhood for women with SMHI during the postnatal period. The study also recommends the use of external influences, such as the use of education campaigns, information support groups and the use of social media. This will create awareness as the root of reducing stigma and discrimination against SMHI and, in this way, improve care management.

This study has also highlighted the importance of research in a variety of fields to improve the experiences of women with SMHI during their transition to motherhood. This study suggests conducting a systematic review of the literature, or conducting a qualitative study, on awareness of SMHI management in primary care. In this case, more training and education are necessary, as is the involvement of a specialist perinatal mental health midwife in primary health settings to improve access and minimise relapse. The study's findings indicate that social context, personal resilience, and childbirth experience all influence how women with SMHI experience this transition, either positively or negatively. It shows that support with effective coping mechanisms has the most positive effect, while poor personal resilience and stigma have the most negative effect. It will be interesting to conduct additional research to evaluate the ‘resilience-led-behavioural model' developed in this study in other aspects of motherhood transition.

8.9 Contribution to knowledge

This study contributes to knowledge in various ways: conceptually, methodologically, and in terms of training and educational awareness. At the conceptual level, the resilience led-behavioural model is presented in an explanatory pattern. Women may be influenced by the societal context, their personal resilience and childbirth experiences during the transition to motherhood. The work was presented at a Microsoft Teams seminar to MSc mental healthcare students at the University of Applied Science in Amsterdam. At seminars and conferences, I have presented both PowerPoint presentations and posters (some of these are presented in appendix 7).

On a methodological level, the grounded theory provides a unique contribution to knowledge by approaching research from a qualitative perspective that allows for an in-depth and rich explanation from the participants' perspective and perceptions while remaining grounded in the data in ways that a quantitative approach would not have permitted. Additionally, it is hoped that this study will be of significant benefit to students and researchers as well as a reference point for other academic and research purposes. Additional training and education on postnatal SMHIs, as well as increased information sharing with women and their families, are necessary for establishing healthy boundaries and decreasing the stigma associated with SMHIs.

Furthermore, additional research is required on the perspective of care providers for women with SMHIs during the transition to motherhood. A further quantitative research study is necessary for a much broader research study.

8.10 Conclusion

There is evidence that women’s poor experiences of severe mental health issues during the postnatal period could result in morbidity and poor transition to motherhood, as well as delaying recovery. A reflection is also supplied to provide the context for how some of the findings have been received when presented thus far. The study's concluding remarks must reaffirm the overall findings of the study. Many variables can influence the experience of women with SMHI, including societal norms and attitudes; stigma associated with severe mental health issues; and cultural differences surrounding the ideas of mental illness (KrendI et al., 2020). Women have been unable to express their experiences and distress associated with mental health concerns during the motherhood transition (Brockington, 2017). The most common barriers to disclosure include stigma, sleep deprivation, and some negative thoughts about their babies and isolation, but some participants also reported that they felt supported by their families and were satisfied with the care received while hospitalised in the mother and baby unit. This is because they felt accepted and were able to discuss their emotional health needs upon recovery (Higgins et al., 2016).

Furthermore, there is a perception of a lack of specialist services, especially specialist perinatal mental health midwives together with long waiting lists which affect access during the perinatal period. There is also a need for continuity of care with a clear role for a safety net of care to aid in disclosure of onset or relapse of illness among women with SMHI. Participants with SMHI have different views of their coping mechanisms in terms of support and sleep deprivation, particularly because many were affected by Covid 19 restrictions, and the rules applied at the time of the study.

There are few qualitative research studies in the UK, particularly in the Northeast and Cumbria regions, and there was no published research on the experiences of women with SMHI in relation to motherhood during the postnatal period. It is believed that taking part in this study has helped the participants to share their experiences, and the study has also helped to enhance my qualitative research skills. It has been a challenging and fulfilling experience for the researcher.Finally, the outcome of the study’s ‘resilience led-behavioural model (figure 5.9) explains that individual perceptions of experience are influenced by the social context, as well as personal resilience and childbirth experiences.

This explains that individual resilience could influence the present experience, either positively or negatively, in turn influencing the RLBM. The model's strength is its emphasis on personal resilience, which indicates that the individual traits of women with SMHI (such as confidence, support, coping and self-awareness) will facilitate a positive transition to motherhood. Being a mum is an important role to every participant in this study. The question 'Can l still be a mum' brought about an emotional and uplifting response. Every mother felt blessed to have a child despite all the hurdles they may have faced.

Appendix 1: Impacts and Outputs associated with Study.

2019

A poster presentation presenting an overview of the study at European Patient Safety Education Conference held at Northumbria University. The conference including National and International patient safety Specialist highlighting Sharing Learning from Practice to Improve Patient Safety (SLIPP).

2020

Northumbria University. PGR Research Conference. Power point presentation.
Abstract call Nursing, Midwifery and Health, Social work And Education and Community wellbeing.

PowerPoint presentation of the study at Two days teaching programme.

2022

University of – January. Meeting with MSC student – visual presentation of the study.

See next page for the poster presentation.

UNDERSTANDING THE EXPERIENCE OF WOMEN WITH A SEVERE MENTAL DISORDER IN RELATION TO MOTHERHOOD DURING THE POST-PARTUM PERIOD.

AUTHORS: THEODORA OJIAKO, KEITH FORD AND MICHELLE GLASCOTT
CONTACT EMAIL: THEODORA.OJIAKO@NORTHUMBRIA.AC.UK

Northumbria University
NEWCASTLE

Background

- Around one quarter of all maternal deaths between six weeks and one year after childbirth are related to mental health disorders.
- In the U.K, 1 in 5 women will develop some form of mental disorder during pregnancy or one year after childbirth.
- It is a concern across governments (USA, UK, Australia and Canada) it costs the UK £8.1 Billion shortfall in tackling Perinatal mental disorder which is 5 times the cost of improving mental health services.

Facts/ challenges

- Suicide accounts for about 20% of postpartum deaths and a leading cause of maternal mortality in the postpartum period.
- Women with severe mental disorder are at increase risk of relapse during the postpartum period
- Outside been diagnosed with a mental disorder, most women who become mentally unwell following childbirth will have been well before and during pregnancy

Research Aims and Research Objectives

1. To develop an understanding of women's level of knowledge and awareness of mental disorders in relation to motherhood.
2. To explore factors influencing women's experience of mental disorder during the postpartum period.
3. To utilise grounded theory methodology in understanding the in-depth experience of women with severe mental disorder.
4. To understand how these women cope with the challenges of mental disorders in relation to motherhood.

EVERY MOTHER COUNTS

Who are we interested in?

- Women aged 18 years and above
- Women with mental disorder and have given birth within six weeks and not more than 3 months if in -patient.
- Women who are in-patient and can give consent.

Research Methodology

- Qualitative design using grounded theory method.
- Participants (Patients who have had their baby within six weeks)
- Data Collection method (Semi structured interview, and review of literatures, memos and diary).
- Coding and constant comparison.

Why is this Research important?

- To empower and support women to open up the conversations around mental disorder and acknowledge and share their experience without been afraid of been looked down on.
- To understand women experience of mental disorder, in order to improve the care managements in midwifery setting.
- The study will help in identifying the onset of women becoming unwell by understanding their lived experiences.
- The study will help us understand and manage those factors that can make you becomes mentally unwell after the birth of your baby.

References

Bauer, A., Parsonage, M., Knapp, M., Iemmi, V. and Adelaja, B., (2014) Costs of perinatal mental health problems. https://www.cambridge.org/core/journals/psychologicalmedicine/article/impact -of

World Health Organisation (2017) Maternal Mental Health. (http://www.rcgp.org.uk/clinical -and-research/toolkit/ media/7C68D992BC914A3283F3ACACA829AC8B.ashx). (accessed 20/03/2018)

Perera, D.N., Short, L. and Fernbacher, S., (2014) There is a lot to it: Being a mother and living with a mental illness. Advances in mental health, 12(3), pp.167 -181.

Appendix 2: NHS, HRA and Health and Care ethics approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mrs Theodora Ojiako
Midwife/Research Midwife

Newcastle Hospital
Royal Victoria Infirmary
Queen Victoria Road
Newcastle Upon Tyne
NE1 4LP

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

28 April 2020

Dear Mrs Ojiako

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Understanding the EXperiences of women with severe MEntal Health Issues in relation to Motherhood during the Postpartum Period.**
IRAS project ID:	**268783**
REC reference:	**20/NE/0061**
Sponsor	**University of Northumbria at Newcastle Upon Tyne**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

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

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **268783**. Please quote this on all correspondence.

Yours sincerely,

Isobel Lyle

HRA Approvals Manager

approvals@hra.nhs.uk

Copy to: *Samantha King* **List of Documents**

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of advertisement materials for research participants		
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Certificate of Employers' Liability Insurance]		
GP/consultant information sheets or letters	1	21 October 2019
Interview schedules or topic guides for participants [interview guide]	1	21 October 2019
IRAS Application Form [IRAS_Form_21012020]		21 January 2020
Letter from sponsor		04 February 2020
Letter from statistician [project approval panel report]		25 June 2019
Letters of invitation to participant [Service user invitation]	1	21 October 2019
Non-validated questionnaire [demographic and obstetric history]	1	21 October 2019
Organisation Information Document [Organisation Information Document]	1	21 February 2020
Other [Second person CV]	1	19 February 2020
Other [Demographic Questionnaire]	2	24 March 2020
Other [Ethics Revision]		24 March 2020
Other [A27-1 (additional response info HRA)]		21 April 2020
Other [Revised Research summary]		21 April 2020
Other [A76-2 (additional info response HRA)]		21 April 2020
Other [Amended document]		24 April 2020
Other [Service User Contact Form]	1	21 October 2019
Other [Thank you message]	1	21 October 2019
Other [Lone Working Policy]		
Other [screening and recruitment log]	1	21 October 2019
Other [capacity to consent]	2	13 June 2019
Other [HRA and HCRW info]	1	24 July 2019
Other [Summary of flow chart]		
Participant consent form [Consent form]	2	24 March 2020
Participant consent form [Consent form (changes highlighted)]	2	21 April 2020
Participant information sheet (PIS) [PIS] Aligned to HRA standards	2.1	24 April 2020
Referee's report or other scientific critique report [Scientific review]		

Research protocol or project proposal [study protocol (changes highlighted)]	2	21 April 2020
Research protocol or project proposal [Study Protocol]	2	24 March 2020
Sample diary card/patient card [Thank you card]		21 October 2019
Summary CV for Chief Investigator (CI) [cv]		13 June 2019
Summary CV for student [Student CV]		21 October 2019
Summary CV for supervisor (student research)		13 June 2019
Summary of any applicable exclusions to sponsor insurance (nonNHS sponsors only) [Letter from sponsor / Indemnity Certificate Public & Employer's Liability]		01 August 2019
Summary, synopsis or diagram (flowchart) of protocol in non technical language		

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All participating NHS organisations are undertaking the same research activity, therefore, there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No application for external funding will be made	A Principal Investigator is required at site	No Honorary Research Contracts, Letters of Access or pre-engagement checks are expected for local staff employed by the participating NHS organisations. Where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtaina Letter of Access based on standard DBS checks and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.

The applicant has indicated that they intend to apply for inclusion on the NIHR CRN Portfolio

Appendix 3: NHS research ethics committee (REC) approval

NHS
Health Research Authority
North East – Tyne & Wear South Research Ethics Committee

NHSBT Newcastle Blood Donor Centre
Holland Drive
Newcastle upon Tyne
NE2 4NQ

Telephone: 0207 1048084

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

24 April 2020

Mrs Theodora Ojiako
Midwife/Research Midwife
Newcastle Hospitals NHS Foundation Trust
Royal Victoria Infirmary
Queen Victoria Road
Newcastle upon Tyne
NE1 4LP

Dear Mrs Ojiako

Study title:	**Understanding the EXperiences of women with severe MEntal Health Issues in relation to Motherhood during the Postpartum Period.**
REC reference:	**20/NE/0061**
IRAS project ID:	**268783**

Thank you for your further notification of 21 April 2020, responding to the Committee's request for further information on the above research and submitting revised documentation.

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

Confirmation of ethical opinion

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

Conditions of the favourable opinion

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

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).
Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

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

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

Registration of Clinical Trials

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database. For this purpose, 'clinical trials' are defined as the first four project categories in IRAS project filter question 2. Registration is a legal requirement for clinical trials of investigational medicinal products (CTIMPs), except for phase I trials in healthy volunteers (these must still register as a condition of the REC favourable opinion).

Registration should take place as early as possible and within six weeks of recruiting the first research participant at the latest. Failure to register is a breach of these approval conditions, unless a deferral has been agreed by or on behalf of the Research Ethics Committee (see here for more information on requesting a deferral: https://www.hra.nhs.uk/planning-andhttps://www.hra.nhs.uk/planning-and-improving-research/research-planning/research-registration-research-project-identifiers/improving-research/research-planning/research-registration-research-project-identifiers/

As set out in the UK Policy Framework, research sponsors are responsible for making information about research publicly available before it starts e.g. by registering the research project on a publicly accessible register. Further guidance on registration is available at: https://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparencyhttps://www.hra.nhs.uk/planning-and-improving-research/research-planning/transparency-responsibilities/responsibilities/

You should notify the REC of the registration details. We will audit these as part of the annual progress reporting process.

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

After ethical review: Reporting requirements

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

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report.

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvalshttps://www.hra.nhs.uk/approvals-amendments/managing-your-approval/amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites listed in the application subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants		
Evidence of Sponsor insurance or indemnity (non-NHS Sponsors only) [Certificate of Employers' Liability Insurance]		
GP/consultant information sheets or letters	1	21 October 2019
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Participant information sheet (PIS) [PIS (changes highlighted)]	2	21 April 2020
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Summary CV for supervisor (student research)		13 June 2019
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [Letter from sponsor / Indemnity Certificate Public & Employer's Liability]		01 August 2019
Summary, synopsis or diagram (flowchart) of protocol in non-technical language		

Statement of compliance

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-thehttp://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improvinghttps://www.hra.nhs.uk/planning-and-improving-research/learning/research/learning/

IRAS project ID: 268783 Please quote this number on all correspondence

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

Yours
sincerely
pp

G. Mayer

Mr Ian Campbell Chair

Email:tyneandwearsouth.rec@hra.nhs.uk

Enclosures:	'After ethical review – guidance for researchers'
Copy to:	Samantha King - Research Dept, University of Northumbria at Newcastle
	Dr Keith Ford – Senior Lecturer & Programme Lead (Mental Health Nursing), University of Northumbria at Newcastle

Appendix 4: University HRA sponsor Letter

Northumbria
University
NEWCASTLE

Mrs Samantha King
Research Development
Manager
Research and Innovation
Services
Pandon Building
Northumbria University
Newcastle
NE1 8ST

Health Research Authority
Skipton House
80 London Road
London
SE1 6LH

4 February 2020

IRAS Project ID: 268783

Dear Sir/Madam

Study title: Understanding the experience of women with a severe mental health issues in relation to motherhood during the postpartum period

I am writing to confirm that the University of Northumbria at Newcastle will act as sponsor for the above student project to be led by: Theodora Ojiako, as part of the requirements for Mental Health Nursing PGR, with Dr Keith Ford as first academic supervisor.

Yours sincerely

SKing

Mrs Samantha King
Research Development Manager

On behalf of Professor Dianne Ford, Faculty Pro Vice Chancellor
Health and Life Sciences

Appendix 5 Data saturation

Summary of the data findings covering the three major categories per participant

SOCIAL CONTEXT

Culture/Religion

Belief

P1	P2	P3 (67-72, 272,282-284-290	P4 (87-90)	P5 (182)	P6 (77-82)	P7	P8 (259-260)	P9 (43-45, 153)	P10 (319-320)	Total

Stigma (labelling discrimination isolation)

P1 (54)	P(128, 140	P3 (277, 332-334)	P4 (160)	P5 (261-265), 269	P6 (189,283)	P7 (57, 61, 92,281)	P8 (78-79,114-116,169	P9 (73-75)	

Access (service awareness, Covid 19 impact)

P1	P2 (34, 39, 61	P3 (208, 367-368)	P4 (81-82)	P5 (203)	P6 (306)	P7 (191-194, 284-289, 436-437, 523)	P8 (97-99, 128, 449-454)	P9 (94-95, 103-105, 119-120)	P10 (224-228,)

Perception and attitude (negative thoughts)

P1 (58,	P2(52-53)	P3 (77-80, 338-339,439-441)	P4 (99-105)	P5 (112-113)	P6 (97-98)	P7 (33, 57,58, 69,84, 90, 117-119-122)	P8 (49, 67, 427-429)	P9 (21-22, 166-167)	P10 (37, 41-42, 123-125)

THEME 2

Personal resilience

Coping mechanisms (cognitive behavioural therapy, support networks and service engagement)

P1 (84)	**P2 (38-40,105, 118-120, 241-248)**	**P3 (327-330, 331, 355-356)**	**P4 (336-338)**	**P5 (166-167,197, 233-234)**	**P6 (173, 176)**	**P7(278, 282, 521-524)**	**P8 (90-93**	**P9 (22-23, 135-136, 138-139)**	**P10 (309-311, 320-321)**

Hope (self-belief and positive thoughts)

P1 (148)	**P2 (63**	**P3 (207-208, 450-453)**	**P4 (162-163)**	**P5 (78-82, 156-157)**	**P6 (210-211)**	**P7 (274, 278-281)**	**P8 (158-159, 470-478)**	**P9 (79-80)**	**P10 (76-77, 343-345)**

Sleep deprivation (ASKING FOR HELP)

	P2 (266-269)	**P3 (64-65, 252)**	**P4 (76-77, 84)**	**P5 (193-196)**	**P6 (61-62, 104)**	**P7 (44, 48-49, 51-52, 250)**	**P8 (54)**	**P9 (32, 148-149)**	**P10 (137-138)**

Childbirth experience

Anxiety and fear (fear relating to childbirth, trauma and mode of delivery)

	P2 (355-357, 375-376, 321-323)	**P3 (49-51, 93-94)**	**P4 (71-72, 173-175)**	**P5 (66-67, 256-257)**	**P6 (92-93)**	**P7 (30,92-96, 233-234)**	**P8 (40)**	**P9 (83, 86-87)**	**P10 (138-139)**

Met and unmet needs (service engagement)

P1 (110)	**P2 145-146,**	**P3 (327-330)**	**P4 (347-349)**	**P5 (307-310)**	**P6 (288-289)**	**P7 (213-214, 284)**	**P8 (70)**	**P9 (39-40, 94-95)**	**P10 (295-297)**

Bond and attachment (mother-child interaction and feeding issues)

P1 (68-69)	**P2 (24-25)**	**P3(122-124, 171-172)**	**P4 (376-379)**	**P5 (170-171, 217)**	**P6 (161, 164, 181)**	**P7(31)**	**P8(40-41,72-75, 155-166)**	**P9 (20-23)**	**P10 (33-35, 258-261)**

Service user engagement

(Perinatal mental health awareness)

P1 (65-66)	**P2 (71-72, 337-338)**	**P3 (123, 139-143)**	**P4 (390-392)**	**P5 (311-313)**	**P6 (66-69)**	**P7 (191)**	**P8 (60-63, 71)**	**P9 (39-40, 94-95, 173-176)**	**P10 (280-284, 329-331)**

Appendix 6: Service User Invitation.

Service User invitation

Study Title: Understanding the Experience of Women with Severe Mental Health Issues in relation to motherhood [During the Postpartum Period].

Researcher: Theodora Ojiako

I would like to invite you to participate in a research study. I am interested in hearing your experiences and challenges with mental health issues in relation to motherhood after childbirth. I am inviting you as someone who has had mental health issues following childbirth. This research study is undertaken as part of a PhD and aims to explore and understand the difficulties that you may have faced as someone with mental health issues. I want to understand your feelings, fears, and hopes in relation to this and what ideas you may have for services to consider how best to assist people with severe mental health issues best cope with this during motherhood. It may also be useful in training programs to assist people with severe mental health issues.

Before you decide if you would like to take part, please read the Participant Information Sheets (PIS) attached to this letter. This will help you to understand what this study is about and will help you to decide. If you have any questions regarding this study, please contact the researcher, Theodora Ojiako using the information below. If you are interested in participating in the study, please complete the contact form attached to this form and hand it back to the person who gave you the letter. Please respond within one week of receiving this letter.

Thank you

Theodora Ojiako.

Ph.D. student at Northumbria University Newcastle Upon Tyne.

Email: Theodora.o.ojiako@northumbria.ac.uk Tel: 07466782266

Appendix 7: Service User Contact Form

Cumbria, Northumberland,
Tyne and Wear
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University
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Service User contact form

Project Title: Understanding the experience of women with severe mental health issues in relation to motherhood during the postpartum period.

Please put your initials on the boxes below.

My Name

……………………………………………………………………………………………
……………..

I have read and understood the information sheet regarding the study:

"Experience of women with severe mental health issues in relation to motherhood during the postpartum period''. ☐

I am prepared to be interviewed by the researcher Theodora as part of this study/ PhD study. ☐

I would be happy to be contacted with further details by Theodora Ojiako (researcher) by: ☐

Direct telephone

(Please provide your number below)

……………………………………………………………………………..

Email (please provide address below) ☐

……………………………………………………………………………………………
……………………………………

Postcode (please give address below) ☐

……………………………………………………………………………………………
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Appendix 8: Participants Information Sheets

NHS
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Participant information sheet

Project Title: Understanding the experience of women with severe mental Health Issues in relation to motherhood [during the postpartum period].

Invitation to take part in the study

I would like to invite you to participate in this research study. This invitation has been sent to you because we think that you may help with providing information to help the researcher understand what this means and feels like. Before you decide it is important that you understand why the research is being conducted and what it involves. This information sheet will provide you with information about the research study, take your time to decide whether you wish to take part.

Background to the study

Around one-quarter of all maternal deaths between six weeks and one year after childbirth are related to mental health issues. It has been considered a major public health challenge and a leading risk factor for maternal **illness and death.** In the United Kingdom, one in five women will develop some form of mental health issues during **pregnancy and one year after childbirth. Women with severe mental health issues are at increased risk of becoming unwell after given birth.** This study hopes to talk to women to understand their in-depth experiences, feelings, and emotions from their perspective.

What is the purpose of the study?

This research study is about understanding your experience of mental health issues after childbirth to motherhood. To carry out the study, we would like to talk to people like yourself who have experienced severe mental health issues such as severe depression, bipolar or postpartum psychosis and schizophrenia, to understand your views and perceptions. It is hoped that the information you give may help services consider how best to support people like you cope with mental health issues during this time.

What is patient data?

It is the information that you give to your doctor or the person looking after you about your health. It includes your health problems, tests and treatment you have had. They might want to know about your family history too, if you smoke or what work you do. All this information recorded about you is called patient information. When the information about your health care joins together with your name or your NHS number it is called identifiable patient information. It is important to all of us that this identifiable patient information is kept confidential to you and the people who need to know the relevant information to look after you. There are special rules to keep confidential patient information safe and secure.

What sort of patient data does health and care research use?

There are lots of different types of health and care research.

If you take part in a clinical trial, researchers will be testing a medicine or other treatment. Or you may take part in a research study where you answer some questions in the form of an interview or questionnaire. When you have agreed to take part in the study, the research team may look at your medical history and ask questions to see if you are suitable for the study. During this study you will be asked to complete questionnaires, sign a consent form and be interviewed by the researcher. The research team will record this data in special forms and combine it with the information from everyone else in the study. This recorded information is research data.

Why does health and care research use information from patients?

The information you provided during your visit such as your name, age, how many children you have had and if you have any other health problem. This information recorded about you is called patient data. The information you will provide will tell us; what having severe mental health issues mean to you, whether we are doing everything the way we should make it better or if we need to add or amend the way services are being provided to you. By collecting information from you and lots of people, the researcher will be able to work out what needs doing better.

How does research use patient data?

If you take part in the research study, we will be asking your contact details so that we can contact you to arrange an appointment or send you an information pack. We will make sure that only the researchers that are involved in the study will be able to see this. We will remove your name or any information that will show who you are and replace it with a code number so that nobody will know who you are, this is called coded data.

Where will my data go?

For this study, your doctor or care team will be involved in this research. Often, they will be part of a bigger research team. This may involve other hospitals, or universities or companies developing new treatments. Sometimes parts of the research team will be in other countries. You can ask your doctor or the care team if the data they have will include information that could identify who you are. The computers storing data must meet special security arrangements.

What are my choices about my patient data?

You can choose to stop taking part in a research study at any time, without giving a reason, but the research team will keep the research data they already have about you. You can find out what would happen with your data before you agree to take part in a study. Researchers will manage your records in reliable ways. This means that you won't be able to see or change the data or information they hold about you. The research could go wrong if data is removed or changed.

What happens to my research data after the study?

The researcher will write a report about the study in a way that no-one can work out that you took part in the study. At the end of the study, the data collected will be kept for years in case we need to check it. A copy of the research information along with your name will be kept within the hospital research team and a coded copy of your data will be stored so that the result can be checked. Any information that could identify who you are will be held strictly and securely with limits on who can access it. Your data will not be used for other research studies.

What if I don't want my patient data used for research?

You will have a choice of taking part in the research. If you chose not to take part, that is still fine. Most often you will have a choice about your data being used for other types of research study. Your information will be anonymised. Because it's anonymous, the research team doesn't know whose data it is and can't ask you nor anyone else. This is because of the number of people that have to be contacted. Sometimes it will be because the research could be biased if some people chose not to agree. A special NHS group will check that the reasons given are valid. You can opt-out of your data being used for this sort of research. You can ask your doctor about opting out, or you can do so yourself.

What will happen to me if l take part?

If you agree to take part in this study, you will be interviewed by the researcher at the clinic or hospital setting and at a time that will be convenient for you. You may bring a friend or relative with you for the interview if you wish. For interviews outside of the usual appointment date then travel costs will be reimbursed, but travel tickets must be presented. If a friend or partner/husband drop you for the interview, they will be given a thank you card. The interviews will take between 45 minutes or more. If you wish, the interview can be stopped for you to take a break and continue. The interview will be audio recorded with your permission so that the researcher can record what you are saying in detail. The researcher will continually monitor for any signs of unease if any observed the interview will be discontinued and you will be referred to your care coordinator.

What are the benefits of taking part?

Taking part will have no direct benefit to you. We hope to understand your feelings, hopes and fears and how you manage to cope with it, and also the ideas of what you hope the services to be like. You will not benefit financially from this. The information you give may contribute to service improvement and may help women who are in a similar situation. Services so far have not discovered how best to support people like yourself, and we want to know what is best to make services better for others in the same situation.

Will my taking part in the study be kept confidential?

If you tell me that you or someone else is at risk of harm, l will have to pass this information to your care coordinator or your team lead (duty of care) but I will discuss this with you first. The information you have given will still be used with your permission and following the

GDPR ACT 2018. All the information and identifiable data obtained from you during this study will be made anonymous with the aim that you remain unidentifiable by others in this study report or any other publication. Reference code or number will be given to all information gathered so l will have a record of what has been said in the interview. If you wish to see the report of this study, it will be made available on request. If you are interested to receive the study report, it can be provided to you through your chosen method such as email or home address or l will leave it for you to collect at the clinic or the hospital. You can specify your interest in the consent form. Once the study has ended, the information will be destroyed according to the Northumbria University guidelines and Data Protection Act 2018.

Who is organising and funding the research study?

The research study is part of my Ph.D. study, which is self-funded and organised with the support of Northumbria University (principal supervisor Dr. Keith Ford and Dr. Michelle Glascott). No other funding has been sought.

What will happen to the results/data of this research after the study?

The summary of the study result will be published nor guaranteed to be published in health journals and the Northumbria University Research weblink to inform other healthcare practitioners and researchers. The researcher hopes to present the results of this study at conferences to healthcare staff and service users. Any of the quotes from participants that may appear in the presentation will be anonymised; therefore, although you may be able to recognise your words nobody else will. The data will be stored for a few years in case we need to check it. The data will be coded with a number only the consent form will have your signature and name and cannot be matched with other data and will be filed in your record and the research office.

Who can I contact if I have a complaint?

If you have any complaints regarding this study, or you are not pleased with how the study handled your information and you do not want to discuss this with me. You may get in touch with my project supervisors' details below, or the Patient Advice and Liaison Services (PALS) office. You can also contact the Data Protection Officer; you can get their details from the research team. If you are still not happy with their response or you believe they are processing your data in a way that is not right, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 03031231113).

Project Supervisors Contact Details:

Dr. Keith Ford, Senior Lecturer, Programme lead Mental Health Nursing, Faculty of Health and Life Sciences, Northumbria University. keith.ford@northumbria.ac.uk

Dr. Michelle Glascott, Senior Lecturer, Subject Lead for Mental Health Nursing, Faculty of Health and Life Sciences, Northumbria University.

michelle.glascott@northumbria.ac.uk

Further contact details:

You may wish to contact me directly for more information or if there is anything that is not clear that you would like to discuss. Please contact me on theodora.o.ojiako@northumbria.ac.uk **Mobile: 07448436249**

EVERY MOTHER COUNTS

Appendix 9: Consent Form

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CONSENT FORM FOR SERVICE USERS

Project Title: Understanding the experience of women with severe mental health issues in relation to motherhood [during the postpartum period].

	Please initial boxes
I have read and understood the patient information sheet (version1 21/10/2019) about this study and l am willing to be interviewed.	
l have received enough information about this study and have been given enough time to ask questions. I have received satisfactory answers to all my questions.	
I am willing to take part in this study and understand that the interview may take between 45-60 minutes.	
I understand that relevant sections of my medical record may be viewed, and the data looked at by the researcher and the regulatory authorities where it is relevant to my taking part in the study, will be kept confidential.	
I agree with the interview being audio recorded.	
I consent to allow quotes from my interview to be used and l understand that my real name will not be attached to any of these quotes.	
I fully understand that my participation is voluntary, and l can withdraw at any time if I change my mind and this will not affect any treatment l may receive.	
I agree to take part in this research and have answered the questions above.	
I wish/l do not wish the summary of the study to send to my email address and l have provided my email address. Please indicate yes/no/initial.	

I have been given a copy of this consent form

Participant's signature Name Date

.... ……………………

Researcher: I confirm that I have explained the project to the participant and answered questions about the research.

Principal Investigator (PI) signature Name Date

.... ……………………

EVERY MOTHER COUNTS

Appendix 10: Interview Guide

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Semi-structured interview questions

Congratulations on the birth of your baby.

My name is Theodora, l am a research midwife and a PhD student, is this a convenient time for you? Taking part is Voluntary and Confidentiality and is maintained throughout and you can withdraw at any point, and the care you receive will not be affected.

Before we start l just want to say that anything you say here will be kept confidential and anonymous although, issues or concerns recorded may be reported back to your care team. For example, issues like hurting yourself or someone else will be communicated to your care coordinator for support.

Firstly, I would like to tell you a little bit more about my study and why l think it matters; so, this study is looking into understanding your experiences of mental health from your own perspective in relation to motherhood. I understand that many studies have investigated the mental health of mother and baby but not a lot have been done to understand women's experiences and feelings of how women are finding being a mother.

I hope you wouldn't mind telling me how you are adjusting being a mother?

- Could you tell me about the experiences you had since you have given birth?
- How do you feel about these experiences? Or what are your feelings about having a baby? Do you think that these experiences have in any way affected your feeling and emotions? Do you think that this has affected your mental health wellbeing?
- What do you hope would have been more helpful during this time?
- Did this provoke any feelings of fear?

- What do you think may have contributed to these experiences and feelings? What might have helped your experiences and feelings and what do you think did not help with your experience and feelings.

The researcher will probe for further answers based on the participant's response to the above questions.

- How are you coping being a mother and having mental health issues (**probe more here** find out family, money, friendships, religion or physical, emotional and or spiritual)?
- What things do you currently do to help you manage your mental health wellbeing and parenting? What helps and what does not help? Who, if anyone, was involved? In what way were they involved?
- How would you describe your coping method/ journey during this period? What was it like?
- What are your thoughts and feelings on how services can help make this period (experience) better?
- Is there anything you would like to add, or would you like to summarise in your own words?

Thank you for your time.

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Appendix 11: Databases and Hints, and selected studies

Databases	Number of Hints
PubMed	1000
Midline	1200
Science Direct	200
Google Scholar	100
CINAHL	700
Premium Collection	300
Total	3,500

Selected studies

Selected studies, author and year	Title of the studies	Type of study/statistical method	Aim	Sample size/Sampling(women age at birth 18-49)	Result
Forde, R., Peters, S. and Wittkowski, A., (2019. BMC psychiatry, *19*, pp.1-17.	Psychological interventions for managing postpartum psychosis: a qualitative analysis of women's and family members' experiences and preferences.	Qualitative study	Aim; to explore the experiences, needs and preferences for psychological intervention from the perspective of women with postpartum	13 women with postpartum psychosis and 8 family members	Emphasis was placed on ensuring safety, followed by a need to connect, process and adjust to women's experiences.

			psychosis and their family members.		
Nagle, U. and Farrelly, M., (2018) Midwifery, 66, pp.79-87.	Women's views and experiences of having their mental health needs considered in the perinatal period.	A qualitative design	To explore women's views and experiences of having their mental health needs considered in the perinatal period	8 women were recruited	In getting help, having a baby was a motivator for some women
Perera, Dinali N, Liz Short, and Sabin Fernbacher. (2014):	"There Is a Lot to It: Being a Mother and Living with a Mental Illness." Advances in Mental Health 12.3 167-81	A qualitative grounded theory approach	Aims; to increase understanding, about women's experiences and their needs.	8 women and 11 staff	Women view motherhood as central and meaningful to their lives; a role that is highly valued and provides social connection. Also,

					support from families shaped women's experience of motherhood in keeping women well.
Roxburgh, Emily, Nicola Morant, Clare Dolman, Sonia Johnson, and Billie Lever Taylor. (2022).	Experiences of Mental Health Care Among Women Treated for Postpartum Psychosis in England: A Qualitative Study	A qualitative study	To understand women's experiences of mental health care and services for psychosis in the postnatal period.	12 women using semi-structured interview.	Lack of awareness and knowledge of postpartum psychosis by healthcare professionals in maternity units, including lack of support and patient involvements.

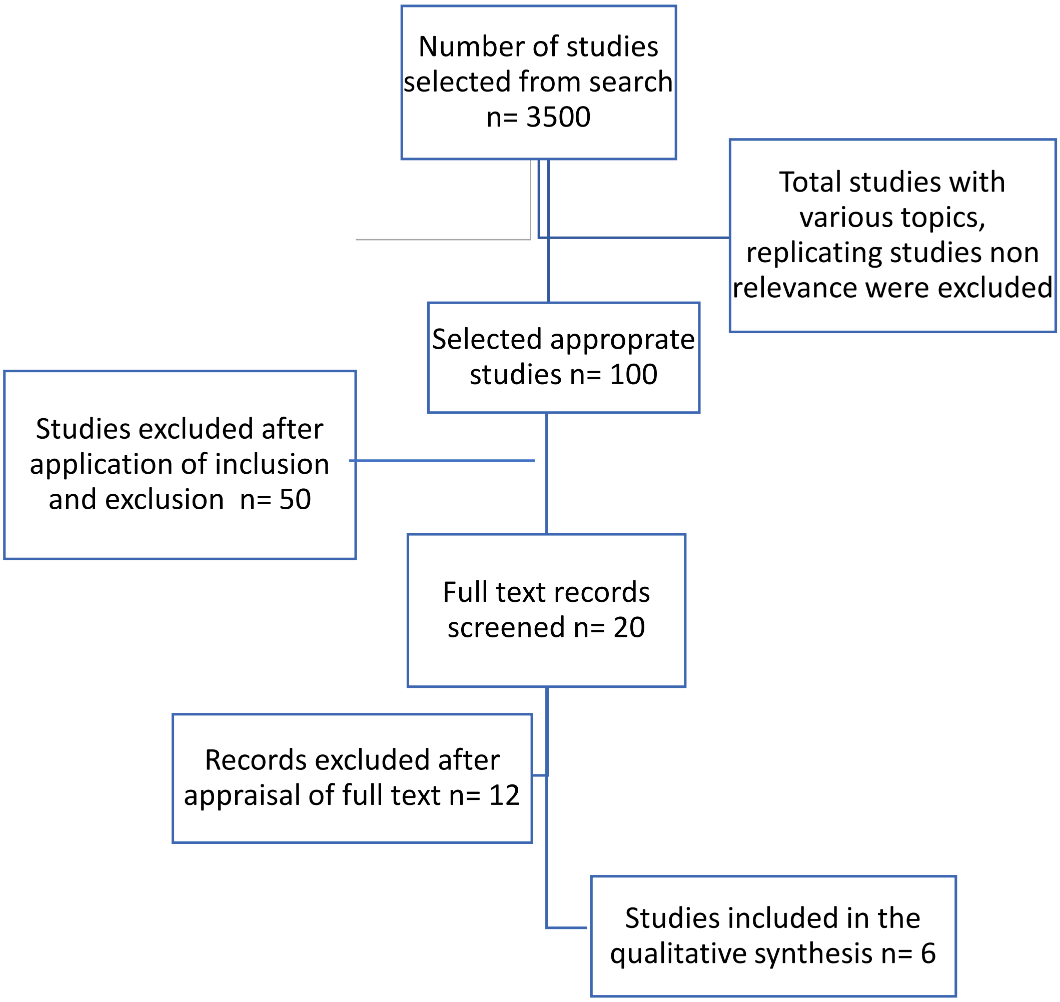
Stockley, R., (2018)	Women's Experiences of Postpartum Psychosis During the Onset and Early Days. *Journal of Prenatal & Perinatal Psychology & Health*, *33*(2).	Qualitative study using IPA	Aim; to examine women’s experiences, according to their own perspective	7 postpartum women.	Four themes were identified; -lack of recognition of seriousness. -Breast is best? -Trauma
Jefferies, Diana, Virginia Schmied, Athena Sheehan, and Margaret Duff. (2021). *Midwifery* 103	The River of Postnatal Psychosis: A Qualitative Study of Women's Experiences and Meanings	A Qualitative study	Aim; to gain an understanding of women’s experiences of postpartum psychosis.	10 women aged 28-35 years,	Women described their experiences as traumatic and the symptoms they experience during recovery

Appendix 12 :Model Checklist

RLBM (a guide)	**SMHI (Transition into the postnatal period)**
Change in sleeping pattern,	Sleep when you can. Make use of support network.
Challenges of breastfeeding	Providing an alternative means of breastfeeding such as expressing milk or use of artificial feeding as a substitute.
Open communication and interaction	Talk to your named healthcare provider family and friends, join groups or classes
Services available and their contact details	Local and mums' groups contact details. Provision of emergency contact number such as MBU. Keep a good dairy.
Childbirth experience	Birth reflections with professional such as midwives or discuss with professional/family if worried
Understanding personal stressors and ways of coping	Have a schedule to allow for easy planning of activities. Minimise stress factors

We are here to listen and not to judge

Study selection flow Chart figure 2.2



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