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Grange, Neesha

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SUPPORTING PARENTS WHO EXPERIENCE MENTAL HEALTH DIFFICULTIES: AN EXPLORATION OF THERAPEUTIC SERVICES AND INTERVENTIONS

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North Wales Clinical Psychology Programme

Submitted in partial fulfilment of the requirements for the degree of
Doctorate in Clinical Psychology

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Thesis Summary

SUPPORTING PARENTS WHO EXPERIENCE MENTAL HEALTH DIFFICULTIES: AN

EXPLORATION OF THERAPEUTIC SERVICES AND INTERVENTIONS

This thesis investigated therapeutic services and interventions for parents who experience mental health difficulties.

Chapter One is a scoping review that provides an overview of interventions aimed at supporting parents with a personality disorder diagnosis in their parenting role. Seventeen studies met inclusion criteria and were reviewed to identify (1) participant characteristics, (2) intervention designs and underlying theoretical frameworks, and (3) outcomes related to parents and children. There is preliminary evidence to suggest that interventions adapted from evidence-based interventions for personality disorders, which incorporate a parent-child relational focus, may be effective for parents with personality disorders and their children. Parents with personality disorder diagnoses may find universal parenting programs that are child-focused challenging. The findings may extend beyond clinical populations to parents who have histories of childhood trauma. Further research is proposed that addresses gaps in knowledge and methodological limitations.

Chapter Two explores narratives of mothers who required support from a mother and baby unit in a rural part of the UK (North Wales) when there was no local provision. A qualitative design adopting a narrative approach was used. Findings revealed a meta-narrative with five chapters common to each mothers' story: (1) Preparing for baby: (Great) expectations, (2) Unexpected events: Vulnerability, fear and confusion, (3) Making difficult decisions: Sacrifices and suffering, (4) Walking the path to recovery: Support and healing, (5) Living with the consequences: Grief, uncertainty, and meaning making. The findings have

clinical implications which identify service development needs to help reduce barriers for women requiring a mother and baby unit admission in a rural area.

Chapter Three highlights implications for clinical practice, future research and theory development, and concludes with a reflective commentary.

Chapter One:

Scoping Review

Interventions to support parents who have a personality disorder diagnosis: A scoping review

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Interventions to support parents who have a personality disorder diagnosis: A scoping review

Background: People with a personality disorder diagnosis are likely to have experienced childhood maltreatment within the context of early caregiving relationships. Many people with a personality disorder diagnosis will go on to be effective parents, however early traumatic experiences can make parenting particularly challenging for some. Purpose: To review literature exploring the effectiveness of interventions aimed at supporting people with a personality disorder diagnosis in their parenting role. Method: A systematic search was performed in February 2020 using Web of Science, PsycINFO and PubMed. A scoping review of 17 studies was conducted to identify (1) participant characteristics, (2) intervention designs and underlying theoretical frameworks, and (3) outcomes related to parents and children. Results: There is preliminary evidence to suggest that adapted evidence-based interventions for personality disorders, that incorporates the parent-child relationship, may be effective for parents with a personality disorder diagnosis and their children. Implications: Parents with a personality disorder diagnosis or history of childhood trauma should be considered a priority in services. Early intervention during pregnancy, for those who require it, is likely to have the best outcomes for parents and children and reduce the likelihood of intergenerational trauma. Further research is required to address the gaps in knowledge and research limitations before firm conclusions can be made.

Keywords: parents; personality disorders; borderline personality disorder; interventions

Introduction

Many parents with a personality disorder diagnosis will have effective parenting skills, however the nature of their difficulties and early relational experiences can make this role particularly challenging. Personality disorders are defined as an "enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in early adolescence or early adulthood, is stable over time and leads to distress or impairment" in the DSM-5 (American Psychiatric Association [APA], 2013, p. 645). There are various categories of personality disorders and the aetiology remains complex, with a range of biological, psychological, and social factors implicated. However, the interaction between an individual and their environment is considered to play a significant role, particularly with borderline personality disorder (BPD; Hoffman & McGlashan, 2003; Linehan, 1993). People with a personality disorder diagnosis have often experienced a significantly difficult start to life within the context of early relationships with caregivers. Many have histories of childhood maltreatment, abuse, and neglect (Battle et al., 2004; Carlson et al., 2009; Widom et al., 2009) and they are likely to develop insecure attachment styles (Levy, 2005). These traumatic experiences can affect the development of fundamental psychological processes, leading to difficulties with cognition, emotion regulation, interpersonal functioning, and impulse control (APA, 2013). This has led to debates around the validity of the diagnosis and whether the difficulties should be considered within the context of trauma rather than a "disordered personality" pathology (Dillon et al., 2014; Shaw & Proctor, 2005; van der Kolk, 2014).

Parents with a Personality Disorder Diagnosis

Some people with a personality disorder diagnosis can find parenthood more challenging than others given their early relational histories (Wilson et al., 2018; Zalewski et al., 2015). For those with unresolved trauma, they may encounter "ghosts in the nursery", whereby traumatic

past experiences intrude into the present parent-child relationship due to unmet childhood needs (Fraiberg et al., 1975). This usually operates outside of conscious awareness and might occur through direct re-enactment, or attempts to repair, early traumatic experiences (Newman & Stevenson, 2005). Parental behaviours might therefore be influenced by unresolved trauma rather than the child's individual needs at times (Newman, 2015).

Several systematic reviews (Eyden et al., 2016; Florange & Herpertz, 2019; Laulik et al., 2013; Petfield et al., 2015) and a recent meta-synthesis (Steele et al., 2019) have found associations between parental personality disorder diagnoses and maladaptive parenting styles. For instance, Laulik and colleagues (2013) identified problematic parenting practices, including insensitive, poorly attuned, intrusive, and inconsistent interactions, alongside harsh and frightening behaviours that lacked affection. Parents with a personality disorder diagnosis can also experience higher levels of parenting stress and feel less competent when compared to other parents (Florange & Herpertz, 2019; Ramsauer et al., 2016). This has been associated with guilt, uncertainty and worry for some mothers with a BPD diagnosis (Zalewski et al, 2015). Findings suggest that some mothers with a BPD diagnosis have a desire to care for their children but may lack the necessary skills to do so effectively (Eyden et al., 2016).

Children of Parents with a Personality Disorder Diagnosis

Research demonstrates that children of parents with a personality disorder diagnosis are at an increased risk of poor outcomes, with most of the literature focussing on parental BPD. Babies of mothers with a BPD diagnosis are more likely to be born prematurely and their overall health at birth is particularly vulnerable when compared to controls (Blankley et al., 2015). Children of parents with a personality disorder diagnosis are vulnerable to developing insecure or disorganised attachment styles (Hobson et al., 2005), alongside emotional, social, and behavioural difficulties across the developmental domains (Dutton et al., 2011; Petfield et al., 2015; Steele et al., 2019). Additionally, they are at greater risk of receiving a

personality disorder diagnosis themselves (Stepp et al., 2012). It has also been found that professionals are more likely to raise concerns about these children to child protection services (Blankley et al., 2015; Stanley & Penhale, 1999). Although there will be several underlying factors contributing to the association between parental personality disorder diagnoses and poor child outcomes, research has identified problematic parenting styles as a substantial mediator (Eyden et al., 2016; Florange & Herpertz, 2019; Johnson et al., 2006).

Parenting Interventions

Guidance from the Royal College of Psychiatrists (2020) states it is crucial that parents with a personality disorder diagnosis have access to evidence-based interventions to help prevent intergenerational patterns. It is recommended that a preventative approach is taken, preferably beginning in pregnancy, which focusses on strengthening the parent-child relationship to promote attachment security and optimise developmental outcomes (Eyden et al., 2016; Florange & Herpertz, 2019; Laulik et al., 2013; Newman, 2015; Steele et al., 2019; Wendland et al., 2014). Additionally, the therapeutic relationship requires careful consideration to support engagement, given the parent's attachment history and relational difficulties (Newman & Stevenson, 2008; Wendland et al., 2014). Despite this growing literature, specialist parenting interventions for people with a personality disorder diagnosis is currently limited, with provision reflecting an "either/or" approach. There are evidence-based treatments for personality disorders, including Dialectical Behaviour Therapy (DBT; Linehan, 1993) and Mentalisation Based Therapy (MBT; Bateman & Fonagy, 2016), however these tend to focus on the personality disorder rather than parenting difficulties. Indeed, some mothers engaging in DBT have expressed a need to specifically target the parent-child relationship in their current treatment (Zalewski et al., 2015). Likewise, there are evidence-based interventions designed for parents, including the Incredible Years programmes (Webster-Stratton, 1992), Video Interaction Guidance (Kennedy et al., 2011),

Circle of Security (Powell et al., 2014), Watch, Wait and Wonder (Muir et al., 1999), and Parent-Infant Psychotherapy (Cichetti et al., 2006; Lieberman et al., 2000), however most of these are considered to be universal parenting programmes and were not designed to meet the complex needs of parents with a personality disorder diagnosis. This has been noted by mothers with a personality disorder diagnosis in need of mental health support during the perinatal period who felt services struggled to meet the complexity of their needs and lacked specialist skills (Zacharia et al., 2020).

Rationale for Review

The literature highlights areas of need for some parents with a personality disorder diagnosis which can have profound implications for their children across the lifespan. There are calls for improved access to specialist parenting interventions for this group, however service provision remains limited. The current research therefore aims to provide an overview of the existing literature exploring the effectiveness of interventions used to support parents with personality disorder diagnoses to inform future research and clinical practice.

Method

During the literature search it became evident that the research topic was in its infancy. The studies varied significantly in study design and outcomes measures, and the methodological quality was not considered to be high. A scoping review, rather than a synthesis, was therefore deemed most appropriate to provide an overview of the current evidence base and identify gaps in research knowledge (Munn et al., 2018). Consistent with guidance for completing scoping reviews (Peters et al., 2015), a formal assessment of methodological quality was therefore not performed but is considered in relation to the findings.

Research Questions

The aim of the current scoping review was to answer the following questions:

(1) What were the characteristics of the study participants?

(2) What types of interventions were used in the studies to support parents?

(3) What were the reported outcomes of the interventions?

Data Sources and Search Strategy

An online literature search was conducted in February 2020 to identify articles evaluating interventions to support people with a personality disorder diagnosis in their parenting role. Three bibliographic databases were used: Web of Science, PsycINFO and PubMed. Only articles available in English were included. Papers were included regardless of publication year to provide a thorough overview of all relevant studies. The following terms were used as a basis to search the databases, identified from titles, key words and abstracts: (parent* OR mother* OR father*) AND (intervention* OR group OR program* OR workshop OR skills OR training OR therap* OR psychotherap*) AND ("personality disorder*" OR "personality difficult*"). Personality difficulties, as well as personality disorders, were included to widen the search. The search terms were adapted accordingly for each individual database. In addition to the electronic searches, the reference lists of all included studies and other relevant articles were hand searched to identify additional material. Search engines were also used to identify "grey" literature (e.g. unpublished theses). The results of the searches were imported into the reference management software Mendeley to help organise the research papers. All titles and abstracts were screened during the initial search to determine eligibility for full text retrieval. For articles that appeared relevant, the full text was obtained, screened, and examined against eligibility criteria.

Eligibility Criteria

The current scoping review includes interventions aimed at supporting people with a personality disorder diagnosis in their parenting role. A broad range of interventions and methods of delivery were considered across a range of settings. The review also included studies with or without a control condition, using any qualitative or quantitative outcomes.

Studies with both mother and father participants were included. This broad focus was considered most appropriate to help cover the breadth of the literature. Studies were included if at least 50% of the sample met diagnostic criteria for any personality diagnosis or were determined to have personality difficulties.

The inclusion criteria were:

(1) Parent(s) with a personality disorder diagnosis or personality difficulties.

(2) Parent(s) to at least one dependent child under the age of 18 years.

(3) Interventions used to specifically support a person in their parenting role.

(4) Outcomes relating to parent(s), children, or other appropriate people (e.g. clinicians).

Results

The electronic database search strategy identified a total of 1947 papers. After duplicates were removed, 1274 remained. A hand search and electronic search using search engines identified a further two papers, resulting in 1949 papers in total. All article titles and abstracts were screened and 69 remained. The full text of the remaining articles was then read to screen for eligibility, which resulted in the inclusion of 17 papers in this scoping review (see Figure 1).

Figure1. PRISMA flowchart of systematic search.
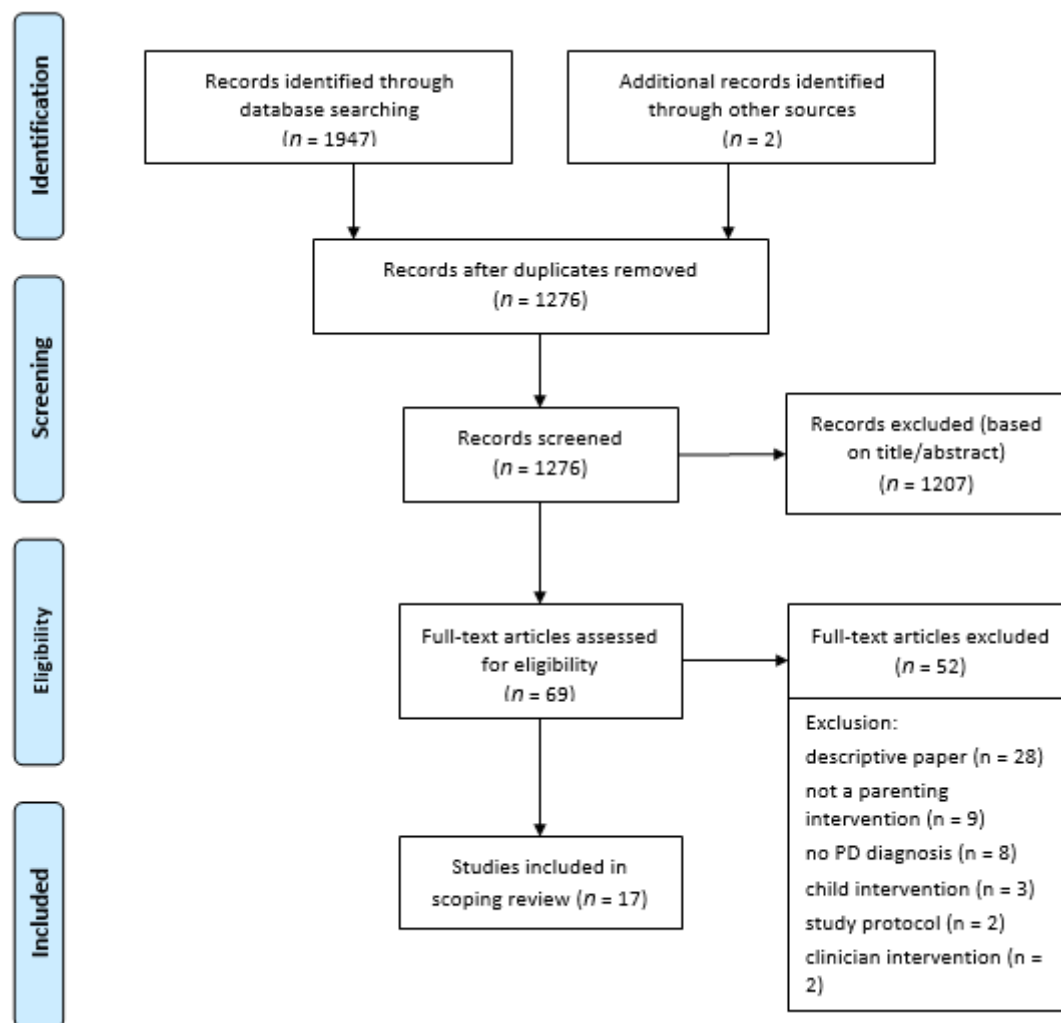
Data Appraisal

The titles and abstracts of 20 included and excluded studies by the primary author were shared with the researchers to assess author agreement. Full texts were retrieved where necessary. Author agreement was 100%.

Overview of Study Designs

Most of the studies were small scale pilot or case studies which investigated new interventions. Only three used comparison groups (Day et al., 2020; Gerull et al., 2008; Ramsauer et al., 2019), with the latter using a randomised controlled study design. Eight collected pre and post follow up measures, with two of these studies also including follow up measures (Day et al., 2020; Ramsauer et al., 2019; Rogers, 2016). One was an unpublished

thesis (Rogers, 2016), two were abstracts presented at conferences (Compés et al., 2016;

Jureidini et al., 2018) and the rest were published in peer-reviewed journals. (See Table 1 for

an overview of studies.) Given these features, the papers are considered to be weak forms of

evidence within the hierarchy of research evidence (Greenhalgh, 1997), however they do

provide useful information about a research area that is in its infancy.

Table 1. Overview of included studies.

Reference	Study Design	Intervention	Sample	Key Findings			
				Parent	**Child**	**Parent/Child**	**Other**
Compés et al. (2016)	Case study.	Attachment-focused dyadic group therapy; 6 weekly sessions.	Mothers with BPD.	Improved: breastfeeding; relationships; attitudes to job seeking.	Positive reactions.	Minor but positive change in relationship.	-
Day et al. (2020)	Randomised feasibility trial; mixed-methods; pre, post and follow-up measures.	Helping families programme-modified vs. TAU; 16 sessions.	Mothers (n=47) and father (n=1) with severe personality difficulties.	Improved: parenting; satisfaction; concerns about child No changes: parenting behaviour; mental health.	Improved: behavioural problem severity.	-	Good retention; acceptable intervention; longer delivery than planned.
Gerull et al. (2008)	Quasi-experimental; pre and post measures.	The conversational model vs. TAU; 12 months.	Mother (n=27); Father (n=10). BPD (n=45).	Improved: relationship with partner.	-	Improved: relationship.	-
Holman (1985)	Case study.	Time limited group treatment program; 21 sessions.	Mothers with BPD (n=6).	Improved: separation from child; less intrusive; less possessive; depression; emotional availability No changes: criticalness; physical clinging.	-	-	-
Jureidini et al., (2018)	Qualitative.	Mother-infant dialectical behaviour therapy; 26 weekly sessions.	Mothers with BPD (n=10).	Improved: motivation to seek treatment; symptom burden; parenting skills.	-	-	-
Keren and Tyano (2001)	Case study.	Parent-infant psychotherapy; 4 years.	Mother with BPD (n=1) and father with narcissistic	Improved: maternal attachment; self-	-	-	-

			personality disorder (*n*=1).	observation; reflective functioning.			
Knafo et al. (2018)	Case study.	Group attachment-based intervention; maximum of 3 sessions per week.	Mother with BPD (*n*=1).	Improved: observation; sensitivity to child's needs; reflective functioning.	-	-	-
Marziali et al. (2006)	Qualitative.	Group psychotherapy for people diagnosed with severe personality disorder; 35 weekly sessions.	Mothers with severe personality problems (*n*=6).	Improved: relationship with partner.	-	Improved: relationship with child.	Improved: relationship with child welfare system.
Newman and Stevenson (2008)	Case study.	Watch, wait, and wonder; 12-14 sessions.	Mothers with BPD (*n*=6).	Challenges to the intervention: low tolerance for being present with child; resentment for child attention; re-enactment of past trauma; limited capacity for self-reflection.	-	Challenges to the intervention: need to engage the therapist.	Challenges to the intervention: child focused protocol.
Perez (2018)	Case study.	Parent-infant psychotherapy; approximately 12 months.	Mother with BPD (*n*=1).	Improved: reflective functioning.	Improved: engagement with others; exploratory behaviours.	Improved: play.	-
Ramsauer et al. (2019)	RCT; baseline and follow-up measures.	The circle of security-intensive intervention vs. TAU; 20 weekly sessions.	Mother (*n*=72). BPD (*n*=18); avoidant, dependent or obsessive (*n*=23); paranoid (*n*=2); schizoid (*n*=1) personality disorder.	Improved: sensitivity for unresolved mothers. No changes: overall maternal sensitivity.	No changes: infant attachment.	-	-

Renneberg and Rosenbach (2016)	Mixed-methods; pre and post measures.	Parenting skills for mothers with borderline personality disorder; 12 weekly sessions.	Mothers with BPD (n=15).	Improved: behaviours and attitudes towards parenting.	-	-	Positive group evaluation by parents and trainers.
Rogers (2016)	Pilot study; mixed-methods; pre, post and follow-up measures.	Mindful parenting group intervention for mothers with personality disorder traits; 12 sessions.	Mothers with full or partial BPD (n=7).	Improved: parenting; experience of being a mother; emotion regulation; mindfulness; reflective functioning; psychopathology; self-concept; self-care.		Improved: outcomes in mother-child relationship.	Positive group evaluation.
Suchman et al. (2016)	Pilot study; quantitative; pre and post measures.	Mothering from the inside out; 12 sessions.	Mother (n=17). Deferred diagnosis (n=8), BPD (n=2), personality disorder not otherwise specified (n=1).	Improved: stress; psychiatric symptoms No changes: reflective functioning.	-	Improved: interaction quality.	-
Sved Williams et al. (2018)	Pilot study; quantitative; pre and post measures.	Mother-infant dialectical behaviour therapy; 24 weekly sessions.	Mothers with full or partial BPD (n=29).	Improved: mood; anxiety; BPD symptoms; parenting competence.	-	Improved: dyadic relationship quality.	-
Wendland et al. (2014)	Case study.	Parent-infant psychotherapy; approximately 3 years.	Mother with BPD (n=1).	Improved: sensitivity to child's needs; depressive symptoms.	Entered kindergarten with no problems; but remained at risk due to maternal mental health.	Prevented separation of mother and child; improved play.	-
Wilson et al. (2018)	Pilot study; qualitative.	Helping families programme-	Mothers who met research or clinical diagnosis	Difficulties in the parenthood experience; challenges of being a parent	-	-	Positive evaluation of intervention.

modified; 16
sessions.

of personality
disorders (n=5).

affected by personality
disorder.

Participant Characteristics

Parent Participants

All 17 reviewed studies included parent participants. Sixteen of the 17 studies specified the total number of parent participants which came to a total of 271 parents (range 1-48). The gender and role of parents was reported across all 17 studies, however one study (Compés et al., 2016) reported that all participants were mothers but did not specify the number. In the remaining 16 studies, there were 251 mothers and 20 fathers. Eleven of the 17 studies provided some information about the parent's age, which ranged from 18-49 years.

All 17 studies provided information about the diagnostic status of parents. One study reported that all parents had BPD but did not specify the number study (Compés et al., 2016). In the remaining 16 studies, 237 parents were identified as having a personality disorder diagnosis or personality difficulties. The majority of parents were reported to have a BPD diagnosis ($n = 142$), followed by severe personality difficulties ($n = 54$), avoidant, dependent or obsessive personality disorder ($n = 23$), deferred personality disorder ($n = 8$), personality disorder ($n = 5$), paranoid personality disorder ($n = 2$), narcissistic personality disorder ($n = 1$), schizoid personality disorder ($n = 1$) and personality disorder not otherwise specified ($n = 1$).

Four of the 17 studies included information about the parent's ethnicity (Day et al., 2020; Holman, 1985; Ramsauer et al., 2019; Suchman et al., 2016). The most common ethnic group was Caucasian/white parents ($n = 112$) across all four studies. Additionally, Day et al. (2010) also had parents from Black/Black British ($n = 9$) and dual heritage ($n = 6$) backgrounds, Suchman et al. (2016) had parents from Hispanic or Latina (6) and African American ($n = 4$) backgrounds and Ramsauer et al. (2019) had African parents ($n = 1$).

Eight of the 17 studies included information suggestive of the parent's socioeconomic status. Of these, six studies reported parent's educational history (Day et al., 2020; Gerull et

al., 2008; Holman, 1985; Suchman et al., 2016; Ramsauer et al., 2019; Renneberg & Rosenbach, 2016). Most parents had completed some form of education, varying from school to postgraduate level. Parent's employment status was also reported in five of these studies (Compés et al., 2016; Day et al., 2020; Gerull et al., 2008; Perez, 2018; Rogers, 2016), with the majority of participants identified as unemployed. Ramsauer et al. (2019) reported household income ranging from <€1500, €1500-3000 and >€3000 per month, with the majority of participants earning within the highest category. Three of the participants in Holman's (1985) study were defined as having serious economic problems and all participants ($n = 6$) in this study were described as having middle class values.

Child Participants

Sixteen of the 17 studies provided some information about the parent's children, however two of these described one case example from a larger sample and did not provide details regarding the overall child sample (Gerull et al., 2008; Newman & Stevenson, 2008). Twelve studies specified the number of children which came to a total of 159. Of these children, 93 were boys and 60 were girls. One study did not report the children's gender (Holman, 1985). Children's ages were reported in 14 studies and ranged from 6 months-24 years. Six studies provided information relating to the children's presenting difficulties, including social, emotional, behavioural, language and academic difficulties and insecure or disorganised attachment styles. Marziali et al. (2006) reported an instance of parental neglect. One study (Suchman et al., 2006) also reported children's involvement in child protection services ($n = 5$) and children's living arrangements, most of whom lived with their mother ($n = 15$).

Intervention Type

All 17 reviewed studies included information regarding the intervention utilised. Eleven of the 17 studies also provided information about the intervention setting. Four took place within hospital settings (including a hospital-based clinic, parent-infant mental health unit

and mother-and-baby units) and seven took place in community settings (including homes, community services, private practice). All but one study (Jureidini et al., 2018) documented the duration of the interventions, which ranged from 6 weeks to 4 years. Eight studies described interventions delivered in a group setting and nine were delivered individually to the parent and/or the parent-child dyad. A total of 13 different interventions which drew on various models were described across all 17 studies:

Group interventions:

- "Attachment-focused dyadic group therapy" (Compés et al., 2016): Aim to be listened and accompanied to share motherhood experiences. No further detail provided.

- "Time limited group treatment program" (Holman, 1985): Aim to improve the ego functioning of mothers to enable them to participate in their child's separation-individuation phase and to promote typical development. Grounded in psychoanalytic theory, influenced by the work of James Mann (1973) and Irvin Yalom (1970).

- "Mother-infant dialectical behaviour therapy" (MI-DBT; Jureidini, Sved Williams & Yelland, 2018; Sved Williams et al., 2018): Based on the DBT model (Linehan, 2015) with adaptations focussing specifically on parenting and mother-infant relationships. Modules include mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness.

- "Group attachment-based intervention" (GABI; Knafo et al., 2018): Developed from the integration of clinical experience with the theory and research findings in attachment theory. Components include reflective functioning, emotional attunement, affect regulation, reticence, intergenerational patterns, nurturance and group context.

- "Group psychotherapy for people diagnosed with severe personality disorder" (Marziali et al., 2006): Based on a model of group psychotherapy (Marziali, Damianakis & Trocme, 2003). Components include the provision of a therapeutic environment that supports the re-enactment, observation and self-reflection of problematic interpersonal transactions and their outcomes, and the opportunity to modify expectations of self and other in the context of group member-member and member-cofacilitator transactions.

- "The circle of security-intensive intervention" (COS-I; Ramsauer et al., 2019): Grounded in the principles of attachment theory and empirically derived knowledge. Mother-infant interactions are videotaped and analysed to address the core difficulties of the dyadic relationship with regards to the attachment, signals and needs of the child.

- "Parenting skills for mothers with BPD" (Renneberg & Rosenbach, 2016): Based on the DBT model (Bohus & Wolf-Arehult, 2013; Linehan, 2006) with adaptations focussing on parenting. Modules include psychoeducation, mindfulness, children's basic needs, stress and stress management, structure and flexibility, dealing with conflicts, dealing with emotions, the body, basic assumptions about parenting and self-care.

- "Mindful parenting group intervention for mothers with personality disorder traits" (MPG-BPD; Rogers, 2016): Mindfulness-based and informed by existing BPD interventions (Acceptance and Commitment Therapy for BPD group program, DBT, MBT), attachment-based interventions (Watch, wait and wonder and Circle of security), and mindful parenting principles. Psychoeducation is provided and mothers are supported to make connections between their childhood and parenting experiences.

Individual and Dyad Interventions:

- "Helping families programme-modified" (HFM-P; Day et al., 2020; Wilson et al., 2018): Based on a transtheoretical model of parenting which draws on attachment, social learning and cognitive affective theories. Components include core therapeutic process, parent groundwork and parenting strategies.

- "The conversational model" (CM; Gerull et al., 2008): A form of relational psychotherapy developed from the work of Hobson (1985) and Meares (2000; 2005). The main aim is to foster the emergence of 'self' to enhance the capacity for empathy and to integrate traumatic memories.

- "Parent-infant psychotherapy" (Keren & Tyano, 2001; Perez, 2018; Wendland et al., 2014): Each study utilised interventions based on different models. Keren and Tyano (2001) combined mother-infant psychodynamic therapy and interactional guidance and highlighted the influence of Fraiberg (1975) and Stern's (1985) work. Wendland and colleagues (2014) intervention is described as psychoanalytically grounded and based on widely recognised principles formulated by Fraiberg and colleagues (Fraiberg et al., 1975), Kernberg (1984) and Bateman and Fonagy (2004). They also incorporated video feedback.

- "Watch, wait, and wonder" (Newman & Stevenson, 2008): Attachment-focused approach developed by Muir et al. (1999). Parents are supported to observe and follow their child's lead in activities.

- "Mothering from the inside out" (MIO; Suchman et al., 2016): Based on the MBT model (Allen, Fonagy & Bateman, 2008). Mothers supported to engage in mentalisation processes and are offered developmental guidance and parenting strategies.

Intervention Outcomes

Parent Outcomes

All 17 reviewed studies reported parent outcomes in relation to the effectiveness of the intervention, which varied across psychopathology/symptom severity, skill development, feelings associated with being a parent and several other outcomes. All reported mainly positive outcomes.

Seven studies reported outcomes relating to parental psychopathology. Six of these reported improvement in parental psychopathology, across general mental health (Holman, 1985; Suchman et al., 2016), BPD symptoms (Jureidini et al., 2018; Rogers, 2016; Sved Williams et al., 2018), depression (Rogers, 2016; Suchman et al., 2016; Sved Williams et al., 2018; Wendland et al., 2014), anxiety (Sved Williams et al., 2018) and stress (Rogers, 2016). However, one study (Day et al., 2020) did not find a significant improvement in parental psychological symptoms.

Eight studies reported outcomes relating to parental skill development. Seven of these studies reported positive outcomes overall, including general parenting (Jureidini et al., 2018; Rogers, 2018), reflective functioning (Keren & Tyano, 2001; Knafo et al., 2018; Perez, 2018; Rogers, 2018), sensitivity (Knafo et al., 2018; Ramsauer et al., 2019; Wendland et al., 2014), observational (Keren & Tyano, 2001; Knafo et al., 2018), emotion regulation and mindfulness skills (Rogers, 2018). However, one study only found a modest increase in overall reflective functioning skills which remained at a pre-mentalising level (Suchman et al., 2016). Holman (1985) found mixed results, with some parents becoming less intrusive, possessive, conflicted and more emotionally available and better able to tolerate separation, whilst others became more critical and physically clingy. Day et al. (2020) did not find any improvement in parenting behaviours.

Four studies reported outcomes relating to feelings associated with being a parent. All of these reported improvements across parental satisfaction (Day et al., 2020), maternal experience (Rogers, 2018), competence (Wendland et al., 2014), and attitudes and behaviours towards parenting (Renneberg & Rosenbach, 2016).

Three studies reported outcomes relating to wider relationships with family and/or services, all of which were positive (Compés et al., 2016; Gerull et al., 2008; Marziali et al., 2016). One study reported improvements in maternal attachment (Keren & Tyano, 2001). Another study highlighted additional improvements in breastfeeding and attitudes to job-seeking (Compés et al., 2016). Jureidini et al. (2018) reported that parents were motivated to seek additional treatment to improve the experience of their children and disrupt the intergenerational transmission of BPD.

Child Outcomes

Six of the 17 reviewed studies reported child outcomes, with five reporting some positive outcomes. Compés et al. (2016) reported positive reactions in the children but did not provide specific detail. Day et al. (2020) found reductions in behavioural problem severity and parents had less concerns about their child. Perez (2018) reported increased exploratory behaviours and improved engagement with others. Wendland et al. (2014) found that the child entered into kindergarten with no difficulties but remained at risk due to maternal mental health. Ramsauer et al. (2019) found no significant effect on infant attachment style, as the majority of the sample were securely attached prior to the intervention.

Parent-Child Outcomes

Eight of the 17 reviewed studies reported outcomes related to the parent-child relationship, which were all positive. Five studies noted general improvements in the relationship (Compés et al., 2016; Gerull et al., 2008; Marziali et al., 2016; Rogers, 2018; Sved Williams et al., 2018), whilst others found improvements in interactions (Suchman et al., 2016) and play

(Perez, 2018; Wendland et al., 2014). Additionally, Wendland et al. (2014) identified the intervention as preventing separation between parent and child.

Intervention Feasibility and Acceptability

Six of the 17 reviewed studies provided some information regarding the feasibility and acceptability of the interventions by participants. Three studies included parent feedback regarding the intervention (Renneberg & Rosenbach, 2016; Rogers, 2016; Wilson et al., 2018), which were overall positive evaluations. Four of the studies included clinician or intervention focused feedback regarding implementation (Day et al., 2020; Newman & Stevenson, 2008; Suchman et al., 2016; Wilson et al., 2018), which were mixed. One study concluded that the intervention was feasible, acceptable and well attended (Suchman et al., 2016). Day and colleagues (2020) also had good retention rates, however difficulties characteristic of personality disorder created delays in screening, data collection and intervention delivery. Likewise, Newman and Stevenson (2008) reported challenges with the delivery of the intervention due to common difficulties associated with personality disorder, for example the re-enactment of trauma and limited capacity for self-reflection.

Discussion

The purpose of this scoping review was to examine the literature on interventions to support parents with a personality disorder diagnosis in their parenting role. The review identified 17 studies that were mostly conducted in the last decade, which highlighted the limited existing knowledge base. Several aspects of the research were examined, including participant characteristics, intervention type and intervention outcomes.

Mothers made up a large proportion of the participant samples and there was limited involvement of fathers. This reflects the wider literature where fathers tend to be a "forgotten" parent within research and services (Wong et al., 2015). Although mothers are

important to include, the importance of fathers is increasingly being understood and they can be a vital form of support to mothers struggling in their parenting role (Stanley et al., 2006). Many fathers can also struggle themselves in their parenting role, particularly if they experience mental health difficulties, and may require parenting support (Singley & Edwards, 2015). Similarly, most of the parents in the studies had a BPD diagnosis, which is consistent with the current literature that largely focusses on this population. However, there is evidence to suggest that parents with various personality disorder diagnoses can experience significant challenges in parenting (Laulik et al., 2013). Perhaps the focus on BPD reflects the gender of the participants, and the idea that BPD tends to be a female malady, whereas antisocial personality disorder predominantly affects males (Paris, 1997). Additionally, ethnic diversity was limited as most parents were Caucasian/white. Considered together, the findings may not generalise to fathers or parents with personality diagnoses other than BPD, and there may be implicit, or explicit, gender and racial biases in the research that warrant further consideration in the future.

Most of the children were infants and young children and the outcomes were generally positive. This is consistent with research highlighting the importance of early intervention for parents with a personality disorder diagnosis and their children (Newman, 2015; Wendland, 2014). However, only a few studies measured child outcomes so it cannot be said with confidence that improvements in parenting were associated with improvements in child outcomes. Additionally, most of the outcomes focused on behavioural changes, which is concerning given that children of parents with personality disorder diagnoses are vulnerable to the intergenerational transmission of trauma and attachment difficulties that can have a profound impact across several developmental domains (Adshead, 2018; Laulik et al., 2013; Stepp et al., 2019). Similarly, follow up measures were rarely incorporated so it is unclear whether improvements lasted over time. This is important to consider as it is likely

that changes in parenting result in changes in child outcomes over time, rather than immediately.

There were a range of group and individual interventions based on various underlying theoretical frameworks, delivered across a variety of settings. Most were adapted versions of evidence-based interventions for BPD for mothers and babies and a few were evidence-based interventions for parenting. Interestingly, the universal parenting programmes (Watch, Wait, and Wonder and Circle of Security) appeared to generally be less effective than the interventions adapted from existing BPD treatments. Newman & Stevenson (2008) found that parent's unmet childhood needs created challenges for the Watch, Wait, and Wonder intervention, as the focus on the child often left them feeling neglected. This suggests that the key ingredients for interventions to be effective in supporting parents with personality disorder diagnoses might be those that allow parents the opportunity to discuss their individual needs within the context of their relationship with their child, whilst increasing their skill development. Indeed, the literature highlights the parent-child relationship as a key area for interventions to target (Eyden, 2016; Laulik, 2013; Newman, 2015; Wendland, 2014; Steele, 2020). Some of the interventions, particularly those based on a psychotherapy model, were lengthy in duration and may not fit current service models.

Scoping Review Strengths and Limitations

This scoping review was carried out to identify the existing literature exploring interventions aimed at supporting parents with a personality disorder diagnosis and is the first to provide an overview. This review does however have some limitations. Although the aim was to be inclusive all of relevant studies to provide a through overview, the exclusion of non-English language publications could have excluded relevant studies. This was unavoidable given the researchers' spoken language. Additionally, as the research topic is still in its infancy, the scientific rigour and quality of the studies was not evaluated, however the papers were

broadly considered to be weak forms of evidence within the hierarchy of research evidence (Greenhalgh, 1997). Finally, although the scoping review aimed to provide an overview relevant to all personality disorder diagnoses, the majority of studies focused exclusively on parents with a BPD diagnosis. This limits the accurate interpretation of the findings which should be considered with caution.

Research Implications

Although the overall findings of the interventions were positive, firm conclusions cannot be made as the studies had several limitations with their methodological designs. Most were small scale pilot or case studies evaluating new interventions, which may be subject to publication bias. Additionally, only three studies included a comparison group, therefore it remains unclear how effective the interventions were in relation to other programmes or treatment as usual. Future research might wish to address these limitations and gaps in the research by:

(1) Recruiting larger sample sizes. This will require careful consideration and planning as parents with personality disorder diagnoses can sometimes be challenging to engage (Newman & Stevenson, 2008; Wendland et al., 2014).

(2) Using comparison groups to measure effectiveness against other interventions, ideally with a randomised controlled trial design. Particularly comparing those which significantly vary in duration to support an economic analysis for services.

(3) Including measures of both parent (e.g. mental health symptoms and parenting skills), child (e.g. emotional, social, cognitive and behavioural) and parent-child (e.g. attachment) outcomes.

(4) Assessing maintenance over time using follow up measures, preferably over months rather than weeks.

(5) Recruiting parents from diverse populations, taking into consideration gender, ethnicity and personality disorder diagnoses.

(6) Including non-English language studies.

Clinical Implications

This scoping review highlights that the existing literature is in its infancy and the findings should therefore cautiously be interpreted as a promising sign that these interventions may be beneficial to parents with a personality disorder diagnosis, predominantly those with a BPD diagnosis. There is preliminary evidence to suggest that various interventions, mainly those adapted from existing evidence-based interventions for BPD, can be helpful. To be most effective, services should focus on early intervention that begins in pregnancy, and parents with personality disorder diagnoses, particularly BPD, or histories of childhood maltreatment should be considered a priority in services. This highlights possible training needs for midwives, health visitors and GPs. Parents may find it difficult to trust professionals and may be sensitive to rejection and criticism, given the likely history of relational trauma. Therefore, relationship building will require a sensitive, non-judgemental compassionate approach over time. Interventions that consider the parents' needs within a relational context with their child may help parents feel supported and reduce the likelihood of them feeling invalidated. Universal programs that are child-focused may wish to incorporate a component that allows parents the opportunity to have their needs heard. Finally, in line with debates around personality disorders reflecting a trauma history (Dillon et al., 2014; Shaw & Proctor, 2005; van der Kolk, 2014)., the findings may extend beyond this clinical sample to parents who have experienced traumatic childhood experiences.

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Chapter Two:

Empirical Study

"All I wanted was a bit of TLC": Narratives of mothers who required inpatient perinatal mental healthcare in a rural part of the UK

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"All I wanted was a bit of TLC": Narratives of mothers who required inpatient perinatal mental healthcare in a rural part of the UK

Aim: To explore experiences of mothers who required support from a mother and baby unit in a rural part of the UK (North Wales) when there was no local provision. Design: Qualitative approach using a narrative interview style. Participants: Five mothers who had experienced perinatal mental health difficulties. Findings: Analysis revealed a meta-narrative with five chapters common to each story: (1) Preparing for baby: (Great) expectations, (2) Unexpected events: Vulnerability, fear and confusion, (3) Making difficult decisions: Sacrifices and suffering, (4) Walking the path to recovery: Support and healing, (5) Living with the consequences: Grief, uncertainty, and meaning making. Implications: Service development needs are identified to help reduce barriers for women who require a mother and baby unit in areas where there is no local provision.

Keywords: perinatal mental health; mother; inpatient; mother and baby unit; rural; Wales

Introduction

The mental health needs of mothers during the perinatal period (defined here as conception to one year after birth) has gained increased recognition in recent years (Howard et al., 2014). Pregnancy and motherhood can bring substantial biological, psychological and social changes which make women vulnerable to developing mental health difficulties (Oates & Cantwell, 2011; Royal College of Psychiatrists [RCP], 2015). Many of the risk factors are shared with those in the general population, however the perinatal period is associated with unique

additional factors, including traumatic births and infant complications or mortality (National Institute for Health and Care Excellence [NICE], 2014). Around one in five women are thought to be affected by perinatal mental health (PMH) difficulties, however it is likely that figures are an underestimate as many are believed to go undetected (Bauer et al., 2014). The most common PMH difficulties are mild to moderate anxiety and depression, whilst a smaller number of mothers will be affected by severe difficulties, including postpartum psychosis and major depression (NICE, 2014; RCP, 2015).

Implications of PMH Difficulties

PMH difficulties are one of the leading causes of maternal death in the United Kingdom (UK), with over half caused by suicide (Oates & Cantwell, 2011). There is an increased risk of neonatal death and still birth (King-Hele et al., 2009) and severe PMH difficulties have been associated with infanticide in rare circumstances (Craig, 2004; Flynn et al., 2013). During the early years, PMH difficulties can disrupt the mother-infant bond leading to the development of insecure attachment styles (Hipwell et al., 2000; Martins & Gaffan, 2000; Wan & Green, 2009). Problems in attachment security are well documented and are associated with long-lasting effects across the child's emotional, social and cognitive developmental outcomes (Murray et al., 2015; Stein et al., 2014). Additionally, PMH difficulties create a long-term cost to society of approximately £8.1 billion for each one-year cohort of births in the UK, most of which (72%) relates to the impact on the child (Mental Health Foundation, 2016).

PMH Service Models

Historically, there has been a lack of awareness of PMH difficulties and limited service provision, however increasing specialist PMH services is now part of the NHS long-term plan (2019) in the United Kingdom (UK). Guidance recommends a specialist multidisciplinary PMH service in each locality that focusses on early intervention and follows a stepped-care

model of delivery (NICE, 2014). It is recommended that interventions should target both the mental health needs of the mother and the mother-infant relationship. Women experiencing severe mental health difficulties who require inpatient care during the perinatal period should typically be admitted to a specialist mother and baby unit (MBU). Joint admission for mother and baby is recommended, unless there are specific reasons not to do so, as separation is often distressing and can have long-lasting negative effects on both mother and child (Main, 1958; Heron et al., 2012; Robertson & Lyons, 2003).

PMH Service Outcomes

Women who have accessed PMH services have described the service as a "lifesaver" (Coates et al., 2017). A systematic review and meta-synthesis into the experience of mental healthcare in the perinatal period highlights the importance of developing a trusting relationship with a skilled healthcare professional who can offer individualised care and treatment in a compassionate and non-judgemental manner (Megnin-Viggars et al., 2015). This can provide mothers with a safe space to reflect on, and work through, their difficulties (Coates et al., 2017). Women requiring inpatient care have reported a preference for a MBUs when compared to a general psychiatric unit, as remaining with their baby was deemed important and helped with recovery (Antonysamy et al. 2009; Griffiths et al., 2019; Neil et al., 2006; Wright et al., 2018). Research exploring the effectiveness of MBUs has generally reported improvements in mother and baby outcomes (Conellan et al., 2017; Gillham & Wittkowski, 2015; Stephenson et al., 2018), with high satisfaction levels (Antonysamy et al., 2009; Nair et al., 2010; Neil et al., 2006).

Current PMH Service Provision in the UK

Findings create a compelling argument for the existence of PMH services. The expansion of services in the UK is in progress but remains limited in some localities, particularly for MBUs. Maps from the Maternal Mental Health Alliance (2019) show that MBUs tend to be

located in cities in England, rather than more rural areas, and there are none currently in

Wales or Northern Ireland. Research from a rural African district highlights that women in

rural areas can have an unmet need for PMH care due to significant gaps in knowledge

amongst both mothers and healthcare providers (Nakku et al., 2016). Key barriers to

treatment included poverty, problems with transport, poor partner support and stigma. This is

concerning, given the profound impact of PMH difficulties for both mothers, their babies and

wider society, and requires further attention within a UK population. Additionally, gaps in

service provision are not unique to perinatal mental health services. Inconsistencies in quality

of care are found more broadly across physical and mental health services and can be

associated with adverse outcomes. For example, delays in receiving specialist assessments

and interventions have been linked with poor cancer survival rates (Allemani, et al., 2018),

poor basic care provision for older adults with chronic conditions (Beach et al., 2020),

prolonged suffering for adults with eating disorders (Weissman & Rosseli, 2017) and high

economic costs in adulthood for children in need of mental health services (Heckman, 2012).

Aims

To date, there is limited research exploring womens' experiences of requiring mental

healthcare during the perinatal period in an area of the UK where specialist provision is

limited. This study therefore aimed to explore the experiences of mothers living in a rural part

of the UK, North Wales, who required inpatient mental healthcare from a MBU when there

was no local service provision. It is acknowledged that this is not only a rural concern as

there is limited MBU service provision across the UK (Maternal Mental Health Allice, 2019).

A qualitative narrative approach was selected to gain a detailed understanding around the

impact of these experiences over time and the wider implications, including the impact on

baby and wider family relationships.

Method

Design

Narrative interviews were utilised for participants to share their stories. In line with guidance, a semi-structured interview schedule was developed that allowed participants to tell their stories without suppression by the interviewer (Elliott, 2005; Mishler, 1986). This included an explanation about the style of the interview and an open-ended question to help participants tell their story. The schedule included prompt questions to support the flow of the narrative if needed.

Participants

Inclusion criteria for participants were:

(1) Female.

(2) Aged 18 years or over.

(3) Previously had a clinical need to receive treatment from a psychiatric inpatient service during the perinatal period.

(4) Clinical need to receive treatment from a psychiatric inpatient service occurred between 6 months and 5 years prior to the research interview.

Potential participants were identified by clinicians associated with a specialist community PMH service. They were contacted by clinicians during routine appointments or over the telephone and consent to be contacted by the research team was sought. The contact details of $n = 14$ women who met the research inclusion criteria were provided to the researchers. All potential participants were initially contacted by telephone to discuss the research and share the information pack, where appropriate. We were unable to contact $n = 7$ women and $n = 2$ women declined. A total of $n = 5$ consented. A follow up contact was made at least 24 hours later, and a date and time for the interview was agreed.

The sample consisted of five women who have experienced PMH difficulties. All

participants were white-British. Two were bilingual Welsh and English. Ages ranged from

22-40 years, with a mean age of 32. Participants differed in the mental health treatment and

the diagnoses they received during the perinatal period. (See Table 1.)

Table 1. Participant information.

Participant Pseudonym	Age	Diagnosis	Service(s)	Time since required MBU
Bethan	40	PTSD; Postpartum psychosis	Adult mental health; community PMH	Child 1: 18 years; Child 3: 10 months
Lowri	39	Bipolar disorder; Postpartum psychosis and catatonic depression	Adult mental health; community PMH; MBU	9 months
Hannah	22	Postpartum psychosis and anxiety	Psychiatric liaison; community PMH	10 months
Louise	36	Postpartum psychosis and depression	Adult mental health	5 years
Rhian	25	Emotionally unstable personality disorder	Adult mental health; Home treatment; community PMH; MBU	2 ½ years

Although Bethan's first clinical need for a MBU admission was outside the participant

inclusion criteria (more than 5 years ago) her second clinical need for a MBU admission was

within the participant inclusion criteria. Bethan was initially recruited based on her second

need for admission and it was unknown that she had an earlier need to be admitted that was

outside the participant inclusion criteria during recruitment. This knowledge was gathered

during the interview process as it was part of Bethan's narrative. The first clinical need for a

MBU admission was an important part of Bethan's narrative that had associations with her

second clinical need for a MBU. Considered together, it was deemed appropriate that Bethan

should be retained within the study.

Procedure

Participants engaged in one face-to-face or video interview between February and April

2020. Interviews took place in participant's homes or local children's centres. Interview durations ranged from 52 to 88 minutes, with a mean duration of 71 minutes. At the start of the interview, the information sheet was reviewed and discussed. Participants provided written informed consent to participate in the research, be audio-recorded for their interview and for the use of their direct quotes in publications. Participants could refuse to answer questions during the interview, stop the interview and had the right to withdraw from the research at any time, however their interview data could not be removed once it had reached analysis.

During each interview, participants were invited to share their story about their experience of developing PMH difficulties and receiving services in North Wales. The interviewer actively listened, whilst avoiding interrupting, and participated in the telling of the story through non-verbal cues, brief additional questions, or short statements, when appropriate. Interviews were audio-recorded and transcribed verbatim by the primary researcher.

Analysis

"Narrative analysis" describes an overall approach that includes a diverse range of techniques with different theoretical assumptions. According to Elliot, "there is no standard approach or list of procedures that is generally recognised as representing the narrative method of analysis" (2005, p. 36). However, central to each approach, is the idea that people make sense of their experiences by constructing them into stories, which are determined by the social context within which they are created and told (Elliott, 2005; Mishler, 1986; Riessman, 1993). The current narrative analysis therefore drew on several narrative analysis techniques, influenced by the data, research question and resonance with the researchers in providing valuable insights.

Lieblich and colleagues (1998) identify two independent dimensions through which to

analyse narrative materials, "holistic" versus "categorical" and "content" versus "form".

There are polar ends of each dimension and also middle points between the two. This

technique was used as an underlying framework through which other narrative analysis

techniques were employed. The social context and function of the narrative was also

considered within the life of the individual and society more broadly (Mishler, 1995;

Plummer, 1995; Riessman, 1993).

Analysis was not directly linear, rather, it was an iterative process that moved back

and forth between stages, through several readings of the text. Initially, the interview

recordings were listened to in order to connect with the emotions of the participants and

interviewer, which helped provide some insight into meanings made (Fraser, 2004).

Information gathered was recorded in a reflexive journal which was added to throughout the

following stages. Next, a categorical approach was adopted to analyse the transcripts,

including consideration of both content and form (Lieblich et al., 1998). Through a series of

readings, each transcript was analysed with a particular purpose in mind. This included:

content to identify initial themes (Elliott, 2005), emotional tone (Fraser, 2004), characters

(Elliott, 2005; McAdams, 1993), genre (Plummer, 1995; Elliott, 2005), chronology (Elliott,

2005) and cultural references (Mishler, 1995; Plummer, 1995; Riessman, 1993). A "story-

summary" (Skippon, 2010) was created for each narrative which reflected these areas of

enquiry. Each participant received their story-summary, to assess for accuracy and feedback.

Each narrative was then considered together holistically, alongside the recordings and

reflexive journal, to identify similarities and differences in both content and form (Lieblich et

al., 1998). This led to the development of an overall "meta-analysis" (McMahon et al., 2012)

that reflected each participant's story. The meta-analysis was likened to a book, and divided

into distinct chapters (Crossley, 2000). The transition between each chapter represented a

"turning point" in the narrative (e.g. thoughts, feelings, meaning, events), rather than the

chronological passage of time (Lieblich et al., 1998).

Validity

The primary researcher's thoughts and feelings during the research process were recorded in a reflexive diary to consider the researchers position and assumptions, and the influence this may have had on the analysis (see Reflexivity statement). Participants were also given the opportunity to provide feedback on the final analysis of their interview to improve the accuracy of the findings. Additionally, regular meetings were held between the researchers to support analysis.

Reflexivity Statement

I have been raised by a single mother within a predominantly female family, which has led me to develop a feminist perspective. I have experienced first-hand the powerful position of women within families, and the influence they have not only on their own children, but on subsequent generations. I am drawn to relational theories and often view the world through this lens.

I believe we have inherited implicit, and sometimes explicit, biases from previous generations, where patriarchy and female oppression remain embedded in our systems. I consider this to be reflected in the limited perinatal and infant mental health services both nationally and internationally, where the needs of women and the importance of the early mother-infant relationship is not considered a priority.

Both my natural curiosity in the lives of human beings and professional role within clinical psychology lend well to a narrative approach. I am interested in the stories people create and the meaning attached to them, alongside the cultural context within which they are created and told. I also feel it is important to give voice to those who often go unheard within our society.

Results

To maintain a holistic approach and preserve the womens' narratives, the different elements of the analysis (e.g. characters, genre, cultural references, emotional tone) are weaved into the following chapters, rather than being presented as separate categories.

Chapter One. Preparing for baby: (Great) expectations.

Most of the women started their stories positively by describing their pregnancy experience. Lowri started slightly earlier explaining the preparations she and her partner made before trying to have a baby, given her diagnosis of bipolar disorder and the medication she was taking. This involved seeking support from the PMH team, and weighing up several options, including adoption.

The women described their first pregnancies as a period of optimism overall. They looked forward to welcoming their new baby into the world and starting a family. For example, Rhian felt "ecstatic" and was "dead excited" during pregnancy, whilst Lowri thought it was "amazing" how quickly she became pregnant.

Some women were not aware of PMH difficulties at this time. Those who were, felt, or hoped, that this was unlikely to affect them: "I guess even if you hear about these things before you just kind of don't take any notice, 'cause you're like, well that's not gonna happen to me (laughs)." (Louise)

Bethan and Rhian have more than one child and their experience of PMH difficulties with their first child negatively impacted on their subsequent pregnancies, creating high levels of fear and anxiety:

"I remember speaking to [clinician] and crying about it. I was like, I don't wanna have this baby and feel the same way I did when I had [first baby], where I look at her and I don't wanna hold her, I don't wanna touch her and I don't feel anything for her. I don't want them thoughts. I wanna love her, I wanna hold her." (Rhian)

Chapter Two. Unexpected Events: Vulnerability, fear and confusion.

Each mother suffered physical complications during pregnancy or childbirth which were stressful and sometimes traumatic. Additionally, most women were separated from their partners due to hospital visiting hours, and Bethan, Lowri and Louise were separated from their babies due to medical reasons. This went against expectations: "With the bonding and things, and chest to chest, you know what you see on TV, what you think is gonna happen didn't happen with us at all." (Lowri)

Shortly after birth, the mothers started to become aware of unusual changes to their thoughts and feelings: "It's like you have your mind but you're stuck behind a glass wall, and you know you're okay on that side, but you can't get back to you." (Bethan). These changes were experienced as frightening, confusing and shameful. Lowri was prepared for these changes by the PMH team, however the other mothers struggled to make sense them and believed they were unique to them:

> "I even went to the section in the baby bump book where it talks about mental health during pregnancy and it obviously had about blues and postnatal depression, and it had bits, like one sentence, about postpartum psychosis, but I thought someone had written that after I'd been ill or something (laughs). It was all kind of feeding my delusions about it all being made up." (Louise)

The general postnatal ward was experienced as overwhelming with limited support available, and being provided with an individual room helped Lowri, Louise and Rhian feel cared for:

> "When I was ill in the hospital I just felt like they didn't even notice. It was weird being integrated with everyone else that's having normal births, because at times I did feel like I was a crazy person on the ward." (Bethan)

Help-seeking behaviours during this time varied, oscillating between crying out for help, minimising or hiding their internal experiences. Coping was influenced by unhelpful cultural narratives:

> "I felt fine, but I don't think I was. I think I was just saying I'm alright 'cause it's easier to say I'm alright than saying how things are. I was just worrying what would happen really, because I thought they would take [baby] off me or something (laughs). You just think the worst." (Lowri)

The mothers felt these unexpected experiences triggered or exacerbated their mental health difficulties. They found themselves in a vulnerable and fragile state, in desperate need of being cared for whilst trying to care for a baby. Their threat systems were heightened, and they felt unsafe: "It felt like fight or flight, like there was a bear that was gonna get me or my baby, that's how it was." (Hannah)

Chapter Three. Making difficult decisions: Sacrifices and suffering.

The mothers were faced with a difficult decision once professional help was offered. Each woman had a clinical need for a MBU admission, however the lack of service in Wales meant that various alternatives were suggested: MBU in England and separated from family, general psychiatric unit and separated from baby, or managed in the community at high risk and remain at home. The women felt neglected and let down:

> "I was really confused about how there wasn't any (MBUs) around. I was so shocked. It was like wow! You know, mental health is generally increasing and rising, and the closest I can go after having my baby is 2 ½ hours away?!" (Hannah)

The women were faced with a challenging dilemma due to competing priorities. Remaining close to family was a significant factor in the decision-making process as they were a vital form of support. There was also a perceived need to maintain, or establish, the expected roles and responsibilities of a mother, despite struggling:

"I can remember just thinking oh my god, I can't go there! It impacts on everything

… It's too far away from home. What about my children? What about my family? I'm

gonna be taken away and I'm not gonna come back. That can't happen to me!"

(Bethan)

For Lowri and Rhian, this stage of their narrative was relatively brief, as they quickly

agreed to a MBU admission. Their existing relationship with the community PMH team

meant they felt informed about MBUs and it was possible to stay somewhat connected to

family.

However, the opposite was true for Bethan, Lowri and Louise. They felt losing

connections with their family when going to a MBU would be detrimental for the whole

family, so they were supported by different community and psychiatric inpatient services

instead. Some aspects of this care were described positively, however it lacked the specialist

perinatal knowledge and intensive support that they needed: "I definitely felt, even though I

was poorly, that people were kind of scrabbling to work out what to do with me at the time."

(Louise)

Family and friends were skilled at providing practical support, however most of the

women sought little emotional support from them. They feared how friends and family might

respond or had previously received invalidating responses: "I remember my mum saying to

me 'Don't be so bloody stupid, there's nothing wrong with you. I've had 6 children.' and that

always stuck in mind." (Bethan)

The mothers and wider families made significant sacrifices, including travelling long

distances or temporarily moving location. The women were dependent on others and either

shared, or handed over, caring responsibilities of their baby. Although this brought a sense of

relief, it was a painful experience that disrupted the mother-infant bond and left them feeling

inadequate:

"It was hard to sometimes pick up in the morning, 'cause it's like 'How much milk

has she had? How much sleep has she had?' And it shouldn't be me asking other

people about my own baby, it should be me knowing, because I should be doing it."

(Hannah)

Chapter Four. Walking the path to recovery: Support and healing.

It took varying durations for each woman to get to this stage, which was longest for Bethan

(almost 20 years) due to the lack of PMH service provision. Each mother identified different

aspects that facilitated recovery for her. For Bethan, this included support from the

community PMH team and members of the medical team in maternity care. For Lowri, this

was support from her AMH team, the MBU and electro convulsive therapy (ECT). For

Hannah, this included support from the community PMH team. For Louise, this was ECT.

Finally, for Rhian, this was a combination of support from the community PMH team, MBU,

AMH, home treatment team and her health visitor.

Each woman spoke positively of the specialist PMH support they eventually received.

They valued clinicians' expertise and most felt it saved their life: "Honestly, I highly doubt

I'd still be here if they (MBU) didn't get involved." (Rhian). Receiving a formal diagnosis or

thorough explanation of their experiences also helped women feel understood, reassured and

less confused.

The professionals who played a pivotal role in the narratives shared key

characteristics, including being non-judgemental, compassionate, sensitive, available,

consistent and honest. The women felt contained by them which reduced their perception of

threat and enabled them to effectively access support:

"I did see a light at the end of that tunnel, and that's only from the support that I've

had that I was able to do that. It wasn't just support from 9-5, it was 'if you need me

I'm here', and because I knew I had that, that helped me sleep better at night."

(Bethan)

Lowri and Rhian perceived the MBUs to be a "safe" place, however receiving care in a different country made the transition back home difficult. Lowri relapsed during this time and attributed this to the long geographical distance. Receiving care in England also created language barriers: "If I'm not well I don't speak English I speak Welsh ... So, speaking Welsh is really important really. And, you know, everybody from Wales having to travel to England is a bit of a nightmare." (Lowri)

Remaining in close proximity to baby, no matter the location or severity of mental health, was an important factor that enabled recovery. As was meeting other women who had experienced PMH difficulties, which broke down barriers of stigma and shame. This occurred relatively quickly for Lowri and Rhian due to their MBU admission, however the same wasn't true for others:

> "Even a year and a half down the line I hadn't met anyone that had been through it
>
> face to face … It was amazing just to meet someone, but it took me a long time to
>
> realise that lots of women from lots of different backgrounds go through it." (Louise)

Chapter Five. Living with the consequences: Grief, uncertainty and meaning

making.

Each story seemed tragic in many ways, filled with pain, suffering and regret. A large part of the pain was the grief they felt over the loss of early bonding experiences with their baby: "It would've been good if we could have had that room from the start. Me and my husband together, rather than being separated. We were all separated wasn't we? We were all in different places." (Lowri). This was relevant for all the women, despite the service they received, as they believed their mental health difficulties caused delays in bonding.

Despite this, the women noticed new connections that had been established between

themselves, their babies and family members. Receiving professional help enabled them to build trust with others and talk more openly about their mental health. They were now keen to challenge unhelpful cultural narratives by sharing their story. Hannah explained how she would "do absolutely anything" to make other mothers' journeys "more bearable" than hers.

For Bethan, Hannah and Louise, they felt largely let down and neglected by services, and believed the lack of adequate service provision prolonged their pain and suffering unnecessarily, in contrast to Lowri and Rhian who received timely access to PMH services. Bethan and Hannah were unhappy with the care they received on the maternity ward, which was an important aspect of their story, and believed this exacerbated their difficulties.

All the women had recommendations about how PMH service provision could be improved in Wales. They hoped there would be a local MBU in the future, and Lowri and Rhian felt "lucky" to have received such care. They all felt timely access to appropriate services, within a reasonable distance to their family, was important for both their mental health, the mother-infant bond and the wider family:

> "I would've maybe recovered more quickly but recovered in a nicer way if you like. So instead of suffering, on my own, at home, feeling so bad, and gradually just waiting for that to go, maybe I would've felt better in my recovery. Maybe it wouldn't have been so dreaded, every day and night wouldn't have been so dreaded, 'cause I would've had that support, I would've had that reassurance. I just felt so lonely. I just felt like I was the only one in the world that had ever been like that." (Hannah)

Additionally, Bethan felt maternity care should be more mindful of women's mental health difficulties. Hannah highlighted the importance of continuity of care and familiarity with professionals, so that women don't have to repeat their stories. She also would have valued psychology, nursing and psychiatry support from the community PMH team at the same time. Louise would have liked more information about MBUs to make an informed

decision and highlighted the importance of consistency amongst services and professionals, given how confused new mothers can feel. Rhian highly valued early planning from the PMH team during pregnancy and felt this was crucial in preventing deteriorations.

The narratives did not come to a firm conclusion. The mothers felt fearful of deteriorations in their mental health and closely monitored symptoms. They experienced anxiety wondering if their PMH difficulties might have negatively influenced their child's future development. They also questioned whether they would be able to cope, or be effectively supported, if they had more children: "You're literally battling yourself, you're battling your own head, your own thoughts, your own mind … I think that's the only thing that would stop me getting pregnant again, is the fact that I'm scared of my own head." (Rhian)

Discussion

The aim of this study was to explore mothers' experiences of mental healthcare in a rural area during the perinatal period, where there was a clinical need for inpatient care. A narrative approach was used which assumes that people find meaning from their experiences through creating and telling stories (Elliott, 2005). A "meta-narrative" (McMahon et al., 2012) was created from each mother's individual narrative that identified five chapters common to each of their stories. The chapters illustrate how the women made sense of their experiences and the influence of cultural discourses.

There were several barriers that prevented the women from initially disclosing their difficulties, which were influenced by unhelpful cultural narratives. This included expectations that motherhood should be positive and fears of social service involvement if it is not. This is consistent with other research demonstrating that some mothers wait until crisis point before seeking help due to fears that disclosure will lead to the loss of custody of their child (Megnin-Viggars et al., 2015). Additionally, many of the women in the study had

limited knowledge about PMH, particularly the less common difficulties, and the subsequent fear and shame they experienced made it difficult for them to open up to professionals. This might be explained by the geographical area in which they live, whereby mothers may not often come across others experiencing PMH difficulties (Hanley & Long, 2006). It may also reflect the literature and public awareness of PMH which has historically largely focussed on postnatal depression, rather other difficulties that these women experienced (e.g. postpartum psychosis, birth trauma, anxiety).

The mothers took various pathways through services depending on service availability and what they believed fit best for them and their family at the time. They identified some aspects of physical and mental healthcare that was helpful, however it tended to be the specialist PMH support that created positive changes in their wellbeing, reflected by shifts in their narratives. Despite the service, professionals who were valued were those who adopted a non-judgemental compassionate approach within their interactions. This enabled the women to feel safe sharing and exploring some of their vulnerabilities. This is in line with other studies which have highlighted the importance of the therapeutic relationship in supporting women's engagement in PMH services (Coates et al., 2014; Megnin-Viggars, et al., 2015; Watson et al., 2019). Alongside this approach, the women also appreciated receiving support by professionals who had specialist PMH knowledge and were able to provide diagnoses and evidence-based interventions. This echoes other research findings where counselling-based support provided by professionals with specific perinatal skills and knowledge was valued by women requiring PMH care (Myors et al., 2014).

All the women believed support from a MBU within reasonable distance to home would have been ideal following the birth of their children, consistent with the recommended service models (NICE, 2014; RCP, 2015). The women who went to a MBU valued the care and attention provided towards themselves and their baby which facilitated recovery. These

findings are reflected in other studies demonstrating mother's high satisfaction levels with MBUs (Antonysamy et al., 2009; Nair et al., 2010; Neil et al., 2006) and positive outcomes for mother and infant (Connellan et al., 2017; Gillham & Wittkowski, 2015; Stephenson et al., 2018). Those who didn't go to a MBU thought an admission would have alleviated their mental health difficulties sooner and helped them to bond with their baby. The mothers separated from their babies could understand why this happened but found it distressing nevertheless, whereas those who received support alongside their baby found it a comfort knowing their babies were in the safe hands of another. Other studies highlight women's preferences for MBUs in comparison to general psychiatric units due to the distress that can arise when separating from baby (Antonysamy et al. 2009; Neil et al., 2006; Wright et al., 2018).

Receiving care from a MBU in a different country to home created further obstacles in accessing and receiving appropriate support for the women. There was a language barrier for one mother who primarily speaks in Welsh, rather than English, when her mental health deteriorates. This is concerning and research has highlighted the importance of culturally competent staff within PMH services to meet the needs of mothers from diverse backgrounds (Watson et al., 2019). Additionally, the transition home from a MBU can be a struggle for many women (Connerty et al., 2016), however the geographical distance and change in service provision across two countries added an additional layer of difficulties for the women in this study. The long geographical distance meant that the women spent a large part of their time travelling and had a limited period of time at home. This also caused problems if the women wished to quickly return to the MBU as it physically wasn't possible. Similarly, the length of the journey provided them with extended periods of time to ruminate and worry about how home leave might go. The change in service provision across two different countries limited consistency and continuity of care which the women struggled with as there

was perceived to be limited communication between the community and inpatient perinatal teams. This goes against guidance which recommends that a good specialist PMH service should be organised on a "hub-and-spoke" basis where inpatient and community services are closely integrated to ensure continuity of care (RCP, 2015).

Within the perinatal literature, birth is commonly viewed as a social event (Cree, 2015) and an African proverb "it takes a village to raise a child" is often cited. Indeed, the women's family were important characters within the narratives and staying in close proximity to them was vital for recovery. Relationships with family members developed through the narratives, moving from one which largely involved practical support, to one which also incorporated effective emotional support. Findings were consistent with other research which suggests the quality of support from family members is crucial to women's psychological wellbeing during the perinatal period (Coates et al., 2014; Dennis & Chung-Lee, 2006; Raymond, 2009; Stanley et al., 2006). Similarly, having the opportunity to connect with other mothers experiencing PMH difficulties was an important part of recovery which helped to reduce feelings of loneliness, guilt and shame. This is a recurrent theme in other studies where both informal and formal peer support has been highly valued by mothers who are struggling (Hanley & Long, 2006; Raymond, 2009; Wittkowski et al., 2011). Social support therefore seemed to play a vital role in reducing the women's threat systems (Gilbert, 2005).

Clinical Implications

Generalisations should be made with caution given the small sample size, however the findings have important implications in areas where the "good" model of integrated specialist PMH community and MBU services (NICE, 2014; RCP, 2015) is not readily available. Indeed, the limited provision of MBUs is not specifically a rural concern as there are limited MBU services across the UK, specifically within Northern Ireland and Scotland where they

are currently no MBUs (Maternal Mental Health Alliance, 2019). The findings therefore have implications that extend beyond the North Wales rural community.

Firstly, given the high levels of guilt and shame that formed a barrier to help-seeking and disclosure, a non-judgemental compassionate approach may reduce women's sense of threat and enable them to access support. As the perinatal period brings a high level of professional contact, the likelihood of disclosure may be increased if those from both physical and mental health services adopt this approach. This may be especially important within maternity services.

Secondly, it is important that mothers are made aware of, or supported to make sense of, the various PMH difficulties that they may experience through a biopsychosocial lens. Including important family members in these discussions may improve their ability to provide effective emotional support which can help to alleviate some mothers' distress. Similarly, it is vital that mothers have access to peer support, however this can be problematic in a rural area. In light of recent service adaptations resulting from Covid-19, it is being demonstrated that video platforms can be an effective way of connecting people when there are barriers to doing so physically, which might be on possibility.

Thirdly, mother and baby should be cared for together, where appropriate, and access to specialist PMH services is crucial. For women who are removed from their "village" and admitted to a MBU in another area, it will be important to sensitively consider possible cultural and language barriers. This might include having translators connected to the MBU who are familiar with the service.

Finally, the transition from a MBU to a community team is a significant event that requires careful consideration through discharge planning. Effective collaboration between services will be crucial to support continuity of care.

Study Limitations and Recommendations for Future Research

One limitation of this study is that it may represent a select group of mothers. Each woman had sought help for her mental health during the perinatal period and had received support from specialist PMH clinicians or services. They had also made attempts to make sense of their experiences and were willing to share their stories through research. Mothers who have not received help for their PMH difficulties, or made sense of their experiences, may therefore have different narratives to the ones presented in this study. Recruitment through alternative routes (e.g. maternity services, children's centres) may be beneficial for future research. Another limitation of this study is that Bethan's first clinical need for a MBU admission lay outside the participant inclusion criteria (more than five years ago) and was a large part of her narrative in that it had associations with her most recent need for admission which lay within the participant inclusion criteria. Given the perinatal mental health service developments since Bethan's first clinical need for a MBU admission, it may be that part of her experience is not currently typical of mothers who have required a MBU admission in North Wales in the past five years. Another limitation of this study is that transcription was carried out by one author, and the validity and accuracy of the verbatim transcripts of the mothers' audio-recorded verbal accounts was not assessed. This may have implications for the accuracy of the findings. A further limitation is the focus on the narratives of mothers only. It is acknowledged that PMH can affect the whole family and gaining these additional perspectives would be an important consideration for future research (e.g. fathers). Finally, as narrative analysis involves a broad, rather than in depth, focus of interest, details around specific experiences were not explored. Future research may wish to investigate topics of importance further (e.g. care that was perceived to be helpful) to inform clinical practice.

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Chapter Three:

Contributions to Theory and Clinical Practice

Contributions to Theory and Clinical Practice

Implications for Clinical Practice, Future Research and Theory Development

Service Provision

An important question that arises from both papers is around which services are most appropriate to support the mental health needs of parents and children. Ideally, all parents and young children should have access to specialist perinatal mental health (PMH) and infant mental health (IMH) services, including mother and baby units (MBUs), however provision across the country is currently based on a postcode lottery. This is particularly important to consider within North Wales, where PMH and IMH services are either limited or non-existent in some localities.

There are demands for governments to prioritise parent's and children's wellbeing (e.g. the Maternal Mental Health Alliance's 'Everyone's Business' campaign and the 'First 1001 Critical Days' movement). This is supported by a compelling economic argument that demonstrates how early intervention achieves the greatest health, social and economic benefits compared to interventions later in life (Heckman, 2012). Despite this, the current UK government appears to have prioritised aspects like retail and football over children's educational needs during a global pandemic. It may therefore be idealistic to think that we are anywhere near gold standard mental health service provision for parents and children and more realistic to firstly consider how existing services can be developed.

During the perinatal period, parents have frequent appointments with various professional groups (e.g. midwives, health visitors, GPs), which is commonly viewed as a "window of opportunity" for preventative action (Helfer, 1987). Providing training to these professionals in PMH and IMH to increase awareness, knowledge and skill set is likely to be beneficial. This will support early identification of parents in need of support and may prevent poor outcomes for the parents, children and society across the generations. Training

may also be helpful for existing generic mental health services (e.g. adult mental health [AMH] and child and adolescent mental health services [CAMHS]) who do not necessarily specialise in perinatal or infant mental health, but who may still come across this client group, nevertheless. Additionally, existing mental health teams (e.g. PMH, AMH, IMH, CAMHS) should receive training to develop their skills in delivering specialist interventions that meet the unique needs of parents within their services (e.g. those with a history of childhood trauma or particular mental health diagnoses).

Looking to the future, it is vital that colleagues across the country in existing PMH and IMH services are consulted with to effectively plan or develop services. Those that are well established should be prioritised where possible. For example, Manchester is known as one of the leading cities in the UK for perinatal and infant mental health services, including the "Children and Parents Service", which is considered a model of best practice for early years social and emotional wellbeing by NICE (2014). Ideally, access to services would be based on the parent and child's relational needs, rather than typical diagnostic criteria which are not developmentally sensitive.

Services could also support the identification of "hidden need" through regular audits that are disseminated to higher management and service leads. This might include documenting numbers of 1) clients in AMH who are parents, 2) parents of children open to CAMHS with a mental health diagnosis or history of childhood trauma, 3) women open to AMH and community PMH teams who have a clinical need for a MBU but are not admitted and the reasons why, and 4) young children referred to CAMHS who do not meet the lower age threshold.

Taking a Whole Family Approach

Donald Winnicott's famous quote "there is no such thing as a baby" highlights the importance of the wider environment within which a child develops. The empirical study

highlighted the important role that family play in supporting parent's mental wellbeing and providing care to children. Both the scoping review and empirical study primarily focus on the needs of mothers, however the profound impact of maternal mental health on children and the wider family requires further consideration. Specifically, fathers are largely neglected from both papers but are of vital importance to consider. This reflects a wider theme within the literature that is likely driven by historical cultural narratives around the roles and responsibilities of mothers and fathers. For example, traditionally, within Western societies, men have taken a minor role in childcare and PMH has generally been perceived to affect women only. However, the transition to fatherhood can be experienced as particularly challenging.

It is estimated that around 1 in 8 fathers experience mental health difficulties during the perinatal period (Da Costa et al., 2017). As with maternal PMH difficulties, presentations can vary, however the most common difficulties include depression and anxiety (Singley & Edwards, 2015). Many studies have also found close associations between maternal and paternal perinatal depression (Paulson & Bazemore, 2010). These experiences can lead to reduced engagement with children (Paulson et al., 2006) which is likely to disrupt their attachment bond. Additionally, fathers feel they are perceived as less important than women during the perinatal and unsupported by services (Daniels et al.,, 2020).

Services and professional groups that parents access during the perinatal period require a shift in focus from maternal to parental wellbeing, to identify and meet the needs of fathers too. Universal services should provide information about paternal PMH and screen for difficulties during routine practice. This early identification of fathers will enable timely access to appropriate support. Additionally, mental health services should be trained to effectively detect, assess and treat common paternal PMH difficulties.

Research into paternal PMH is in its infancy, therefore future research could support clinical practice by further exploring this area. This might include gaining accurate prevalence rates and understanding the aetiology of paternal PMH difficulties (e.g. associations with traditional gender roles and coping styles). The mechanisms through which maternal and paternal PMH difficulties are linked could be explored further to identify risks and targets for treatment. Additionally, further research to explore how perinatal services might develop to help men feel more involved and included is of importance.

It is acknowledged that we live in a modern society where the British nuclear family structure may not be relevant for all. Therefore, in addition to fathers, future research and clinical practice should take into consideration other family structures (e.g. same sex parents) or other important family members (e.g. grandparents) to inform theory and effectively meet the needs of diverse families.

Black, Asian and Minority Ethnic families

The empirical paper highlights how mothers being removed from their "village" to be a minority in another country can present barriers to receiving appropriate care. Findings from both papers largely reflect a sample of white mothers experiencing mental health difficulties. It is likely that mothers and families from ethnic minorities have unique needs which have not been captured and require further attention.

It is widely established that BAME groups are more likely to have poorer outcomes across physical and mental health when compared to white people in the UK, and the picture appears no different in perinatal health. BAME women have a heightened risk of death during the perinatal period (MBRRACE-UK, 2018). More specifically, black women are five times more likely to die during pregnancy and childbirth compared to white women, and Asian women twice as likely. Similarly, BAME babies have higher mortality rates than white babies (MBRRACE-UK, 2019).

There is very limited literature around the mental health of BAME parents and children, however it is likely that they are particularly vulnerable to developing mental health difficulties. For BAME women who require PMH services, research demonstrates that they can often have poor experiences of services within the UK (Watson et al., 2019). Women in this systematic review perceived services to be culturally insensitive and experienced prejudice and discrimination based on their ethnicity. The authors conclude that women face a "double stigma" (p.12) based on their ethnicity and mental health difficulties which acts a significant barrier to accessing and receiving appropriate care.

Addressing the wider determinants of ethnic inequalities in mental healthcare requires action at a national level from parliament and a local level within services. All family services should be culturally competent in order to effectively meet the needs of BAME groups using a person-centred approach. This might include being educated about the unique cultural needs and practices of the communities they serve (e.g. perceptions of mental health, child-rearing practices, family expectations, roles and responsibilities). Assessments, interventions and information provided should be culturally appropriate and families should have access to an interpreter or advocate if needed. Additionally, clinicians should be supported to reflect on their own world view to identify unconscious biases that might be maintaining ethnic inequalities, perhaps through supervision or reflective practice groups. This will help to break down and reduce barriers whilst enabling appropriate and timely support for families.

Future research is crucial to support the development of theory and clinical practice due to the dearth of literature in this area. The prevalence of perinatal and infant mental health difficulties amongst BAME families is largely unknown, and Western models of aetiology and presentations may not apply to these groups. Likewise, it remains unknown whether evidence-based interventions which are largely based on Western white populations

are equally effective for BAME parents and children. Future research may wish to explore these areas as a starting point.

Compassionate Approaches

An important take home message from both papers is that parents experiencing mental health difficulties can have an extremely difficult time and should be treated with compassion. Parenting is incredibly challenging, and most, if not all, parents will question their ability to be a competent parent. This will bring with it experiences of guilt, shame and self-criticism. Findings from both papers highlight that parents experiencing mental health difficulties are likely to experience an additional layer of threat which can impact on the parent-child relationship, act as a barrier to help-seeking and ultimately maintain difficulties. It therefore makes logical sense that an approach designed to reduce feelings of threat, shame and guilt, whilst increasing compassion and soothing might be effective for parents experiencing mental health difficulties.

Compassion focused therapy (Gilbert, 2009) was developed for people with high levels of shame and self-criticism who struggle to experience warmth and soothing. There is a growing evidence base for this approach, however the literature is in its infancy in relation to PMH. Michelle Cree's *"Postnatal depression: using compassion focused therapy to enhance mood, confidence and bonding"* book (2015) is part of the national Reading Well scheme in England and there are several other self-help books describing compassion-based approaches for parents. Additionally, research has demonstrated that compassionate mind training leads to greater reductions in depression and anxiety compared to CBT for women in the perinatal period (Kelman et al., 2018). Anecdotally, based on clinical experience, compassion-based approaches work well for this client group, by supporting engagement and enabling parents to access their creative thinking brain.

Considered together, it may therefore be of benefit for professionals to treat families with compassion, particularly parents experiencing mental health difficulties. This could include the important qualities of compassion within interactions, such as sympathy, empathy, non-judgement, distress tolerant, care for wellbeing and distress sensitive (Lee & James, 2012). Or, it might include a more intensive intervention using CFT. This does not have to be a stand-alone treatment and could be delivered alongside other evidence-based interventions. A compassionate based approach may reduce parent's shame and blame and create opportunities for learning and growth which will likely benefit the whole family.

Future research might wish to explore the effectiveness of compassion focused approaches with parents in a systematic way using clinical samples. Parents experiencing mental health difficulties, particularly those experiencing high levels of threat (e.g. trauma histories), would be useful to target. It would be important to compare compassion focused approaches with other evidence-based interventions to assess effectiveness, alongside monitoring change over time for both parents and children, or other key family members.

Reflections on the Research Process

From the very beginning of training, I had a relatively clear sense about the area I wanted to research for my empirical study. I had spent most of my professional life thus far working in a mental health hospital on a low secure unit for female adolescents "with emerging emotionally unstable personality disorder". Of course, what this label really meant, was that they had experienced significant breakdowns in their attachment with caregivers, ranging from childhood abuse and neglect, to intrusive and/or emotionally absent parenting. Life was so incredibly difficult for these girls and I often found myself wondering "What was going on for their caregivers? … Would things have been different if services had supported them earlier? … What kind of parents might these girls be when they are older?".

From these experiences, I developed a curiosity around PMH and MBUs. My mum has raised me to know the important role of women in society, so this fit nicely with my feminist values. When I started training, I learned about the lack of service provision in Wales and felt excited about the opportunities for research. I met with Dr Dwynwen Myers (Consultant Clinical Psychologist and Systemic Psychotherapist, North Wales Community Perinatal Mental Health Service) during my first year and we identified a topic during that meeting. Dwyn was mindful that my interests may change once I get a taste of other services and client groups so encouraged me to sleep on it for a while. A comment by my mum popped into my mind "Neesha's always clearly known what she wants and doesn't want since being little. There was no changing her mind." So, I agreed with Dwyn, appreciating that it was a wise idea, whilst also knowing that my opinion was unlikely to change.

Second year came and, unsurprisingly, I still wanted to research the same topic. Dwyn was delighted and so was I. We spent that year fine-tuning our ideas and putting together a proposal. I felt a qualitative project fit best for the research area and had experience in Interpretative Phenomenological Analysis but considered Narrative Analysis to be most suitable. I also felt this approach was in line with what I do in my day job, which felt more natural and comfortable than statistics. The research team approved our proposal after a few tweaks and it was time to start the dreaded ethics process. We submitted in July 2019, and I thought we would be able to get going with it soon. Little did I know…

It was January 2020 and we still hadn't received full approval. There were significant delays with the process and we regularly had to "chase" people. The June deadline was creeping closer and I was starting to feel anxious, frustrated and fed up with the situation which was out of my control. I started to feel physically unwell and thought it was probably stress-related as I knew I was trying to spin too many plates – placement, research, boyfriend, family, friends, me. Whilst spending around 4 hours travelling in my car each day for

placement. I quickly became very ill with symptoms suspiciously similar to coronavirus which wiped me out for almost two months. Bessel van der Kolk's book was flashing in my head, my body was "keeping the score". I remember a nagging voice in my head criticising me for taking sick leave, so I quickly returned to work which probably prolonged my illness.

By the end of February, I was starting to feel my usual self. My strength was back and I was motivated to face my thesis again. I chased up approval, along with support from the research team, and we were finally given the go ahead in March 2020. This was a whole 8 months after the original submission, in which I pretty much could have grown a baby and become a parent myself. The clinicians from the community PMH service already had a few ladies in mind and passed me their details. We were aiming for around six participants and managed to book all six in relatively quickly, which was a huge relief. Time was now very tight, but I was confident we could do this and was looking forward to our plans finally becoming reality.

Then a global pandemic hit. Thankfully, I had managed to complete three face-to-face interviews before the world went into lockdown. I offered telephone or video interviews to the remaining three ladies, however they all cancelled, which was completely understandable. I was so disappointed as it felt really important for me to share as many stories as possible and have women's voices heard. In addition to these feelings, catastrophic thoughts starting whizzing around in my head – "What does this mean for my research study? My thesis? My qualification? My new job?". I had discussions with course members around whether I could pass my thesis with three participants, but nobody could give me a definitive answer. I didn't want to risk it and somehow we eventually managed to find another two ladies who wished to take part. By this time it was April. One month left until hand in. The pressure was certainly on.

I looked forward to analysis and was excited to find the common narrative. But the analysis brought up many different thoughts and feelings that I didn't anticipate. I was deeply moved by the ladies' stories and felt angry and upset at the lack of adequate service provision for them, at a time when they were so desperately vulnerable. The feminist in me wondered if this would be the case if it had been a male issue. Hearing their stories and reading the literature brought up anxieties for my future. I started to mentally plan what my childbirth would look like and who I would lean on for support, to try and reduce the likelihood of my mental health deteriorating. If I was ever lucky enough to have children that is. I felt guilty for not supporting my sister more when she recently gave birth and worried that she might be another mum who is silently struggling. I worried about my niece's future. I wondered about the other females in my family across the different generations and appreciated everything they must have gone through to raise their children during times where maternal wellbeing was not really considered at all.

I feel guilty saying that I feel ambivalent about the lock down, but I do. It is such a tragic and frightening time, filled with pain and loss, but on the other hand, I have had more time to focus on me and completing my qualification. Initially, I focused on the positives, which, on reflection, was probably a way of avoiding the negatives. I reconnected with mindfulness and Buddhism, did my daily exercise, cooked new exciting recipes and generally tried to give myself a much-needed dose of self-compassion to buffer the stress. I felt I couldn't complain, my family and friends were all safe and well, and I still had a job. After a short period of time, my Fitbit told me my average resting heart rate had dropped by 12 points from "poor" to "above average". Self-care was working and my compassionate system was growing. Although I did wonder "How do you know the difference between being good at coping with adversity versus being good at avoiding pain?".

As time passed, the negatives started creeping in. I hadn't seen my boyfriend for a long time, as we live separately, and I realised how much I missed him. I started to recognise that I was feeling alone which brought up memories of separation and loss. Stories were being reported in the news about ethnic inequalities in relation to coronavirus, the death of George Floyd and the subsequent Black Lives Matter movement. Being of mixed ethnicity myself, white and black African, this hit home and made me acknowledge vulnerabilities that I didn't want to think about. I could feel my threat system growing and my compassionate system shrinking. My Fitbit confirmed this, telling me my resting heart rate was back in the "poor" category. Unsurprisingly, I struggled to think clearly or creatively, which made the final stages of thesis writing a huge challenge. A quote from a book I had been reading resonated with me: "Those who work in a playful, relaxed manner tend to work efficiently and creatively. Those who work nonstop, driven only by stress, work without joy." (Sunim, 2012, p.31).

On reflection, the research process has helped me to appreciate all the blood, sweat and tears that go into writing a paper. I really hope that my papers get published so that they might create even a tiny bit of difference for families in need of support. I would love to be able to do more research in the future, in the hope that it might create broader changes in clinical practice or service provision, however I do wonder how feasible it is to complete research alongside a full-time clinical based job. When thinking about my current and previous supervisors' workloads, I imagine research time might not be viewed as a priority in a job plan, especially when working in services that are overstretched. I have learnt more about my coping style and my need to continue building my soothing compassionate system. Although the process has felt stressful, I remain passionate about both papers and it is so rewarding to see them in their final format. I am incredibly grateful to the women who shared their stories with me, and it is an honour to be in a position where I can help to have their

voices heard. I have a poster of Emmeline Pankhurst up in my office and I am sure she would have something good to say about this.

"We have to free half of the human race, the women, so that they can help to free the other half." - Emmeline Pankhurst.
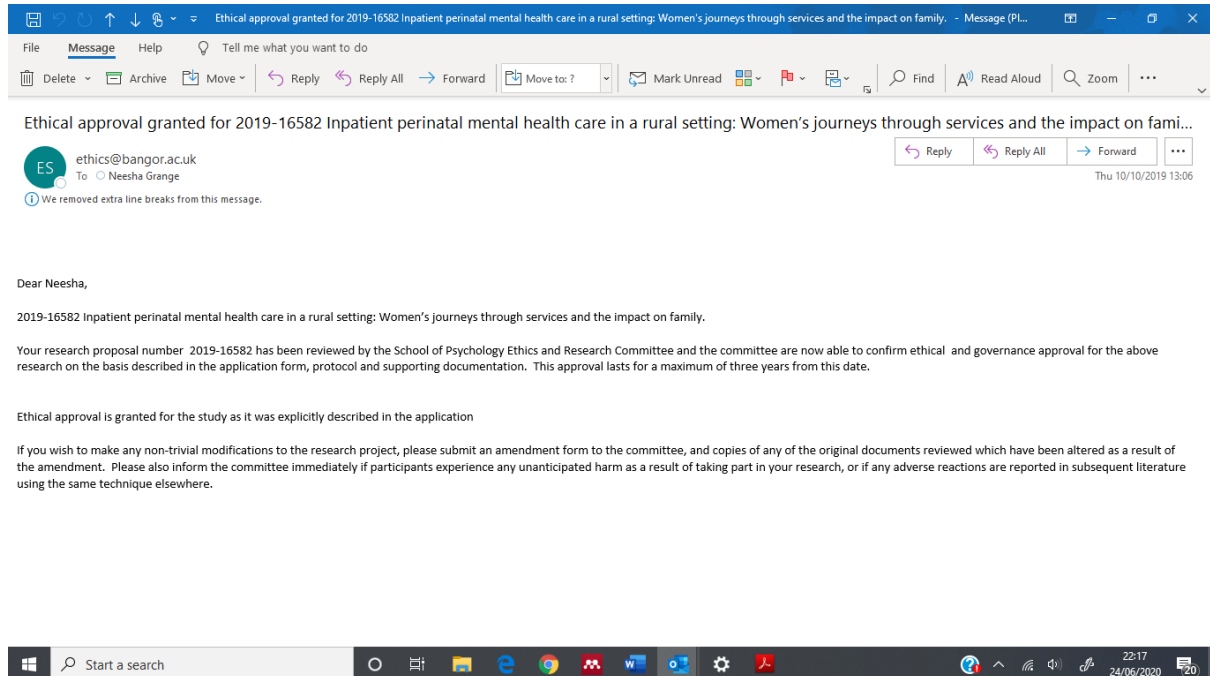
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Appendices

Appendix 1. Confirmation of ethical approval from the School of Psychology Ethics and Research Committee, Bangor University

Ethical approval granted for 2019-16582 Inpatient perinatal mental health care in a rural setting: Women's journeys through services and the impact on fami...

ethics@bangor.ac.uk
To   Neesha Grange

Thu 10/10/2019 13:06

We removed extra line breaks from this message.

Dear Neesha,

2019-16582 Inpatient perinatal mental health care in a rural setting: Women's journeys through services and the impact on family.

Your research proposal number 2019-16582 has been reviewed by the School of Psychology Ethics and Research Committee and the committee are now able to confirm ethical and governance approval for the above research on the basis described in the application form, protocol and supporting documentation. This approval lasts for a maximum of three years from this date.

Ethical approval is granted for the study as it was explicitly described in the application

If you wish to make any non-trivial modifications to the research project, please submit an amendment form to the committee, and copies of any of the original documents reviewed which have been altered as a result of the amendment. Please also inform the committee immediately if participants experience any unanticipated harm as a result of taking part in your research, or if any adverse reactions are reported in subsequent literature using the same technique elsewhere.

Appendix 2. Confirmation of HRA & HCRW approval

IRAS 266664. HRA & HCRW Approval issued

hra.approval@nhs.net <noreply@harp.org.uk>
To ○ dwynwen.myers@wales.nhs.uk; ○ Neesha Grange; ○ Mike Jackson; ○ dwynwen.myers@wales.nhs.uk
Cc ○ Huw Ellis

Reply | Reply All | Forward | ...
Wed 11/12/2019 11:03

(i) You forwarded this message on 19/02/2020 11:47.

266664 Letter of HRA Approval 11.12.19.pdf
214 KB

Dear Dr Myers

RE: IRAS 266664 Perinatal mental health care and family relationships. HRA & HCRW Approval issued

Please find attached your HRA and HCRW letter of Approval.

You may now commence your study at those participating NHS organisations in England and Wales that have confirmed their capacity and capability to undertake their role in your study (where applicable). Detail on what form this confirmation should take, including when it may be assumed, is provided in the HRA and HCRW Approval letter.

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-the-hra/governance/quality-assurance/.
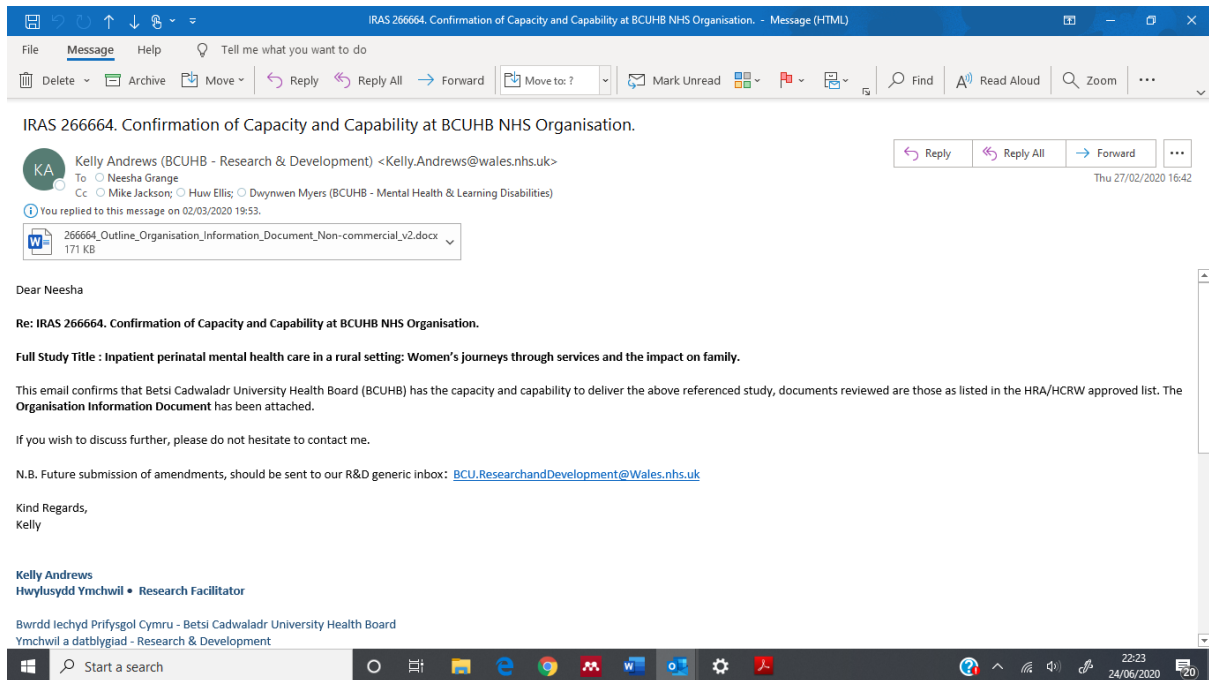
We welcome your feedback on the use of the UK Local Information Pack. If you would like to provide feedback, please take the UK Local Information Pack Survey.

If you have any queries please do not hesitate to contact me.

Kind regards

Appendix 3. Confirmation of capacity and capability at BCUHB NHS Organisation from the Research and Development department.

Word Count

	Excluding references, tables, appendices, etc	Inclusive
Summary	291	291
Scoping review	5511	7915
Empirical study	6709	8215
Contributions and reflections	3644	4055
Title page, declaration, acknowledgements, contents, word count	-	606
Total	16155	21082