Swansea University
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Understanding the lived experience of mother's coping mechanisms in the face of mental illness: An interpretative phenomenological analysis.

A thesis presented to the-

School of Health and Social Care,

Faculty of Medicine Health and Life Sciences, Swansea University.

In fulfillment of the requirements for the degree of PhD in Health Sciences.

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Declarations

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed- [redacted]

Date- 16/09/2022.

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references.A bibliography is appended.

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Date- 16/09/2022

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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The University's ethical procedures have been followed. Approval was granted for this study by the Research Ethics Committee, College of Human and Health Sciences, Swansea University on 25/08/2019, reference- 150719.

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Abstract

This thesis examines the phenomenon of coping in relation to the lived experience of being a mother with mental ill-health. Interpretative Phenomenological Analysis (IPA) was the chosen study approach, using semi-structured interviews to obtain in-depth accounts. Twelve women were recruited via social media sites and invited to take part if they had experience of mental ill-health and had a child aged 0-2 years old. Interviews were conducted in three phases: phase one- six initial interviews conducted pre Covid-19 initial lock down; phase two- six follow-up interviews to capture longitudinal elements of consistency and variability in the data; phase three- six initial interviews conducted post Covid-19 initial lock down. The interviews were transcribed and analysed through engagement with the interview transcripts, recurring patterns of meaning were grouped together and the results were presented thematically.

Through the study it was possible to give voice to women's lived experiences of coping with motherhood and mental ill-health: coping was found to be in many instances a very practical affair for the mothers and the mothers were able to identify what was effective support for them. Mother's emotional coping strategies predominantly featured self-talk with the mothers using rationalising self-encouragement to support their emotions. There was an emerging significance for the mothers in being able to have a sense of their own mental health, which was enabling to the process of taking back control. There is a bi-directional nature of coping within the maternal/infant dyad, which was recognised as a potential source of coping for women.

In terms of planning for health and social care practice, supporting coping skills by building on existing strengths is felt to be important. Recognising that individuals are unique and have potential for strength and competence can offer a self-compassionate stance that can take account of individual vulnerabilities and coping choices.

Table of Contents

List of figures, tables and explanatory boxes

Acknowledgements

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Chapter one: Introduction

"We humans are bundles of adaptations" (Plotkin, 1997, p.182).

This thesis presents an Interpretative Phenomenological Analysis (IPA) study into what women's lives can tell us about surviving adversity and the development of coping mechanisms, with particular reference to the experience of mental illness and being a mother. The study utilises a feminist lens, with a focus on reflexivity and power sharing in the research process (Leavy & Harris, 2019). The study broadly aimed to explore mother's lived experiences of survival, their knowledge of their own survival strategies and how they develop their coping mechanisms. The use of the singular possessive construct of 'mother's' and 'women's' in this thesis was a purposeful decision to emphasise the ideographic nature of the study about the individual lived experiences of women and mothers. The specific study intent was to examine the phenomenon of coping in women's narratives, as an occurrence that could be described by mothers who have experienced mental health difficulties. The purpose of the study was to better understand this experience to be able to inform practice and inform the theoretical basis for future practice interventions.

This study considers 'coping' as a phenomenon through conducting in-depth interviews with twelve women who had self-reported mental health difficulties and who were mothers. Six follow-up interviews were completed in order to identify temporal consistencies or developments in mother's experiences of coping. The study methodology was Interpretative Phenomenological Analysis (IPA), which was chosen as the approach because it was felt to be consistent with the epistemological position of the research question. The use of interviews as a data collection strategy was felt to be an appropriate fit within IPA methodology and with the professional

background and skill set of the researcher. The aim of the study was to explore the phenomenon of coping by in depth analysis of women's individual lived experiences of coping in relation to motherhood and mental health difficulties, thus creating understanding.

Thesis overview

This chapter explains the reasons behind the choice of subject area, introduces the study and places it in the context of its area of importance. The background of the study is briefly outlined with the study rationale. The research question, sub-questions, aims and objectives are introduced and concepts integral to the study are clarified. The research design and methodology are established and the delimitation (boundaries) of the study are introduced.

Chapter two presents the broad general background concepts of ideas around motherhood, maternal mental health difficulties, the development of coping as a theoretical entity and finally introduces concepts around resilience, coping and maternal/infant attachment. Chapter three presents the specific literature review question and integrative review into *What is the available literature on mother's coping mechanisms in the face of mental illness?*

Chapter four introduces the study design and methodology with the theoretical foundations of Interpretative Phenomenological Analysis (IPA), including phenomenology, hermeneutics and ideography, which underpin the study. The inclusion of a feminist lens is explained here as a celebration of contributions from women, about women, for women. The study methods specific to this study are described in chapter five, which details the practical considerations and the theoretical aspects of ethical and governance approval, sampling strategy, recruitment and the

development of the interview schedule. The theoretical frameworks supporting the stages of data analysis are described in chapter six, with the practical applications of these concepts within the research process. Chapter six also introduces the approach to reflexivity and research appraisal in the study.

Chapters seven, eight and nine contain the thematic presentation of results in each of the three phases of the study respectively, with each theme being written up presenting extracts from the participants narratives and interpretative analytic commentary. These chapters conclude with discussion, placing the thematic findings within the context of the existent literature. Chapter ten presents three overarching super-ordinate themes that were written across the study as a whole, inclusive of the three phases of the study together. Chapter eleven discusses and evaluates the study by: returning to the research questions; through the contextualisation of the study; reviewing the strengths and limitations of the study; and offering a reflexive view and recommendations for future research. The final chapter twelve relates the thesis conclusions and provides a brief a summary of the study findings.

Rationale for this thesis

There were many different factors that led to the decision to pursue this thesis. In terms of rationale and motivation, there was a learning journey that occurred through a health care practice career. While working within Specialist Community Public Health Nursing (SCPHN- health visiting) practice, with mothers who were experiencing mental health difficulties, I had observed mothers who demonstrated incredible levels of coping and adaptation in their endeavor to focus on the needs of their children. It was the stories of these women that created a desire to understand how their experiences could inform practice.

These experiences within practice led me to an academic journey, which was principally about a personal recognition that maternal/infant attachment and mental health were intricately linked. I pursued an academic learning path, which was focused on learning about the development of attachment theory through principal pioneers such as John Bowlby in his seminal work *Attachment and loss Volume 1: Attachment* (1971) and Patricia Crittenden who developed the Dynamic Maturational Model (DMM) in her *Raising Parents: Attachment, parenting and child safety* (2008) and the developments from neuroscientists such as Allan Schore who writes about the effects on brain development of attachment relationships in infancy (2003a; 2003b). Following this area of practice interest, I became involved with a Maternal Infant Mental Health Support (MIMHS) practitioner education programme.

I subsequently became involved in a mental health support programme called Emotional Coping Skills, which was based on Marsha Linehan's Dialectical Behavior Therapy (DBT), (Linehan, 2015). This programme which was offered to mothers who were suffering from mental health conditions, led me to thinking about coping as a concept, what did it mean, how do we know how to do it, or when to do it, do we know when we are doing it, is it an instinctual or a learnt behaviour?

When thinking about the mothers on my case load who were living with mental health difficulties, I was more often astounded by their ability to cope, to survive rather than the times when they were unable to cope and be strong and resilient. The stories that they told me of severe adversity from childhood into adulthood were deeply distressing and only made me wonder how they were still here, still trying, still coping with a myriad of daily stressors, still managing to get up, feed their children and get their children to school each day or most days. I had observed mothers demonstrating the use of effective coping in their daily lives and I was inspired to develop an

understanding of coping as a phenomenon within the context of mothering and mental health difficulties.

I conducted a brief preparatory pre-study literature review to establish viability for the research proposal (see appendix a.). This was an important initial step in initiating the research process. This initial review of the literature suggested that there was a prevalence of literature on the impact of parental mental health problems upon children (Agnafors, Svedin, Orland, Bladh, Comasco, & Sydsjo, 2017; McDonald, Kehler, & Tough, 2016; Savage-Mcglynn et al., 2015), but there was less available literature on resiliency factors within family relationships and the development of coping processes in mothers with mental health conditions.

There were however significant culturally based studies (Alex, 2016; Dolbin-Mcnab et al., 2016; Jana, Ghazinour & Ritchter, 2016), which addressed the phenomenon of coping and resiliency and gave insight into ways of researching the subject in question and the requirement for sensitivity to the subject group. Alex (2016) drew attention to the potential for power imbalance to exist between the interviewer and interviewee and suggested ways of facilitating conversations that are able to illuminate the subject area, including suggestions for the use of interviews. Davidsen, Harder, MacBeth, Lundy and Gumley (2015) who conducted a systematic review investigating the mother-infant interaction in mothers with schizophrenia and factors around the transmittance of risk or resilience, concluded that there was an absence of empirical evidence into the bio-psychosocial mechanisms of risk and that there was a pressing need to explore the sources of resiliency in this area, which would be able to inform therapeutic interventions and social policy.

A complex study by Sexton, Hamilton, McGinnis, Rosenblum and Muzik (2015), using validated questionnaires to assess the roles of resilience and childhood trauma

history on post-partum functioning, found that there was a need for additional research to enhance understanding of positive adaptation in the context of stress. The study suggested that resilience was a key predictor for wellness in mothers and that pregnancy and childbearing could represent a motivational window for some women (Sexton et al., 2015). Sexton et al. (2015) pointed out a need to identify protective factors that expand beyond illness and do not constrain the understanding of resilience to a lack of pathology: arguing that this could lead to the development of interventions that aim to bolster wellbeing in at risk post-partum women. From this early initial scoping review of the literature it was possible to start to refine a research question. It was also important to understand the methodological lessons from previously conducted research in order to identify the best way to approach the research question.

When reviewing existing knowledge, I had found that the predominant focus of the existing literature was on the impact of parents' mental health difficulties on their children; however there was a gap in the literature on the resilience of mothers with mental health problems and their ability to develop coping mechanisms. Within the context of coping, the experience and knowledge of mothers with mental health difficulties appeared largely undocumented, marginalised and unheard. It is important that researchers can enable these women's voices to be heard.

This thesis intended to explore the gap identified in the literature, into ways of coping related to motherhood and mental ill-health that are not constrained to lack of pathology and that are able to inform practice (Sexton et al., 2015). The study presented in this thesis aims to inform practice about the coping skills of mothers who suffer from mental health conditions, which will enable practitioners to build on the existing strengths of mothers when implementing interventions for these women

around coping skills. The understanding, experience and motivation of the researcher is acknowledged here as having an influence on the research process: this will be considered in chapters six and eleven where reflexivity is addressed through consideration of the researcher as immersed in a continual process of engaging with and articulating the place of the researcher within the context of the research.

Introduction to study context

It is estimated that 14% of children are living in households affected by mental illness (Public Health Wales, 2015). Health Education England (2016) estimate that 1 in 10 women are affected by mental health problems during pregnancy or after the birth of their baby; equating to 70,000 families in the UK. Maternal mental health difficulties can include; depression, anxiety disorders, panic attacks, obsessive-compulsive disorder, post-traumatic stress disorder and post-partum psychosis. For parents who have a severe and enduring mental illness including schizophrenia, personality disorders and bi-polar disease, it is estimated that 50-66% have one or more children under 18 years old living at home; this amounts to about 17,000 children in the UK (Mental Health Foundation, 2015).

Inter-generational impacts of chronic mental ill-health are identified as Adverse Childhood Experiences (ACEs) (Public Health Wales, 2015). ACEs are described as experiences occurring during childhood that directly harm a child or affect the environment in which they live. Some conditions may affect the baby during pregnancy; stress hormones such as cortisol can pass through the placenta and affect fetal development. Chronic trauma and stress in early life is now known to alter how a child's brain develops altering the development of the nervous system and

making these children more vulnerable to poor outcomes in childhood. The inequalities and hardships affecting children have increased in the Covid-19 pandemic and lockdowns, with the impact on mental and physical health and wellbeing for some children being considered as an ACE (Holt & Murray, 2021; Singh, Shah, Mbeledogu, & Garstang, 2021).

However the ability to understand and value women's perspective and experience is important when working with families and potentially could enhance practitioners ability to empower women and support children within these families. The information gained in this research can potentially be used to develop interventions to better support mothers with mental health difficulties by building on their existing strengths: this would be preventative in focus and would aim to contribute to reducing the impact of poor mental health on child and family well-being. The inter-generational impact of mental illness on children is recognised and reducing this impact is one of the long-term goals of public health strategy (Public Health Wales, 2015).

The focus of this study is on women's experience of survival, through the examination of their knowledge of their own survival strategies and the development of their individual coping mechanisms in relation to the experience of mental health difficulties and being a mother. Rutter (2012) explains that the effects of experiencing adversity may be either to increase vulnerability through a sensitisation effect or decrease vulnerabilities, by a steeling effect. The research aims to draw on these women's experiences with the intent to give voice to their knowledge and experience.

The experience and knowledge of mothers who have understanding of mental health difficulties can be viewed as largely undocumented, marginalised and unheard: it is the aim of this research to "create understanding of the processes by which certain social relations produce identity and other effects" (Cerwonka,

2013, p. 65). Svenaeus (2010) explains the value of the stories we tell about ourselves and others, that make us better able to understand our lived experience. This will be relevant to practice as it aims to create understanding of women's perspectives and experience.

Prevention and early intervention would be facilitated by this research from the deepening of understanding and knowledge of mothers' coping mechanisms in the face of mental illness; this could enable practitioners to build on mothers existing strengths and develop understanding of where support needs to be focused. It was felt that it was important for the approach be value-neutral, not engaging in judgments about the 'right' or 'wrong' ways of coping, but simply accepting that it was perceived at the time or on reflection as a coping skill, mechanism or process. It is hoped also to be able to contribute to the management of chronic conditions, while some mental health disorders are treatable, many are episodic and women may live with these conditions for their whole lives.

Interventions that aim to improve coping and resilience, have the potential to support individuals to manage chronic mental health problems and enable them to live healthier lives. In relation to this study, this would specifically include being able to support and assist mothers to provide safer, more secure home environments for their families and children. Through the context of women's lives and lived experiences, this study aims to offer an interpretative approach to women's stories of surviving adversity and the development of coping mechanisms, with particular reference to motherhood and mental illness.

Examining concepts and terminology

The concepts of ‘resilience’, ‘coping’ and ‘maternal mental health difficulties’ are clarified here in relation to their use in this study as reference points of understanding. Resilience can be described as a concept that has evolved through the literature that is used across disciplines (Earvolino-Ramirez, 2007). The definition included in the Oxford Essential English Dictionary (2011) includes a person being “able to recover quickly from difficult circumstances” (p.496). Rutter (1999) describes resilience as the ability to overcome risk or substantial adversity. However he suggests that there is a need to pay attention to the suggestion that the psychopathological effects of risk experiences, are strongly moderated by how individuals cognitively and affectively process their experiences and how the resulting working model of relationships is integrated into their self-concept (Rutter, 1999). Jana et al., (2016) discuss resiliency in terms of resources that are available to the individual in the form of social, psychological, cultural and physical resources.

The concept of coping itself can be defined as “managing or dealing with something successfully” (Oxford Essential English Dictionary, 2011, p.133), but has developed within mental health care provision to involve a set of cognitive and affective responses to stress and adversity (Linehan, 2015). There are many ways of delineating coping for example, Gutierrez-Zotes et al. (2016) describe passive coping, cognitive and behavioural coping; whereas Jana et al. (2016) differentiate problem focused coping, emotional focused coping, adaptive coping such as avoidant coping and maladaptive coping such as substance misuse. It may be considered however that coping can include responses that would not necessarily be envisaged within the understanding of resilience.

Mental health difficulties during pregnancy may involve impairment of a mother’s ability

to prepare psychologically for her baby's arrival; following the birth mental health difficulties can affect the way a parent interacts and cares for their child (Health Education England, 2016). Impaired parent-infant relationships can lead to insecure attachment relationships between a care-giver and child, which can contribute to difficulties for children with social behaviour and cognitive competence; making it more difficult for them to access learning and education, and become resilient to life's challenges (Health Education England, 2016).

Major mental illnesses are characterised by changes in mood, thoughts and behaviours which can make it difficult to perform activities of daily living such as work, study and social interaction (American Psychiatric Association, 2017). Hill (2015) suggests that the common feature of severe mental illness is unwanted severe mood alterations that cause distress and difficulty controlling inner and outer states. The care-giver's emotional and psychological well-being affects their capacity to observe, reflect and respond sensitively to their baby's communications (Health Education England, 2016). If reflective function is affected, the care-givers' capacity to be aware of the infant, holding the baby in mind, thinking and reflecting on the infants physical and emotional development may also be impaired (Health Education England, 2016).

The research was envisioned to be conducted from a salutogenic perspective, focusing on the factors that support human health and well-being, rather than the factors that cause disease (Antonovsky, 1996). Concepts around salutogenesis have been evolving, Antonovsky (1996) presented the salutogenic theory that the way people view their life can have a positive influence on their health. Luxford (2016) finds that there needs to be a paradigm shift from the 'do no harm' requirement in medicine, to a creation of health requirement which focuses on factors that support health. Antonovsky (1996) argues that it is a mistake for researchers and health promoters to always focus on the negative risk factors for health and well-being and

that human beings have a salutogenic orientation which leads to a 'sense of coherence'.

This sense of coherence incorporates the wish to be motivated, the belief that the person can understand and comprehend challenges and the belief that the resources to cope are available to the person in terms of manageability (Antonovsky, 1996). Eriksson & Lindstrom (2006; 2007) find that salutogenesis concepts are valuable when used as an approach in research and health promotion, and could be beneficial to practice if implemented. At the center of the concept of salutogenesis and the sense of coherence is "the fundamental belief that individuals and families have dispositional qualities that serve to promote their health and well-being" (McCubbin, 1998, p.xiii).

Research aims and objectives

Crittenden (2008) proposes "all parents have strengths – if one knows how to tap them" (p.294). This encompasses the primary function of this research study, which entailed a paradigm shift from looking to support areas of weakness to looking to tap and work on enhancing existing strengths.

The aims of the study are encapsulated in the thesis title and the research question-

What can women's lives tell us about surviving adversity and developing coping mechanisms, with particular reference to mental illness and being a mother?

The sub-questions were developed around exploring how mothers with mental health conditions experience coping-

- What are the lived experiences of coping for mothers with mental health conditions?
- How are mother's experiences of coping affected by motherhood and mental illness?
- What ways of coping come out of past experiences of coping, where does strength come from?
- What supports coping for mothers with mental health conditions?
- What coping strategies do mothers with mental health conditions want to pass on to their children in terms of being strong and resilient?

A qualitative research approach was chosen because it attempts to describe life from the inside out and seeks to contribute to understanding of social realities, their processes, meanings and patterns (Flick, Von Kardorff, & Steinke, 2004). Knowledge is the primary goal within qualitative research and data is usually collected by asking questions, orally or in writing, standardised or non-standardised, or by observation, covert or overt (Von Rosenstiel, 2004). Additionally qualitative research can also have an advocacy role, where the participants' voices can be heard and are able to raise awareness of experiences previously marginalised or misunderstood (Larkin, Shaw, & Flowers, 2018).

It was determined to use Interpretative Phenomenological Analysis (IPA) to explore mother's accounts of their experiences of mothering with a mental health difficulties and the development of coping mechanisms. IPA is an established qualitative method used within health and social psychology, which provides a stance and a protocol for the analysis of experiential qualitative data (Flowers, McGregor Davies, Larkin, Church, & Marriott, 2011). It has a history of addressing sensitive and under-explored areas of research, for example in sexual health (Flowers et al., 2011). The participant led focus facilitates the emergence of original insights, which have the

potential to give light and understanding to important unexplored areas (Flowers et al., 2011). Theoretical narrative approaches can examine the dynamics of stress, emotion and coping from person-centered perspectives: giving accounts of appraisal and coping constructs to capture the essence of this field of research (Lazarus, 1999).

Within IPA data is typically collected by semi-structured interviews where the interview schedule is used responsively and flexibly, following the lead of the participant (Smith, Flowers, & Larkin, 2012). This was perceived as suitable for this study because it incorporates the needs of potentially vulnerable women in to the research design with the use of semi-structured interview guides, which are able to be utilised flexibly following the lead of the participant (Smith, Flowers, & Larkin, 2022). IPA is dedicated to detailed examination of experience and aims to be able to reveal something of the experience of the individual participants, therefore the studies have a small number of participants and only go on to examine similarities and differences between cases after an initial case has been examined in depth (Smith et al., 2012). The specific methodology and philosophical underpinnings of IPA are considered within chapter four.

These factors supported the formation of the following objectives for the study-

- To examine the literature on coping as a phenomenon
- To conduct an Interpretative Phenomenological Analysis (IPA) study to explore coping as a phenomenon in mothers with mental health conditions using in-depth interviews to obtain data
- To analyze the data using Interpretative Phenomenological Analysis
- To place the data within the context of the existent literature to create context and enable the formation of recommendations for practice

This chapter has introduced the study and outlined the background and rationale of the study. Several concepts including the concepts of ‘resilience’, ‘coping’ and ‘maternal mental health difficulties’ have been clarified here in relation to their use in this study as reference points of understanding. The research question has been introduced together with the research sub-questions, aims and objectives. The research design and methodology have been put forward and the delimitation (boundaries) of the study have been introduced. The next chapter continues with a more detailed examination of the broad general background concepts that support the study.

Chapter two- Background

"Yesterday's children, todays mothers and fathers" (Crittenden, 2008, p.3).

This chapter examines the broad context of the study in terms of motherhood and maternal mental health difficulties, exploring the feminist perspective and how it contributes to the understanding of motherhood. It goes on to examine: the historical development of the theoretical understanding of 'coping' itself; the ongoing position of motherhood and mental health difficulties; and the relationship of resilience with coping and infant attachment. A specific integrative review of the available literature on *mother's coping mechanisms in the face of mental illness* is included in chapter three.

A broad background review of the literature was undertaken to examine concepts around motherhood, mental ill-health and coping as phenomenon. Coping was examined in the existent literature as a concept within its classifications and through its theoretical understandings. This was undertaken in order to identify, assess and interpret the body of knowledge on the phenomenon of coping so that the researcher would be able to identify coping within the participants' stories, and to place the study within the broad existent theoretical literature.

This was facilitated through initially using broad search terms for example 'motherhood', 'maternal mental illness', 'post-natal depression', 'resilience', 'attachment' and 'coping'. It involved reading as widely as possible and following concepts through, for example, to explore specific coping strategies and understandings, including adaptive and maladaptive coping responses.

This background review of the literature is written using a narrative style; there is an inclusion of opinion as well as theoretical and conceptual ideas at this stage so as to gain a comprehensive understanding of the subject, which is inclusive of diverse opinions including insider perspectives from women themselves.

The theoretical concepts surrounding coping, resilience, and maternal infant attachment are used to provide the context and theoretical framework in which this research study can be situated. The purpose of this context setting is to provide evidence of the researchers understanding checking and facilitate transparency of the orientation of the study (Crawford, 2020).

Becoming a Mother

The transition to motherhood involves a psychological and emotional journey that has to be navigated by each individual woman, as she becomes a mother. Maushart (1999) points out that becoming a mother is filled with extremes of emotion; pregnancy can blur the boundaries of selfhood and women may perceive a loss of individuality as they accommodate the needs of a newborn child. The psychological pregnancy is an important part of the preparation for the arrival of a new human, but women may struggle to talk openly about their feelings due to concerns that they will be seen as a 'bad mother' (Maushart, 1999).

Physical isolation is recognised as a problem for some mothers, but Stadlen (2004) argues that the real problem is "not being understood" (p. 12). Mothers may not identify when they are successful and doing a good job because our language lacks the ability to express what 'mothering' is within our cultural norms (Stadlen, 2004). A mother who has given up her morning shower and her lunch for her baby, when

asked what she has done today will probably say ‘nothing’; in reality she has in fact been devoting her time and energy to mothering her baby (Stadlen, 2004). How mothers comfort their infants is an extremely complex skill that involves high levels of emotional competence, but maybe considered to be taken for granted in today’s society (Stadlen, 2004).

Motherhood holds the potential opportunity for high levels of personal growth and development, how we parent our children may be the most important decision we ever make (Maushart, 1999). However many mothers may feel that they just muddle through, juggling work, home and motherhood; a common complaint in our modern age is that women are expected to work as if they have no family commitments and parent as if they have no work commitments. Education, employment and equality mean that women technically can have it all, but Maushart (1999) questions, what is the cost to women? Maushart (1999) argues that there is a ‘mask’ over motherhood that minimises the enormity of women’s work; women can lose a sense of self in caring for the needs of others and this is positively accepted historically, socially and psychologically.

The caring role that many women naturally fall into is often accepted subliminally; Simone de Beauvoir (1949, 1997) calls it fulfilling a woman’s “psychological destiny” (p.542). She goes on to describe the transition for women in pregnancy-

> *But pregnancy is above all a drama that is acted out within the woman herself. She feels it as at once an enrichment and as an injury; the foetus is a part of her body, and it is a parasite that feeds on it, she possesses it, and she is possessed by it; it represents the future and carrying it, she feels herself vast as the world; but this very opulence annihilates her, she feels that she herself is no longer anything* (de Beauvoir, 1949,1997, p.554).

Many women experience these poles of emotion during pregnancy and childbirth, however some of the emotional experiences are dependent upon external factors such as the quality of the birth and social support and relationships. Another feminist writer, Germain Greer (1970, 2012) in *The Female Eunuch,* points out that "childbearing was never intended by biology as a compensation for neglecting all other forms of fulfillment and achievement" (p.109). She does however spend remarkably little time discussing the role of motherhood in women's lives, considering the enormity of the role for most women whether they choose to be mothers or not.

Betty Friedan in The Feminine Mystique (1963, 2010) emphasises that "occupation housewife…cannot provide adequate self-esteem, much less pave the way to a higher level of self-realisation" (p.254). The questions for modern mothers' satisfaction in the role of motherhood is possibly not understood at a level that would reflect the importance of the role and the transition to motherhood can be perceived as socially invisible. Some modern feminists question why if we live in an age of equality are women still left holding the baby: Asher (2012, p.3) comments that her "illusion of equality was completely shattered" when she had a child and despite determined efforts to share the parenting role more equally she became the foundation parent in all areas of child care. While the UK has advanced the political agenda on statutory maternity leave, the gap between maternity leave and paternity leave has widened (Asher, 2012). Whereas some women may find giving birth the most empowering experience of a lifetime, it is not so for many women (De Cruz, 2018).

Motherhood and mental illness

Mental illness is one of the most common disorders affecting people worldwide with neuropsychiatric disease accounting for 13% of the global burden of disease (Callaghan, 2015). The peri-natal period that extends from pregnancy to the first year of the child's life is recognised as one of the most significant periods in a woman's life (Cauli et al., 2018). There is an increased risk of mental ill-health in the first year following the birth of a baby amounting to between 13%-20% of women suffering from psychological problems during this period (Monteiro, Fonseca, Pereira, Alves, & Canavarro, 2018). However this excludes pre-existing severe mental illness including: bi-polar disorder; schizophrenia; obsessive-compulsive disorder; eating disorders; and personality disorders (Viveiros & Darling, 2018). In terms of post-partum depression, some estimates are that over 50% of women are undiagnosed or under diagnosed (Payne & Maguire, 2019). Risk factors for post-natal illness include life events and mental health history (see Table 01).

Table 01. Risk factors for post-natal illness.

Moderate to strong risk	Depression or anxiety during pregnancy Past history of mental disorder Life events Lack of or perceived lack of social support
Moderate risk factors	Neuroticism Relationship difficulties
Low risk factors	Obstetric factors Socio-economic status

(Henshaw, Cox, & Barton, 2017, p.11).

Post partum depression is not recognised as a unique diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5); it is classified as a major depressive disorder with a "peri-partum onset", that is an onset in the period shortly before, during or immediately after giving birth (American Psychiatric Association, 2013, p.186). Diagnosis requires five or more of the following symptoms-

- Depressed mood
- Diminished interest in pleasurable activities
- Change in body weight
- Insomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Decreased ability to concentrate or recurrent thoughts of death or suicidal ideation

(Payne & Maguire, 2019).

Despite the increased contact for women at this time with midwives, GP's and other health professionals, identification and treatment of mental health conditions are lower in pregnancy than in women who are not pregnant (Viveiros & Darling, 2018). Viveiros and Darling (2018) reviewed 26 studies into barriers to accessing peri-natal mental health care in midwifery; they found that barriers divided into supply-side barriers and demand side barriers. Supply side barriers included: long waiting lists in peri-natal mental health care services; lack of training, knowledge and confidence; stigma; and inconsistent screening practices (Viveiros & Darling, 2018). Demand side barriers included: normalization of peri-natal mental health concerns as symptoms of pregnancy; emotional isolation and loneliness; and cultural norms surrounding motherhood and mental health (Viveiros & Darling, 2018).

Stone, Kokanovic and Broom (2018) challenge the understanding of early maternal distress and the assumptions around the active versus passive roles of care

providers and care recipients. They identified a theme of 'what is not allowed to be said', finding that women may not want to disclose the level of their depression to health professionals and may be traumatized by the form filling diagnostic practices, which can be interpreted as disciplining technologies that are configured as care (Stone et al., 2018). Childbirth is a significant life event, which at times is life threatening and this is possibly unusual in our modern world; in addition women have to make a transition from being a single person to being responsible for another life. Viveiros & Darling, (2018) conclude that there is a lack of perception of need by mothers and by midwives for peri-natal mental health care.

The psychological process of adjustment involves a developing attachment relationship between mother and infant (Henshaw et al., 2017). Mental health difficulties are associated with poorer attachment and there is longstanding evidence that a baby's social and emotional development is affected by their attachment relationship (Leadson, Field, Burstow, & Lucas, 2013). Early deprivation and chronic stress are thought to effect brain development leading to deficits in memory and reality testing with the prolonged use of primitive defenses: nurturing and support can decrease stress hormone levels and provision of physical comfort and soothing talking to an infant can help the brain integrate experiences (Cozolino, 2017).

The '1001 Critical Days' report states that this time, which includes pregnancy and the first two years of an infant's life, is an incredible window of opportunity in which parents need to feel confident that they can raise their children within a loving and supportive environment (Leadson et al., 2013). What happens during this critical period can lay the foundations for future health for the child in terms of emotional wellbeing, resilience and adaptability (Leadson et al., 2013). Parents who experience mental ill-health can be vulnerable to particular stresses and strains

including: stigma; insecurity in the parenting role; concern over how to explain illness to children; difficulties managing the demands of parenting and mental illness; fear of losing friendship with children and difficulties implementing boundaries and discipline (Shor, Kalivatz, Amir, Aldor, & Lipot, 2015).

Coping

Coping is a complex psychological phenomenon, it is defined as “managing or dealing with something successfully” (Oxford Essential English Dictionary, 2011, p.133). During the 1960’s coping began to be used as a term within social and medical sciences to describe the appraisal of an event as stressful and interwoven with coping abilities (Snyder & Dinoff, 1999). Salovey, Bedell, Detweiler and Mayer (1999) interpret coping primarily as a response to emotions. However the concept of coping has developed within mental health care provision to involve a set of cognitive and affective responses to stress and adversity (Linehan, 2015). Lazarus (1999, p.160) describes coping as the persons attempt to restore “integrity” or self-mastery and “verve” or energy, attempting to restore a sense of wholeness and internal consistency. Lazarus (1999) very much links the three concepts of stress, emotion and coping as three parts of a whole relationship.

Snyder & Dinoff (1999) find that coping is a response that is aimed at diminishing the physical, emotional and psychological burden that is linked with stressful life events and the daily smaller challenges in life. The strategies that we develop to ‘cope’, aim to reduce the psychological burden and their success is dependent upon their effectiveness in reducing distress and contributing to long term well being (Snyder & Dinoff, 1999). Coping may not be able to terminate stress, but rather can often manage it by tolerating it or accepting the distress (Lazarus, 1999). Lazarus (1999)

finds that coping potential arises from a person's conviction that they are able or not able to act in a way that can ameliorate or eliminate a harm or threat, or bring about a benefit or meet a challenge.

Coping is categorised in different ways in the literature, Gutierrez-Zotes et al. (2016) describe passive coping, cognitive and behavioural coping. Jana et al. (2016) differentiate problem focused coping, emotion focused coping, adaptive coping and maladaptive coping. Adaptive coping can be seen as forward looking, flexible, largely conscious and attentive to reality: whereas maladaptive coping tends to be rigid in operation and unconscious, a distortion of reality which largely attends to issues in the past (Snyder & Dinoff, 1999). Lazarus (1984) however argues that there is a need to be open minded to the possibility that coping can work well or not according to the person, the context or the occasion. Similarly Porges (2017) discusses physiological responses to stress as adaptive and finds that a moral veneer of good or bad, needs to be replaced with context appropriateness and whether or not those adaptive responses fit the context. It may however be considered that coping may include responses that would not necessarily be envisaged in the understanding of resilience.

Emotion focused coping centers on controlling emotional responses to prevent being overwhelmed by emotion, through seeking emotional support, placing the problem in context or putting a more hopeful outlook onto the problem (Snyder & Dinoff, 1999). Skinner & Zimmer-Gembeck (2007) argue that emotion is integral to all phases of the coping process, from vigilance, detection, appraisal and action: coping is both more and less than emotional regulation.

Problem focused coping seeks to find a solution to a particular difficulty, controlling or changing the source of the stress by learning new skills, removing barriers or

generating alternative solutions (Snyder, 1999). Baumeister, Faber and Wallace (1999) point out that passive coping may be equally as demanding on the person, as active coping as it demands active control of the self. Demands for affect regulation can be severe when negative emotions such as anger, depression or frustration need to be managed or overcome (Rothbaum, Weisz, & Snyder, 1982).

Coping can be a conscious process, within our awareness or an automatic response that is outside our awareness (Snyder & Dinoff, 1999). Snyder & Dinoff (1999) cite Lazarus (1966) idea of a stressor/coping fulcrum, where stressors are only interpreted as excessive when they exceed existing coping strategies. Both problem focused and emotion focused coping can be used together, however success depends on the person choosing the right coping response for the specific stressor within an appropriate context. Most commonly emotion focused coping is more likely to be used when a person appraises a situation as one in which nothing can be done to change things; while in contrast, problem focused coping is more likely to be used when, the appraisal is that conditions can be changed for the better (Lazarus and Folkman, 1984).

Lazarus (1999) emphasises the importance of appraisal, the evaluative process that construes relational meaning, the relational meaning for the person coming from both the environment and personal qualities. For example a threat can occur from the environment but has to appraised also in terms of the unique personal qualities that a person may possess: psychological stress is a synergy of person-environment relationship (Lazarus, 1999). Primary appraisal is carried out to determine level of risk and secondary appraisal examines available resources for coping (Lazarus, 1966 in Snyder, 1999).

Situational control appraisals describe the extent to which a person believes they are

able to influence a person-environment relationship; the theoretical assumption is that the greater the assessment of control, the lower the stress in the situation; however Lazarus & Folkman (1984) find that this is not necessarily the case. The illusion of control can lead to unrealistic control expectancies or conversely feelings of helplessness in potentially skill opportunistic situations (Lazarus & Folkman, 1994). Coping happens in cycles, involving a shifting back and fore between a coping approach and withdrawal to re-appraise (Lazarus & Folkman, 1984).

Salovey et al. (1999) explore the link between emotional intelligence and coping. They describe an emotional coping hierarchy that has emotional regulation as the most important element, without which we cannot perceive, appraise, express, analyze and understand difficulties that we need to cope with (Salovey et al., 1999). Vitaliano, Russo, Carr, Roland, Becker and Becker (1985) had found looking at a wide range of coping strategies, that there was a link between anxiety and seeking social support and wishful thinking and depression. Watson, David and Suls (1999) discuss personality traits and dispositional measures of coping as opposed to situation specific forms of coping, finding that coping behaviours show trait like properties of stability and consistency. For example extraverts who are highly socially interactive are dispositionally more likely to turn to others for support; conscientious individuals who are more cautious, meticulous and organised are dispositionally more likely to engage in problem focused coping; or individuals who are high in negative emotionality are dispositionally more likely to negative appraisal of circumstance and suffer stress from their over-reactivity (Watson et al., 1999).

A crucial factor in coping is the ability to overcome challenges and setbacks: thriving despite adversity is linked to dispositional optimism, with characteristics such as curiosity, imagination, emotional responsiveness and openness to experience (Peterson & Moon, 1999). People who are dispositionally optimistic are found to be

more likely to be able to meet challenges through a philosophical reorientation and a new direction in life planning (Peterson & Moon, 1999). Recognising the role of our fundamental assumptions and concepts of self in coping as a phenomenon is important, as coping involves negotiating a path between experience and assumptions (Jan Olf-Bulman, 1999).

The implication is that personality types, who already experience a sense of personal control, are more likely to view emerging from difficult experiences as having gained valuable learning and understanding, which may be a source of strength in the future (Peterson & Moon, 1999). Antonovsky (1979) points out three major variables in coping strategies: rationality, the accurate and objective assessment of the stressor; flexibility, the availability of contingency plans and tactics and the willingness to consider them; and farsightedness, the ability to anticipate the inner and outer environmental response to the coping strategy.

Anna Freud (1936,1993) extended her father's work on a psychodynamic model of coping in which coping mechanisms are termed as defense mechanisms, these include: repression, regression, isolation, reaction formation, undoing, introjection, projection reversal, sublimation and turning against self: she added intellectualisation, ego restriction, identifying with the aggressor and denial. Freud (1936,1993) discussed the way in which the ego is able to ward off difficult experiences and anxiety and exerts control over impulsive behaviour and instinctive urges. The ego represents the organised, realistic part of the self, which mediates between the id, the un-coordinated instinctual aspect of the self, and the super-ego, the critical moralizing element of the psyche (Freud, 1936, 1993). There are many unique and individual defense strategies but all act by protecting the conscious self or ego from stress and providing a less painful outlet (Freud, 1936,1993).

Freud (1936,1993) finds that the ego is successful in achieving coping when its defensive measures have effective restricted the development of anxiety and problematic experiences. Similarly Lazarus (1984) contends that 'defense' involves the "maintenance of the integration of the personality and the control of feeling states" (p.126). The integration of the personality and the protection from shattered or uncomfortable states being a natural protective drive of the ego and personal identity. Our minds have the capacity to distort reality in order to enhance survival and decrease anxiety (Cozolino, 2017). The use of defense mechanisms enhances survival by reducing shame, minimising anxiety and reducing a person's awareness of present overwhelming realities (Cozolino, 2017). McWilliams (2020) adds the maintenance of self-esteem to this, explaining that the defenses have a role in maintaining a strong, consistent and valued sense of the self.

Buckley (2019) differentiates between coping and defense mechanisms, finding that there are significant differences: defense mechanisms occur without conscious effort or awareness; are instinctive; function to change an internal psychological state but may have no effect on external reality; tend to be habitual and rigid in application; and can result in distortions of reality. Where as coping strategies: require purposeful effort; are carried out with intent; are reality based; can be developed as a skill and can change over time (Buckley, 2019).

Antonovsky (1979) differentiates the behaviour that results from our attempts to cope with the stressor, and the plan for the behaviour, finding that coping is the plan itself and not the resultant behaviour. Conversely Vitaliano et al. (1985) explain that within the transactional model of stress, of the person in relation to the environment, coping is what a person does or thinks and is not defined in terms of adaptation or distress. McWilliams (2020) offers clarity in this debate, explaining that defenses function outside of awareness becoming part of our developing personalities and part of our

coping styles. They are used increasingly at times of stress, operating through the autonomic nervous system and act effectively to reduce awareness of negative emotions (McWilliams, 2020). However importantly Buckley (2019) explains that both defense mechanisms and coping strategies can be used simultaneously.

Burgo (2012) writing from a psychodynamic perspective argues that defense mechanisms can lead to coping by keeping painful emotions, thoughts and fears outside of our awareness. However Lazarus and Folkman (1984, p. 128) emphasise the imperative of distinguishing coping from automatized adaptive behaviour, and do not acknowledge that coping is necessarily constructive. Burgo (2012) agrees finding that rigid or entrenched defenses can prevent us from getting what we need and preventing us from accessing important emotions that we need to face. Additionally people also tend to develop characteristic defenses that shape their personality; phrases such as, control freak, cold fish, hot head, drama queen, timid little mouse, for example, may all indicate defenses that form a person's personality (Burgo, 2012).

The complexity and scope of defense mechanisms is comment upon human intelligence and ingenuity and the basic survival instincts of human evolution. Darwin's (1859, 2011) work on the significance of natural selection includes ideas about adaptability that are pivotal to evolutionary theory; in a way our ability to withstand adversity may be viewed as part of this process, just as Bowlby (1971) identifies the maternal infant relationship as a survival based evolutionary force. The "maintaining proximity" behaviour and "restoring it when it has been impaired" that Bowlby, (1971) discusses continues into adult life where "in conditions of sudden danger or disaster a person will almost certainly seek proximity to another known and trusted person" (p. 255). Bowlby (1971) disagrees that this is regressive behaviour in its nature and points out that it is a vital behaviour in humans from the "cradle to the

grave" (p. 256).

Cozolino (2017) describes the evolution of maternal care, which has enabled children to develop more slowly within an environment that can support and scaffold their experiences and that allows for the development of more complex brains. However Cozolino (2017) points out that this also increases the impact of early parenting experiences. At birth the reptilian brain is predominant and the paleomammalian brain or limbic system is ready to be organised by early experiences, with the cortex growing much more slowly over the first three decades and into later life (Cozolino, 2017).

Whichever way these aspects of evolutionary attachment behaviours are looked at, the similarities to social and emotional coping strategies are striking. Cozolino (2017) finds that the purpose of the brain and the self, which includes the personality, defenses and coping style, is survival and reflects the conditions to which we have had to adapt. Questions around how we learn coping strategies follow on more clearly from this, in that it appears obvious that some coping strategies are learnt. Moreover it is probably an aim of many parents that they enable their children to cope with adversity, this in a hermeneutic way brings us back to evolution and survival of the fittest.

Skinner and Zimmer-Gembeck (2011) group coping into three families of adaptive processes, the overall groupings contain sub groups with examples in each sub-group. The value of this framework is in being able to identify coping attempts even when at first glance they might not be perceived as a coping action. The adaptive processes include environmental actions, co-ordinating social resources and co-ordinating available options (Skinner and Zimmer-Gembeck, 2011, p.41). The framework was used to integrate 44 studies on coping that enabled a systems

perspective in which regulatory subsystems are integrated into general mechanisms of coping (Skinner & Zimmer-Gembeck, 2007).

Vitaliano et al. (1985) looked at The Ways of Coping Checklist, which comprises of seven scales-

- Problem focused- making a plan of action and following it
- Wishful thinking- wishing you could change the situation
- Growth- changing or growing as a person in a good way
- Minimise threat- making light of situation
- Seek social support- talking to others, accepting support
- Blamed self- taking responsibility for the situation
- Avoidant strategies- not believing in situation
- Help seeking strategies- seeking advice

They found that the scale was a suitable measure of coping strategies (Vitaliano et al., 1985). The Ways of Coping Checklist, places coping into descriptive units which are able to capture how people actually respond to stress when they contend with real life problems (Skinner & Zimmer-Gembeck, 2007). However coping as a phenomenon may not to be measured as a routine strategy within mental health today.

Baumeister et al. (1999) discuss the consequences of the depletion of coping resources, leading to a need to replenish and recover. The person may only return to normal when they have recovered from the coping process and replenished the resources that were depleted (Rothbaum et al., 1982). Recovery from stress and coping may require that the person finds a way to live that does not make serious demands on the self (Rothbaum et al., 1982).

Lazarus (1999) directs attention to the connections between coping, stress and emotions: emotions explain how a person has appraised a situation and how they are

coping with the situation. He categorizes 15 emotions including: anger, envy, jealousy, anxiety, fright, guilt, shame, relief, hope, sadness, happiness, pride, love, gratitude and compassion (Lazarus, 1999, p.43). The emotion contains a corresponding relational theme for example “hope, fearing the worst but yearning for better”: but may not always follow the theme (Lazarus, 1999, p.96). Lazarus (1999) warns against pre-judging negative emotions as stressful and positive emotions as not being stressful, the personal interpretation is widely variable as one person may see happiness as concerning as it can only be short lived and another person may experience fright as stimulating. Tiberius (2015) agrees saying that “emotions are about something” (p.71), they include cognition and feeling and essentially constitute our moral compass and have value. Emotions make us feel something, motivate our actions, give us information about things that matter to us (Tiberius, 2015).

The coping-environment dynamic is complex and infinitely variable from person to person and situation to situation; although people may have individual traits and characteristics, they cannot necessarily be predicted to react in a predictable way (Lazarus, 1999). Snyder (1999) emphasises that even successful coping can be debilitating, if the coping attempts that are required are numerous and the self becomes drained by its efforts to exert self-control, recovery can require a psychological recharging.

Resilience, coping and attachment

There is an apparent lack of consensus regarding an operational definition of resilience despite of the concept being significant in diverse disciplines including; psychology, sociology, biology, genetics, epigenetics, endocrinology, and neuroscience (Herrman et al., 2011). The term resilience is described by Rutter (1999), as an individual’s ability to be resistance to psychosocial risk experiences.

Rutter (1999) suggests however, that “there is no expectation that protection from stress and adversity should lie in positive experiences” (p. 120). It is the experiences of adversity that can prepare us to face other challenges. Variations in our ability to respond to risk and adversity therefore come from our prior experiences (Rutter, 1999). Herbert, Manjula and Philip (2013) describe resilience as compromising a complex repertoire of behaviours including patterns of thought, perception and decision; which act together to help withstand threatening or challenging situations. Individuals may respond to challenges with varying degrees of resilience and vulnerability (Herbert et al., 2013).

Schore (2003a) explores the formation of resilience in infancy, finding that the capacity of the child and parent to transition from positive to negative and back to positive affect again, characterises resilience as the infant learns that negative states can be tolerated. In this way resilience is part of attachment relationships and an individuals pivotal attachment relationship may crucially affect the ability of that person to be resilient. Burgo (2012) explains that humans have a lengthy, vulnerable childhood, which entails the infant relying on the care and protection of a care-giver and establishes the experience of dependency at the core of human experiences. If the needs of the vulnerable and helpless infant are not met by their care-giver, the infant will feel unsafe in the world from an early age which will shape the ability to trust and depend on others (Burgo, 2012). An example of a defense mechanism could be the person who is very self-reliant, unable to depend on the unreliability of others, repressing awareness of their own needs and becoming highly independent and self-sufficient (Burgo, 2012).

Schore (2003a) goes further to suggest that the central adaptive function of attachment is to interactively generate and maintain the optimal levels of positive states for the infant and child. The child internalises these skilled transitions to

become able to respond resiliently in the future. The growth of the brain during infancy is sculpted by early experiences, with healthy relationships providing optimal functioning allowing individuals to: think well of themselves; trust others; regulate emotions; and maintain positive expectations (Cozolino, 2006). Cozolino (2006) indicates that resilience is essentially our ability to utilise intellectual and emotional intelligence in real time problem solving.

Unfortunately when the early experiences of an infant are fearful, it may lead to an individual being on high alert and hypersensitive to stress (Howe, 2011); the resultant effect is compromising to resiliency. Hyper vigilant alarm systems flood the brain with neurochemical and hormonal responses, which can over time impair the functioning of the limbic system and critically affect rationality at times of stress (Karr-Morse & Wiley, 1997). While passive stress may be important for healthy development resilience is more likely to be attained when an individual can avoid strong, frequent or prolonged stress (Herrman et al., 2011).

Experience is internalised into somatic regulation through the vagal system, which is part of the autonomic nervous system; when challenges occur, sympathetic arousal activates high energy output and fight flight responses (Cozolino, 2017). Depending on the quality of the attachment relationships the vagal system modulates sympathetic arousal and enables cognitive and emotional processing that is necessary for relationships; enabling us to be upset and angry without withdrawing and becoming aggressive with people we love (Cozolino, 2017).

Exposure to threat and danger increases the probability of dysfunctional adaptation (Crittenden & Landini, 2011). Crittenden (2008) introduced The Dynamic Maturational Model (DMM) of attachment, which was developed out of the work by Bowlby (1971, 1973, 1980, 1988) and Ainsworth's work on the theory and models of

attachment (Ainsworth, Blehar, Waters, & Wall, 1978; Ainsworth & Wittig, 1969). The DMM approach finds that adults develop an array of strategies, which are developmentally expanded from attachment schema in infancy to include later developing and more complex strategies (Crittenden, 2008).

The DMM represents a conceptualization of the self-protective strategies that individuals develop across the life span; the greater the level of perceived stress or danger, potentially the more complex the response will be (Crittenden, 2008). If there is an overreliance on past experience in current contexts, behaviour may be maladaptive; especially when information understood in the past was missing, ambiguous or false (Crittenden & Landini, 2011). Lower vagal tone correlates with impulsivity, acting out, distractibility and emotional dysregulation; relationships are experience dependent and shape the building of neural circuitry, which effectively build the brain (Cozolino, 2017). Adults who repress awareness of their need for other people may turn to other preferred substances, food, alcohol, drugs or other addictions instead, substituting the unreliable human contact (Burgo, 2012).

This chapter has examined the context of the study in terms of motherhood and maternal mental health difficulties, exploring the feminist perspective and it's contribution to the understanding motherhood. It has detailed the historical theoretical understanding of 'coping' itself, the position of motherhood and mental illness within society and explored the relationship of resilience with coping and infant attachment and the implications of attachment relationships on coping itself. Coping is found to be a complex psychological phenomenon, used as a term within social and medical sciences to describe the appraisal of an event as stressful and

interwoven with coping abilities. The strategies that we develop to 'cope' are driven by the self and aimed at reduction of psychological burden on the self.

The broad review of the literature into the theoretical development of coping as a phenomenon and its development to concepts of infant attachment was submitted in an edited form for publication (Skibniewski-Woods, 2022b). The next chapter moves on to a narrowing down of the literature search focus to look at the specific study research question.

Chapter three: Literature review

"Build on the knowledge that already exists and … avoid 'reinventing the wheel'."

(Denscombe, 2017, p.370).

Introduction

The previous background chapter explored the broader context of motherhood, mental illness and coping. The aim of this chapter was to specifically review the existing literature around the research question *What can women's lives tell us about surviving adversity and developing coping mechanisms, with particular reference to mental illness and being a mother?* Conducting a literature review lays foundations for clarifying ideas, making comparisons, beginning theoretical discussion and identifying where the research proposal fits in with or extends the existing literature (Charmaz, 2014).

Following the identification of the phenomenon of interest, the literature can be drawn upon to develop rationale for the research question, examine further dimensions of the phenomenon and develop insights that can support the research proposal (Willig, 2013). The literature is drawn upon in a continuous process throughout the research passage; this chapter describes the formal literature search that aimed to identify key issues that could be critically examined to support the research process.

From the early initial pre-study scoping review of the literature (see appendix a.), it was possible to refine a research question and from there generate a comprehensive formal literature review question. This could then be used for an integrative literature review to establish a research conceptual and theoretical framework. The purpose of the formal literature review was specifically to be able to identify the appropriate research questions from the gap identified in the literature. It was also important to

understand the methodological lessons from previously conducted research in order to identify the best way to approach the research question. Some authors recommend that a narrative style review is more applicable to qualitative research and the wider background literature review was completed using a narrative style (Newnham & Rothman, 2022). However a more formalised approach was taken with the specific literature review question using systematic review methodology in order to obtain the highest quality review that was possible. The integrative literature review was submitted for publication in an edited version (Skibniewski-Woods, 2022a).

Integrative literature review

Literature review question- *What is the available literature on mother's coping mechanisms in the face of mental illness?*

Methods

The literature review was completed using an integrative approach to reviewing the literature that aimed to locate, appraise and synthesize the evidence that is available on the research question. The following steps were incorporated in accordance with systematic review methodology:

- Review of the background literature, refining research question and deciding on inclusion and exclusion criteria
- Literature searching in Bibliographic databases
- Screening titles and abstracts
- Obtaining papers
- Selecting full-text papers
- Data extraction, identifying relevant data and summarizing
- Quality assessment using Critical Appraisal Skill Programme (2018, a, b, c, d.).
- Analysis and synthesis
- Conclusions and evaluation

(Boland, Cherry, & Dickenson, 2017).

The resultant data is presented using narrative integration, discussing the data rather than undertaking statistical analysis as there was a level of heterogeneity between studies, which were diverse in character and content.

Literature searching in bibliographic databases

The literature search question for this review was-

What is the available literature on mother's coping mechanisms in the face of mental illness?

This was widened to include relevant papers on 'coping' as a phenomenon as the available literature although diverse was found to be limited on mother's coping mechanisms in the face of mental illness. Heidegger (1953, 2010) explains the term 'phenomenon' as meaning "something that can be encountered" or in a direct translation from the Greek "to show itself" (p. 27). It was considered that examining coping as a phenomenon was valid and would be able to contextualize the literature for the examination of Mother's coping in the face of mental illness. The link with coping and mental health was maintained throughout the search. Two searches of databases were carried out on the 23/07/19 and 25/07/19, with a follow-up search on 03/10/19. Databases searched included Medline, Pub Med, Embase, Psyc INFO and CINAHL. Quantitative and qualitative methodologies, mixed methods and reviews were included in this literature review.

The main inclusion criteria were that the papers should be written or translated into English, within the last five years, with available full-text on line; however older papers were included on the secondary search if they were felt to be important to the subject and able to be informative. Search terms were: mothers; mothers and mental

health; mothers mental health and coping. Studies may include data on diverse issues; for the purpose of this review the data extracted was specific to the phenomenon of coping, with some references to resilience when this concept is presented as inter-dependent. A separate search was conducted for the search term defenses of the ego as this was identified as intricately linked to the term coping. Table 02. below shows the search terms and results of the search strategy.

Table 02. Search terms for integrative literature review.

Search terms	Results	Titles and Abstracts reviewed	Full text Critically appraised
Mothers	36,0194		
Mothers and mental health	52,019		
Mothers, mental health and coping	2,833	Titles reviewed for relevance. Abstracts reviewed 26 Papers identified	Full text appraisal 14 papers identified for inclusion
Defenses of the ego	667	Titles reviewed for relevance	
Defenses of the ego and mothers	11	Abstracts reviewed 2 papers identified	Full text appraisal 1 paper identified for inclusion

Following the search, 26 papers that were identified as potentially relevant from reading of the abstracts were critically appraised for trustworthiness, results and relevance using the Critical Appraisal Skills Programme (CASP) Checklist (2018, a,

b, c, d) for: Case Controlled Study; Cohort Study; Qualitative research; and Systematic Review; as appropriate for each individual study. Critical appraisal facilitates the identification of the most relevant papers and can aid the distinguishing of evidence from opinion, assumptions and belief (Morrison, 2017). It also helps with assessing the validity of the study and recognition of potential for bias and reduces the potential for information overload by eliminating irrelevant or weak studies (Morrison, 2017). All studies were found to be acceptable from quality perspectives, although the range of quality was high to medium. Nine studies were excluded during this phase, due to having only limited relevance for inclusion although they could be relevant for wider discussion points; one was excluded as it was a discussion paper only. The remaining 15 papers were included in the review.

The included studies used a variety of methods, including literature and data reviews, interviews, electronic surveys, questionnaires and validated assessment tools. The validated assessments tools used included The Ways of Coping Checklist (Vitaliano et al., 1985). Coping questionnaires can help with understanding the choice of coping strategies towards different situations; the COPE inventory (Carver, 1997) has two main components, problem-focused coping and emotion-focused coping. It was adapted by Carver (1997) in to The Brief Cope which consists of 28 measures with participants using a score to rate frequency.

Table 03. below sets out the full text papers included in integrative review and a summary of findings.

Table 03. Full text papers included in integrative review with summary of findings.

	Author	Title	Reference	Data collection Method	Sample description	Results significant to 'coping' as a phenomenon.
1	Adams, D., Rose, J., Jackson, N., Kara Katsani, E., & Oliver, C. (2017).	Coping strategies in mothers of children with intellectual disabilities showing multiple forms of challenging behaviour: Associations with maternal mental health.	Behavioural and Cognitive Psychotherapy, 46, 257-275.	Questionnaire and validated assessment measures	89 mothers of children who show challenging behaviour	Coping strategies were not associated with child age or disability but were associated with parental mental health. Mothers who adopted more positive coping strategies reported lower levels of depression. Active-avoidance coping was the least frequently reported and was associated with higher levels of anxiety, depression and negative affect.
2	Cherewick, M., Kohli, A., Remy, M.M., Murhla, C.M., Bin Kurhorhwa, A.K., Mirindi, A.B., & Glass, N. (2015).	Coping among trauma-affected youth: A qualitative study.	Conflict and Health, 9(35), 1-12.	Interviews	30 trauma affected youth aged 10-15 years	Cognitive coping strategies were reported and included trying to forget and playing. Behavioral strategies reported included social support seeking and risk taking behaviour. Attachment relationships are critical to helping cope with trauma and stress. Family and community support can be protective to individual's mental health.
3	Ito, M., & Matsushima, E. (2017).	Presentation of coping strategies associated with physical and mental health during health check ups.	Community mental health Journal, 53(3), 297-305.	Validated assessment measures, medical histories, physical examinations and laboratory tests	201 adults in annual health check up clinic	Women were found to be more likely to use active coping strategies including, self-distraction, emotional support and instrumental support, for example counseling, information and advice. Several connections were found between coping and physical or psychological conditions- A link was observed between individuals that used self-blame as a coping strategy and depression. Behavioral disengagement was connected with sleep disorders. The use of humor was connected with lower systolic blood pressure. Venting was correlated with higher levels of cholesterol. The study identified that the younger people tended towards seeking emotional support, whilst older adults were more likely to use emotionally focused coping.
4	Lai, W.W., Goh, T. J., Oei, P.S.T., & Sung, M. (2015).	Coping and well-being in parents of children with autism spectrum disorders (ASD).	Journal of Autism and Developmental Disorders, 1(3), 2582-2593.	Validated assessment measure questionnaires	136 parents of children with Autism Spectrum Disorders (ASD) 80.9% of whom were mothers	Study found the more frequent use of active avoidance coping and this was related with depressive symptoms. Anxiety symptoms were unaltered between parents of children with or without ASD. Coping and psychological well-being were found to be time and context dependent. Longitudinal studies could observe changing trends or highlight possible factors contributing towards parental well-being or coping strategies.
5	Light, A., Holt-Lunstad, J., Porter, C., &	Early life trauma: An exploratory study of effects on OXTR	International Journal of Psycho-	Ques-tionnaires	62 post-partum mothers of	Childhood experiences of attachment figures shape how people respond to social support.

	Light, K. (2019).	and NR3C1 gene expression and nurturing self-efficacy in mothers of infants.	physiology, 136,64-72.		infants aged 3 months	Mothers with early trauma experiences reported their support networks to be less helpful and more upsetting and unpredictable than other mothers. This led to them seeking support less often. The temperament of the infant, in particular whether the infant is perceived to be fussy, had an effect on maternal self-efficacy; maternal self-efficacy is associated with enhanced maternal behaviours, greater responsiveness to the child and warmer parental child interactions. Mothers of fussy babies could feel undermined by support offered to them. Lower nurturing self-efficacy was predicted by higher baby fussiness but not by maternal trauma experience alone; however insecure attachment styles in the mothers tended to lead to more negative perceptions of social support offered. Mothers with three or more children plus an infant were found to have higher levels of oxytocin receptor levels and oxytocin levels which correlate positively to positive maternal experiences.
6	Lowe, S. R., Rhodes, J. E., & Waters, M.C. (2015).	Understanding resilience and other trajectories of psychological distress: A mixed methods study of low-income mothers who survived Hurricane Katrina.	Current Psychology, 34(3), 537-550.	Mixed methods Interviews	54 female survivors of Hurricane Katrina	Protective factors for well being were found to include: -Adaptive coping skills including reframing, positive comparing, taking positive action. -Religiosity, which encompassed supportive communities, practical help and spiritual support. -New opportunities offered by aid programs for victims. Resilient participants revealed a continuity of psychosocial and economic resources that acted in a way that promoted mental health. Coping participants displayed an active approach that was able to secure and maintain resources and prevent their distress from escalating into more serious mental health difficulties. Social support and faith were reported as helpful. In participants with lower levels of resiliency, there was a relative absence of psychosocial resources and an increased risk of mental health difficulties. Participants with increased distress were more likely to show higher rates of strain in intimate partner relationships and higher recorded childhood trauma and Adverse Childhood Experiences (ACES). A life course perspective was found to be important when trying to understand individual's outcomes.
7	Monteiro, F., Fonseca, A., Pereira, M., Alves, S., & Canavarro, M.C.	What protects at-risk post-partum women from developing depressive and	Journal of Affective Disorders, 246, 522-529.	Validated assessment measures and questionnaires	185 post-partum women at risk of developing post-partum	Acceptance-based processes and self-compassion was found to be higher in women not reporting depressive and anxiety symptoms. Non-judgmental appraisal of thought

	(2018).	anxiety symptoms? The role of acceptance-focused processes and self-compassion.			depression	content and self-compassion were found to be protective. Psychological flexibility and acceptance based processes in at risk post-partum women was found to correlate with lower rates of anxiety and depression. Ideology of perfect motherhood can lead to greater difficulty in accepting unwanted internal events and can lead to maladaptive avoidance strategies, which can negatively impact psychological adjustment in the post-partum period. The study recommends the promotion of acceptance-based processes to facilitate better long-term adjustment during this period.
8	Reyes, A, & Constantino, R. E. (2016).	Asian American women's resilience: An integrative review.	Asian pacific Island Nursing Journal, 1(3), 105-115.	Literature review	Literature search of 13 qualitative studies and 8 quantitative studies on resilience in Asian/Pacific women in USA	Resilience is conceptualized as a coping strategy used to persevere through difficult experiences. Resilience is a developmental process, developed through several episodes of stressful events. It can be transmitted through the generations by offspring adopting their parents' resilience to their own lived experience, creating resilience as an enduring phenomenon. It can be enhanced through multiple and inter-related factors including- perceived social support, physical and mental status, income, age and identity. Resilience can be examined under a systems perspective, where the tendency of a system is to be resilient towards external factors and able to maintain its key characteristics.
9	Schoenfeld, T.J., & Cameron, H. (2015).	Adult neurogenesis and mental illness.	Section on Neuroplasticity. National Institute of Mental Health. Bethesda. MD. USA.	Data review	Review of literature on adult neurogenesis and mental illness.	Negative experiences such as stress and anxiety can impact mental health and effect neurogenesis, decreasing the generation of new neurons in the brain. Positive experiences such as exercise and environmental enrichment can have beneficial effects on mental health and increase adult neurogenesis. There is evidence to suggest that new neurons are important for mental health Changes to the hippocampus in several mental health conditions including depression, anxiety and schizophrenia have been observed. The hippocampus is involved in the limbic system with the formation of new memories, learning and emotions.
10	Sharma, M., Fine, S. L., Brennan, R. T., & Betancourt, Y. S. (2017).	Coping and mental health outcomes among Sierra Leonean war-affected youth: Results from a longitudinal study.	Development and Psycho-pathology Cambridge, 29(1), 11-23.	Longitudinal study using interviews	529 war affected youth aged 10-17	Coping is viewed as the management of psychological distress through behavioural, cognitive and emotional strategies. Coping strategies found in this group included: denial; substance use; positive reframing; planning; use of emotional support; religious coping; use of instrumental support; acceptance; and self-blame. Coping is multi-dimensional and different strategies may be more or less effective in different situations, e.g. Avoidance coping which is mainly perceived

						negatively may have a role in promoting self-preserving schema that are threatened in trauma experiences; and may be effective in reducing anxiety and depression for stressors that are perceived as uncontrollable. Socio-Ecological models of coping are useful as they encompass factors promoting resilience across the nested social ecological levels- individual; family; community; institutions; and culture.
11	Siriwardhana, C., Ali, S.S., Roberts, B., & Stewart, R. (2014).	A systematic review of resilience and mental health outcomes of conflict-driven adult forced migrants.	Conflict and Health, 8(13), 1-14.	Systematic literature review	Systematic review of 23 studies 10 qualitative and 13 quantitative into resilience and mental health in adult forced migrants	A theoretical framework for the interaction between resilience and mental health can be conceptualized. Undermining factors include- daily stressors; break down of family; living conditions; social and cultural networks; status; acculturation. Supportive factors include- sense of coherence; family and social support networks; individual coping abilities; community coping strategies and abilities; religion and belief systems; individual personal qualities and strengths; and community support. There is a dynamic, multi-level, multi-contextual nature of resilience that has individual and community trajectories.
12	Tada, A. (2017).	The associations among psychological distress, coping style and health habits in Japanese Nursing Students: A cross sectional study.	International Journal of Environmental Research and Public Health, 14(11), 1434.	Validated assessment measures and questionnaires	181 nursing students	Students with avoidance coping styles were found to use mechanisms of disengagement, venting and self blame as part of their coping strategies; this group were found to display greater levels of psychological distress. Students with active coping styles tended to use humor and reframing coping strategies and exercised more than the avoidant coping group. The study found that there are complex associations between psychological distress, coping style and health behaviours.
13	Van der Ende, P.C., Van Busschbach, J. T., Nicholson, J., Korevaar, E. L., & Van Weeghel, J. (2015).	Strategies for parenting by mothers and fathers with a mental illness.	Journal of Psychiatric and Mental Health Nursing, 23, 86-97.	Qualitative research in-depth interviews	Qualitative study using in-depth interviews with 19 mothers and 8 fathers with a mental illness	The combination of coping with mental illness and caring for a child can make parents vulnerable. Parents with a mental illness can find the strength for parenting from a sense of responsibility, which enables them to stay alert while they are parenting. Parenting provides a basis for social participation through school and the children's friendships. Dedication to the parenting role provides focus and the development of strengths and skills as a parent helps them find a balance between attending to their own lives and caring for their children. Parenting also prompts them to seek adequate sources of social support. The study found that the coping strategies related to parenting were fundamental to mental health and recovery from mental ill-health. A family focused approach was found to be able to help identify strengths and vulnerabilities, address challenges and build resilience.

14	Yanes, T., Humphreys, L., Mchnerney-Leo, A., & Biesecker, B. (2017).	Factors associated with parental adaptation to children with an undiagnosed medical condition.	Journal of Genetic Counseling, 26, 829-840.	Validated assessment measures and electronic surveys	62 parents of a child with an undiagnosed medical condition.	Coping mediates the relationship between appraisal and adaptation. Individuals who had greater uncertainty in their social support had lower levels of coping and reported lower adaptive self-esteem. Individuals who reported higher levels of social support, were found to have greater adaptive social integration. Greater familial uncertainty was significantly associated with decreased spiritual well-being. Affectionate support is widely reported to improve psychological outcomes including individual's quality of life and stress responses. Encouraging people to find sources of love and affectionate support can facilitate the adaptive process in coping. Parents with greater coping efficacy were found to have an increased positive stress response and increased self-esteem.
15	Ziadni, M., Jasinski, M.J., Labouvie-Vief, G., & Lumley, M.A. (2016).	Alexithymia, defenses and ego strength: Cross-sectional and longitudinal relationships with psychological well-being and depression	Journal of Happiness Studies, 18, 1799-1813.	Validated assessment measures with longitudinal follow-up	415 adults longitudinal study	The use of mature defenses and greater ego strength i.e. the ability for complex self-other understanding, correlates with less depression and greater well-being. A deficit in the ability to identify and express emotions (alexithymia) correlated with the use of passive coping constructs: turning against self or others and poor affect regulation.

Thematic integration of data findings

This thematic integration explores aspects of 'coping' as a phenomenon, whilst still holding 'mothers' and 'mental illness' in mind: the available literature although diverse was found to be limited on mothers' coping mechanisms in the face of mental illness.

Adaptive coping

Adaptive coping skills including reframing, positive comparing and taking positive action were found to be protective for survivors of Hurricane Katrina by Lowe, Rhodes, & Waters (2015), and Adams et al. (2017) found that mothers of children with intellectual disabilities showing multiple forms of challenging behaviour, who adopted more positive coping strategies reported lower levels of depression. Lowe et al. (2015) described coping participants as displaying an active approach that was able to secure and maintain resources and prevent their distress from escalating into more serious mental health difficulties. Women were identified as being more likely than men to use active coping such as self-distraction, emotional support and instrumental support (Ito & Matsushima, 2017). Ito & Matsushima (2017) identified age differences in coping styles, with younger people tending towards seeking emotional support and older people being more likely to use emotional coping strategies; adding a life course development into the coping equation.

Schoenfeld and Cameron (2015) point out the positive effects of active coping on neurogenesis; they found evidence to suggest that new neurons are important for mental health; the hippocampus being involved within the limbic system with the formation of new memories, learning and emotions. Neurogenesis was seen to occur particularly with the use of exercise as an active coping strategy (Schoenfeld &

Cameron, 2015). Tada (2017) also found exercise linked with active coping and lower levels of psychological distress in nursing students in Japan.

Avoidant coping

This is in contrast to the findings associated with active-avoidance coping, which was linked with higher levels of anxiety, depression and negative affect (Adams et al., 2017; Lai et al., 2015; Tada, 2017). Ito & Matsushima (2017) specifically linked the negative coping strategy of self-blame with depression. Monteiro et al. (2018) found that avoidance strategies negatively impacted psychological adjustment in post-partum women; conversely they found that acceptance based coping and self-compassion could act in a protective way for anxiety and depression risk. Sharma, Fine, Brennan and Betancourt (2017) in their study of war affected youth, recognise coping as multi-dimensional and point out that different strategies may be more or less effective in different situations; avoidance coping, which is mainly perceived negatively, may have a role in promoting self-preserving schema that are threatened in trauma experiences and may be effective in reducing anxiety and depression for stressors that are perceived as uncontrollable.

Strength from being a parent

The study by Van der Ende, Van Busschbach, Nicholson, Korevaar and Van Weeghel (2015) found that being a parent could bring strengths. The sense of responsibility that occurs in parenthood was found to be enabling for parents, where dedication to the parenting role provided a focus and the development of strengths and skills created a balance for parents between attending to their own lives and caring for their children (Van der Ende et al., 2015). Parenting was also found to

provide a basis for social participation through school and the children's friendships and prompted parents to seek adequate sources of social support (Van der Ende et al., 2015). The study found that the coping strategies related to parenting were fundamental to mental health and recovery from mental ill-health and recommended a family focused approach to be able to help identify strengths and vulnerabilities, address challenges and build resilience (Van der Ende et al., 2015).

Support

The importance of family and community support was identified by several studies (Cherewick et al., 2015; Light, Holt-Lunstad, Porter, & Light, 2019; Lowe et al., 2015; Reyes & Constantino, 2016; Sharma et al., 2017; Yanes, Humphreys, Mchnerney-Leo, & Biesecker, 2017). However attachment relationship and childhood experiences of attachment figures were found to influence how people respond to the social support that is offered (Cherewick et al., 2015; Light et al., 2019). Lowe et al. (2015) were also able to demonstrate a link between participants with increased distress and higher rates of strain in intimate partner relationships and higher recorded childhood trauma and Adverse Childhood Experiences (ACEs). A life course perspective was found to be important when trying to understand individual's outcomes and links with the importance of positive attachment relationships.

Resiliency

The study by Light et al. (2019) with post-partum mothers, identified that mother's who had early trauma experiences, reported their support networks to be less helpful and more upsetting and unpredictable than other mothers leading them to seek support less often. The insecure attachment styles in the mothers tended to lead to more negative perceptions of social support offered (Light et al., 2019). Mothers of

fussy babies could also feel undermined by support offered to them and lower nurturing self-efficacy was predicted by higher baby fussiness (Light et al., 2019). Yanes et al. (2017) study with parents of a child with an undiagnosed medical condition, specify affectionate support as widely reported to improve psychological outcomes including individuals quality of life and stress responses. They suggest that encouraging people to find sources of love and affectionate support can facilitate the adaptive process in coping (Yanes et al., 2017). Lowe et al. (2015) describe the supportive religious community, which encompasses practical help and spiritual support, as identified with being protective for mental health in female survivors of Hurricane Katrina.

The study of Lai et al. (2015) of parents of children with Autism Spectrum Disorders recognised that coping and psychological well-being were time and context dependent. Lowe et al. (2015) describe resilient participants from hurricane Katrina as having a continuity of psychosocial and economic resources that are able to act in a way that promotes mental health. In this way coping is dependent on changeable factors that can undermine or promote coping. Reyes and Constantino (2016) also cite environmental factors that can support resilience and coping, including perceived social support, physical and mental status, income, age and identity.

Lower levels of resiliency were found to be present where there was an absence of psychosocial resources and this was synonymous with an increase risk of mental health difficulties (Lowe et al., 2015). Siriwardhana, Ali, Roberts and Stewart (2014) in their study of adult forced migrants, examined the undermining factors to resiliency that include daily stressors, breakdown of family, poor living conditions, lack of supportive social or cultural networks, perceived status and acculturation. The interdependent dynamic associations between resilience and mental health are

contextualised within a framework of supportive environments, which have sufficient resources that aid individuals or communities to overcome adversity (Siriwardhana et al., 2014). The study highlights the dynamic, multi-level, multi-contextual nature of resilience, which follows individual and community trajectories (Siriwardhana et al., 2014).

This approach considers the idea that resilience can be examined as a systems phenomenon, with a persons resilience system being relatively stable over time, able to maintain its key characteristics and be resistant towards external factors (Reyes & Constantino, 2016). Siriwardhana et al. (2014) differentiate between community coping strategies with the ability of a community to be supportive and individual's abilities and personal qualities and strengths. They find that there is a dynamic multi-level, multi contextual nature of resilience that has individual and community trajectories (Siriwardhana et al., 2014).

Reyes and Constantino (2016) discuss the development of resilience through several episodes of stressful events and conceptualize resilience as a coping strategy. The transmission of resilience is seen to occur through observation of adults coping with stressors, by children who then go on to have a coping repertoire which helps them deal with stressors in their futures; thus creating resilience as an enduring phenomenon (Reyes & Constantino, 2016). Sharma et al. (2017) recommend a socio-ecological model of coping that encompasses factors that promote resilience across the nested social ecological levels of the: individual; family; community; institutions; and culture.

Discussion of integrative literature review

Adaptive coping skills including reframing, positive comparing and taking positive action were found to be protective (Lowe, Rhodes, & Waters, 2015). Avoidance coping, which is mainly perceived negatively, was found by Sharma et al. (2017) to be potentially effective in reducing anxiety and depression for stressors that are perceived as uncontrollable. The emphasis is then placed on understanding coping as multi-dimensional where different strategies may be more or less effective in different situations. In this way many forms of coping can be understood as adaptational, the complexity reflecting the complex world in which coping occurs (Crittenden, 2008). Recognising each coping response as being individual to the stressor and the individual who is appraising the stressor, brings to the fore the need to respect and also treat with compassion individual coping choices.

The conceptualization of resilience by Reyes and Constantino (2016) as a coping strategy is really interesting as most authors seem to place it the other way round, that is coping as part of resilience. When looking at definitions of coping and resilience it is clear that they are intrinsically linked and may be viewed legitimately from both sides. That is, coping forms part of resilience and resilience supports coping. Resilience is described as a concept that has evolved through the literature, which is used across disciplines (Earvolino-Ramirez, 2007), and the definition included in the Oxford Essential English Dictionary (2011) includes a person being "able to recover quickly from difficult circumstances" (p.496). Rutter (1999) describes resilience as the ability to overcome risk or substantial adversity.

Coping can be defined as "managing or dealing with something successfully" (Oxford Essential English Dictionary, 2011, p.133), but has developed within mental health care provision to involve a set of cognitive and affective responses to stress and

adversity (Linehan, 2015). It may be considered that coping may include responses that would not necessarily be envisaged in the understanding of resilience, for example mal-adaptive coping strategies such as self-harm or substance abuse. In this way effective coping can be viewed as an expression of resilience, but mal-adaptive coping may not.

However Crittenden (2008) in her Dynamic Maturational Model (DMM) model which works on the understanding that all behaviour is there for a reason, proposes that trauma may result in behaviour that is not well adapted to the present. The DMM creates an understanding of mal-adaptive coping strategies, which may be put in place as part of the human adaptation and survival drive and can be difficult to understand from the perspective of coping. It is a reminder to us as practitioners of the danger of judging mechanisms for coping that we can come across in our work with patients and clients.

It is nonetheless legitimate to assess coping effectiveness and ineffectiveness, and stability; however Lazarus & Folkman (1984) point out that it is questionable whether most people always know what they are doing to cope and what their coping strategies are. The capacity of humans to self-medicate unbearable pain with a wide variety of things is apparent: from things that can create an endorphin high including shopping, gambling, phone addictions; and things that create adrenaline highs such as extreme exercise or thrill seeking activities (Burgo, 2012).

Yanes et al. (2017) discern that coping mediates the relationship between appraisal and adaptation with higher levels of coping having the potential to reduce perceived threat. Appraisal of stressors in these papers is consistently of stressful circumstances, which include harm/loss threat and challenge (Lazarus & Folkman, 1984). In terms of stress and coping, many of these studies present extreme

situational coping, Hurricane Katrina, war affected youth, forced migration and so on. It is clear that stressors may be extreme such as Hurricane Katrina or war, but how we perceive them is down to our appraisal of them.

In terms of motherhood, an individual woman's experience of pregnancy and caring for an infant may constitute the most extreme demands on her coping abilities that she has ever faced. Motherhood can be potentially life threatening and the demands of motherhood on physical and emotional resources are recognisably great. The appraisal of potential stressors of motherhood in this way can be argued to be the same as the more extreme situational stressors for individual mothers. The demands that motherhood places on women may never have been experienced before. There is an expectation on mothers to cope, which may be experienced differently by women in positive or negative ways. However the sense of responsibility that occurs in parenthood was found to be enabling for parents by Van der Ende et al. (2015), where dedication to the parenting role provided a focus.

This review highlights the multi dimension understanding of coping and resilience. The socio-ecological model of coping cited by Sharma et al. (2017) resembles Bronfenbrenner's (1979) Matryoshka dolls, which see the individual as encased within many layers of involvement and interactions like a Russian Doll. The individual is encased by: microsystems of settings in which the individual directly interacts, family, school, neighbourhood; exosystem of family friends, work, local industry; and macrosystem of social cultural and historical influences (Bronfenbrenner, 1979). In Bronfenbrenner's (1979) model there is also a mesosystem, which encompasses how all the systems relate to each other. Coping is not something that the individual does alone without influence from all that is around them. An individual is born into a social world of family, peers, and even TV

can play a role in the socialization process and the internalisation of the social world in the development of the personality and of coping skills (Lazarus & Folkman, 1984).

The importance of a life course perspective (Cherewick et al., 2015; Light et al., 2019; Lowe et al., 2015) is critically significant for practitioners working with mothers with mental health difficulties. The personal experiences of supportive relationships plainly affect the ability of individuals to perceive support offered as constructive or helpful. The worse a person may feel the harder it may be to support them when they have negative associations with supportive relationships. This is challenging for health and social care practice, good intentions may be counter productive and distinct individual differences need to be acknowledged for support offered to be accepted as supportive and helpful.

The potential for parenthood to bring with it strength, skills and social resources (Van der Ende et al, 2015) however may be encouraging for practitioners, the understanding of parenthood as enabling particularly in terms of mental health and recovery is significant. When working with parents it is valuable to remember the truly helpful motivations that parents have, to provide the best possible care for their children that they can. Additionally the sense of normality that children are able to provide, together with the opportunity for loving and meaningful relationships can give meaning and focus outside mental illness (Dolman, Jones & Howard, 2013).

Strengths and limitations of the integrative literature review

The inclusion in this review of studies of diverse design means that integrative interpretation is potentially problematic and it is not possible to present results that can be generalised. However the phenomenon of coping in many of its forms are presented by these studies, which show a snap shot of the available research base

on coping as a phenomenon and mental health. The inability to separate the concepts of coping and resilience at times within the research has been challenging, but it is hoped that the value of the insights from the literature outweighs the problematic linguistic difficulties.

Conclusions of integrative literature review

This structured integrative review of the available literature aims to demonstrate how the research study presented in this thesis is contextualised within the existent literature on 'coping' as a phenomenon. The aim and purpose of this research study is to explore *what can women's lives tell us about surviving adversity and developing coping mechanisms, with particular reference to mental illness and being a mother*. The research question and sub-questions will focus the inquiry into the phenomenon of 'coping'. The literature is drawn upon in a continuous process throughout the research process, this chapter has described the formal literature searches that took place which aimed to identify key issues that could be critically examined to support the research process and establish a theoretical base from the existing literature.

The literature review question was- *What is the available literature on mother's coping mechanisms in the face of mental illness?* Coping was shown to have been studied predominantly within the context of challenge and trauma situations, including natural disasters, war and migrancy. The prevalence of studies that are situationally specific and culturally based was able to indicate a gap in the literature. The onset of the Covid-19 pandemic has emphasised the realisation that extraordinary things happen to ordinary people. There is a recognition that stress in life is inevitable and causes a physiological response: however it is coping, which makes the difference to adaptational outcome (Lazarus & Folkman, 1984). The apparent lack of literature on mothers and mental health and how they cope on an

everyday basis, the coping strategies they use and what makes them feel supported, substantiates the need for further research in this area.

In terms of methodology, many of the existing studies were found to be predominantly focused on the use questionnaires and validated assessment measures to gather data. It was identified that there was a place for in depth interviews, which could think outside of the box and explore mother's every day experiences. The use of a qualitative approach of Interpretative Phenomenological Analysis (IPA) was identified as an instrumental approach to the examination of the detailed responses of the mother's interviews.

Gadamer (1960,1998) explains that the real power of hermeneutic thought is the ability to see what is questionable. The use of in-depth questions to explore the phenomenon of coping in mother's who have experience of mental health difficulties is hoped to be able to elicit detailed responses about the lived experiences of these mothers in their every day lives. New born infants are not passive recipients of stimuli, but highly sophisticated and complex beings (Hawthorne, 2018); the examination and discussion of the phenomenon of coping within the maternal/infant dyad, is hoped to contribute to the understanding of bi-directional coping in mothers and infants.

This chapter presented the literature review, which lays the foundations for beginning theoretical discussions and identifies where the research proposal fits in with and extends the existing literature. The lack of available literature on mothers and mental health and how they cope on an everyday basis, the coping strategies they use and

what makes them feel supported, was able to substantiate the need for further research in this area. The review of the relevant literature was also able to inform the methodological choices for this study. In the next chapter the methodological considerations for this study are outlined and the justification for the choice of research methods are described.

Chapter four: Methodology

"We can only be sure that it is always the human being who interprets, that is, gives meaning to a fact" (Jung, 1933, 2017, p.74).

This chapter aims to outline the philosophical and theoretical underpinnings of Interpretative Phenomenological Analysis (IPA) and feminist methodology that contextualize this research. The methodological considerations and justification for the choice of research methods for this study are considered. Methodology describes the particular philosophical traditions, which guide the methods chosen to carry out the study (Bazeley, 2013). The philosophical and theoretical underwriting or methodologies provide the justification for using a particular method (Wilson, 2019). The philosophical stance and beliefs of the researcher which shape the conceptions of legitimate research evidence, require awareness of the tacit theory guiding the conduct of the researcher, in this way making the tacit explicit (Wilson, 2019). The specific methods employed will be detailed in Chapter five which explains the applied aspects of the study in relation to IPA's theoretical methodology. Details of ethical and governance processes, sampling strategy, the development of the interview schedule, and the process of data analysis using IPA specifically are considered in Chapter six.

Choosing a methodology

IPA was chosen as the planned approach for this research study because it is an approach which could facilitate the examination of qualitative narratives of women's experiences of coping within their lives and their descriptions of motherhood and mental health difficulties. IPA is an established method within the disciplines of health and social psychology, which requires detailed, rigourous and systematic engagement

with transcripts of interviews (Flowers et al., 2011). It is an approach that is able to use naturalistic verbal reports from semi-structured interviews to create interview transcripts on which textual analysis can be conducted. A full consideration of the theoretical aspects of IPA is considered further on in this chapter.

Grounded Theory (GT) was also considered as a methodology as it is able to examine participant's experience, guiding the collection and analysis of qualitative data using comparative methods and involving the researcher with the emerging analysis (Charmaz, 2014). GT uses comparative analysis to generate theory from the data, which is not aimed at providing perfect description, but is viewed as a developing entity that can develop theory that can account for relevant behaviour (Glaser & Strauss, 2008). GT attempts to move away from the analysis of themes and structure to focus on action and process and the development of theory construction; allowing the research participants to define the main concepts about a topic based on their lived experience (Charmaz, 2014).

Grounded theories are perceived to be relevant if they emerge from the participants experience and can be explanatory, predictive and able to be interpreted (Brown, 2012). It is a requirement of GT to have: fit; relevance; be generated systematically from the data; and be modifiable in light of emerging data (Glaser, 1978). However it was excluded as a methodology principally because the research participants define the main concepts from which theory is generated whereas IPA facilitated the inclusion of theoretical and conceptual frameworks, which in the case of the phenomenon of 'coping' were felt to be relevant.

Other qualitative approaches such as narrative and thematic analysis could also have been considered, however IPA was examined and found to be a good methodological fit for the research question and was felt to be able to incorporate the needs of the

participants into the research design and embrace the interpretative stance of the researcher.

Theoretical foundations of Interpretative Phenomenological Analysis

IPA has an intellectual history of phenomenology, hermeneutics and ideography (Smith et al., 2012). These philosophical foundations guide its use, creating a layered approach, the central focus of which is the detailed examination of the lived experiences of the persons under study (Kirn, Huff, Godwin, Ross, & Cass, 2019). Developing an understanding of the intellectual history of IPA was important in the development of the research proposal, so that the philosophical understanding and theoretical ideas could be respected and reflected in the research design.

IPA research prioritises the participant's view, appraising the participant as the expert on their story and exploring the meaning making processes of individuals by examining the language and emotions surrounding the individual participant's experiences (Clifford, Craig, & McCourt, 2018). It is essentially a bottom up approach, which explores the meaning of specific experiences to specific people (Clifford et al., 2018). The approach has grown to be used across the fields of psychology, humanities, sports science and organisational studies (Smith & Eatough, 2006, 2018). IPA involves the collection of participant's stories of their lived experiences: Jung (1933, 2017) explains that, "speech is a storehouse of images founded on experience" (p.102). Smith (2018) affirms that IPA has a role in getting close to the personal experiences of elusive phenomena.

Phenomenology

Phenomenology is “the science of the being of beings” (Heidegger, 1953, 2010, p. 35). It is one of the major philosophical underpinnings of IPA, described as a “philosophical approach to the study of experience” that aims to examine and comprehend lived experience (Smith et al., 2012, p. 12). Carmen (2014) explains it as attempting to describe the basic structures of human experience from a first person viewpoint. Within phenomenology, the phenomenon of interest is required to be considered from all angles, viewing the variations thought of imaginatively whilst maintaining alertness for commonality (Rennie, 1999).

Phenomenology attempts to found a conceptual apparatus based on lived experience, it uses a first person perspective in contrast to the more usual third person perspective in empirical science (Svenaeus, 2010). The researcher is engaged in a process of discovery of detailed experiences that are salient to both the researcher and the participant (Kirn et al., 2019). Husserl one of the founders of phenomenological inquiry considered that the essential features of an experience could transcend the particular and illuminate the experience for others (Smith et al., 2022).

Heidegger, a student of Husserl, influenced the development of phenomenology by the development of the concept of a person ‘being in’ the world within their own context of time, relationships, location and engagement with the world (Smith et al., 2012). A perceptual phenomenon is dependent upon the perceiver’s location, context, angle of perception and mental orientation or intentionality, their desires, judgments, emotions, aims and purposes (Willig, 2013). Each persons way of ‘being in the world’ having a uniqueness that is at the same time framed within the universal nature of human existence (Boden, Larkin, & Iyer, 2018). Heidegger (1953, 2010)

explains the term ‘phenomenon’ as meaning “something that can be encountered” or in a direct translation from the Greek “to show itself” (p. 27). The phenomenon of ‘coping’ can be viewed in this way as something that can be encountered and that shows itself through women’s lives.

Heidegger’s *Being and Time* was published in 1927 and was immediately recognised as an intellectual event of consequence (Schmidt, 2010). The text was never fully completed which is understandable within the philosophical concepts of Heidegger himself that our thinking and our understanding are never static but always moving and changing (Schmidt, 2010). Heidegger’s *Being and Time* often revisits earlier analyses with regard to their conclusions and how this may effect current thinking (Schmidt, 2010). Heidegger speaks of our forgetfulness which often unnoticed by us involves us in opening up and enables us to ask the questions (Schmidt, 2010): this appears to be of great importance in the quest for understanding and knowledge.

In *Being and Time* Heidegger develops concepts surrounding ‘being’, formulating the term ‘Dasein’ to incorporate our understanding of our ‘being in the world’ in terms of our constant relatedness to other things that exist; that we can not be other than nothing without engagement with the world around us (Heidegger, 1953, 2010). We discover as human beings our “thatness” and “whatness”, our “characteristics of being”; the way in which we interact with the world reflects back our understanding of the world around us (Heidegger, 1953, 2010, p.13).

Phenomenology developed within the psychoanalytic tradition, Adler (1927,2010) describes explaining the phenomenon teleologically, that is in terms of purpose rather than just the cause and also contextually, as in the environment around the person. This will enable analysis of the phenomenon within the complex, nested relational, social and political environments, effectively utilising Bronfenbrenner’s

(1979) model of social ecology. Heidegger (1953, 2010, p.17) explains the many ways which we can use to interpret the world such as philosophy, psychology, ethics, politics, history, poetry: but only when considered in light of 'Dasein' can we receive their existential justification, dasein being the site of the understanding of being.

The concept of phenomenon is attributed to the Greek expression "to show itself", this Heidegger (1953, 2010, p.27) recognises as linked to its meaning and something that can be encountered. However Heidegger also implies that a phenomenon may not show itself and may be covered up or not apparent in some way, and this of course links us to the application of research. Laverty (2003) describes Husserl's description of the 'life world' as a pre-reflective experience, which appears and can be studied through consciousness.

Husserl, 1927, cited in Smith et al. (2012) requires a reflexive response that examines perceptions, in a consciousness that 'brackets' the taken for granted preconceptions. The ability to get beyond preconceptions requires an awareness of such influences of natural assumptions and expectations on perception (Rennie, 1999). Husserl (1931,2012) emphasises the importance of being aware of our unconscious 'judgments' and to put them out of action by bracketing them (p.58). He developed a method of phenomenology which requires the researcher to 'bracket' (as in mathematical equations), preconceptions and 'taken for granted attitudes', in order to focus on the participants intentionality (Smith et al., 2012).

This is important when considering reliability and validity as the process of bracketing involves the researchers intentionality to focus on the participant experience and is central to the rigour of phenomenological studies (Laverty, 2003). This concept is important as the study aims to be non-judgmental and not to hold pre-conceptions about how women experience 'coping' in their lives. Husserl (1931,2012) discusses

‘doubt’ as an important tenet of the researchers mindset, putting out of action our natural standpoint or views to open ourselves up as researchers to new possibilities of understanding (p.57).

Hermeneutics

The second major theoretical concept in IPA is the hermeneutic theory of interpretation and the hermeneutic circle. Bowie (1998) describes Hermeneutics as the “art of Interpretation” which was founded by German theologian and philosopher Fredrich Schleiermacher, who saw it in terms of philosophical understandings of language and epistemology (the theory of knowledge) (p. vii). Schleiermacher (1838,1998) himself describes the “art of understanding”, but differentiates the “art of the presentation of understanding” (p. 5). There are general principles of understanding correctly what another person says and then presenting this correctly in a way that communicates this to another person (Schleiermacher, 1838,1998). Our ways of processing what happens in our lives are complex and dynamic, ever changing in the search for mutual meaning (Larkin, Shaw & Flowers, 2018).

Schleiermacher (1838,1998) encourages a consciousness that embraces both objectivity and subjectivity; he did not exclude the use of intuition, empathetic identification with the author of the text, but advocates that there is a need to be aware when each is in play. The hermeneutic process encourages the researchers attention and openness to the lived experiences of participants whilst engaging with the broader significance of the phenomenon being studied (Kirn et al., 2019). The language we use can represent our thoughts, but relies on the listener’s attunement to correctly interpret the schematization or mental representation and accurately understand the definitions of specific language used (Schleiermacher, 1838,1998). Within phenomenology it is important not to avoid metaphor because of their

subjectivity, but look for the bottom ground, base line meanings upheld in the narrative (Svenaeus, 2010).

Larkin, Shaw and Flowers (2018) describe hermeneutic phenomenology as concerned with three aspects, which are intersubjective in perspective: firstly what happens in between persons and other persons; secondly what happens between persons and objects; and thirdly what happens between persons and cultures. The hermeneutic circle involves dynamic, nonlinear thinking that is able to operate at different levels of 'the part' and 'the whole', for example looking at the use of a word, or looking at a sentence, or looking at a whole text to discover meaning (Smith et al., 2012). Gadamer (2004) states that "language is our fundamental mode of operation of our being-in-the-world" (p.147). This concept prioritises our meaning making and focus on qualitative exploration of expression through language. Dahlberg, Dahlberg and Nystrom (2010) explain that when analysing a text for meaning "each part is understood in terms of the whole, but also that the whole is understood in terms of its parts" (p. 236).

The examination of text for meaning may be entered in to at many different levels, these will be related to one another but also be able to provide differing perspectives on the text as a whole entity (Smith et al., 2012). Smith et al. (2012) emphasise that the nature of the hermeneutic circle within IPA is 'iterative', in that it is not sequential or linear but is able to shift backward and forwards through the data analytically evolving within the process. Laverty (2003) cites Gadamer's (1960, 1998) understanding of hermeneutics as a co-creation that happens between the researcher and the participant, through a process of reading, reflexive writing and interpretation. This double hermeneutic, conceptualizes the meaning making of the participant, and also the meaning making of the researcher (Smith, 2018).

Jung (1933, 2017) explains, “we can only be sure that it is always the human being who interprets, that is, gives meaning to a fact” (p.74). Willig (2013) describes Heidegger’s (1953, 2010) hermeneutic understanding, which embraces the researchers interpretation, awareness and analysis, as an integral part of phenomenological analysis. The insights generated are a product of the relationship and interaction between the researcher and the data; this does not imply bias but accepts that knowledge is only possible through the interaction (Willig, 2013).

Ideography

Ideography is concerned with the detail and depth of the data analysis, how a particular experience is understood by particular people, within a particular context (Smith et al., 2012). The term comes from the Greek word *idios* meaning “one’s own, personal, individual” (Greek-English Dictionary of the New Testament, 1993, p.85). The meaning in terms of phenomenology is not the scientific cause or effect, but rather its meaning in the way it makes sense to the individual (Svenaeus, 2010). The experiential phenomena of an event, process or relationship, for example, focuses on the individual’s unique perspective and allows the researcher to concentrate on single case analysis or small numbers of participants within research (Bryman, 2012; Smith et al., 2012).

Merleau-Ponty (1945, 2014) introduced the differentiation of the things of which we are aware and the contents of our consciousness about them. This can also be described as the difference between situated knowledge and interpretative knowledge (Smith et al., 2012). Merleau-Ponty (1945,2014) argues that we can be open to a phenomenon that only exists to the extent that we take it within our lived experience (p. 381).

Svenaeus, (2010) explains that Husserl (1931,2012) pointed to the relationship between the subject or 'person' and the 'object' or what is happening, and termed it intentionality. The search for meaning and understanding requires thinking and watching from a perspective of phenomenological attitude, which searches for meaning of the experience of the individual (Svenaeus, 2010). The idiographic perspective is in contrast with the nomothetic generalist approach which aims to be able to draw conclusions which are more universal and can be open to statistical analysis (Kirn et al., 2019).

Smith (2018) describes the experience of the participant who reflecting on what has happened, attempts to make sense of its meaning leading to thought processes that are emotionally laden. The use of participant quotes in the presentation of results can demonstrate the ideographic analysis of data; it is important that the quotes are meaningful and accurately represent the participant's experiences (Farr & Nizza, 2018). Smith (2018) describes three levels of meaning: a literal linguistic meaning; the actual meaning within its own context; and the experiential meaning, in terms of identity, purpose or significance. It is this third level, which is in nature existential that Smith (2018) argues is the core of IPA: this experiential level involves building on the other pragmatic levels of meaning to achieve understandings of experiential significance.

Feminist research philosophy

This thesis also considers a feminist research approach. Feminist research is an interdisciplinary area of study, which spans a range of theoretical frameworks and espouses the value of reflexivity and power sharing in research practice (Leavy & Harris, 2019). Reflexivity can address how power comes to bear on the research

process and reminds the researcher to be mindful of any imbalances, focusing an importance on the way we discover something and not just the content of the data, therefore prioritising ethical considerations (Leavy & Harris, 2019). Clifford et al. (2018) describe the feminist perspective as one which incorporates a recognition of diversity and focuses on empowerment of women.

It was the intention that this perspective would help guide the development of this research study that is with women, by bringing these challenges into focus and prioritising their consideration. By the linking of the research with the wider literature on what it is like to be a mother and women's experiences of mothering and mental ill-health, it is hoped to provide an environmental perspective within the literature that is listening to women's experiences. By using a feminist lens we can celebrate unique contributions from women, about women, that can potentially benefit women and also parents as a whole.

Health and illness is a place in which feminist research philosophy has a role, challenging the construction of women as passive participants in research (McNeil & Roberts, 2013). Developing insights from the study of people's experiences has become a foundation epistemology for research into specific gender studies, especially those of marginalised groups (Cerwonka, 2013). There is an imperative not to do "violence to another" especially marginalised groups by speaking for them (Cerwonka, 2013, p.64). The fit with IPA methodology is demonstrated in the use of verbatim quotes from participants that aim to truthfully represent and honour their contributions to knowledge formation and do not reduce individual participant's experience to perspective only.

There is a reflexive requirement in feminist methodology which introduces the recognition that the cultural beliefs and behaviours of feminist researchers shape the results of their analysis and are part of the empirical evidence that needs to be considered when evaluating a study (Harding, 1997). Reflexivity is described as a strategy for exploring the relationship between the researchers preconceptions and experiences and the process of coming to understand the experiences of the participants (Smith et al., 2022). It can also be understood within the context of IPA, as a co-production of knowledge or as part of the shared horizons in hermeneutic interpretation (Clark, 2008).

Belenky, Clinchy, Goldberger and Tarule (1997) describe women's ways of knowing through the concepts of: silence; received knowledge; subjective knowledge; procedural knowledge; and constructed knowledge. The Belenky et al. (1997) model of *Women's ways of knowing* will be used within the research process as a reflective tool for the researcher. This research study aims to give women a voice to tell their stories about what they have learned from experiences of motherhood, mental ill-health and adversity, and how this has created knowledge of coping as a phenomenon.

This chapter has outlined the philosophical perspectives of IPA including phenomenology, hermeneutics and ideography. The understanding of lived experience involves an unfurling of perspectives and meanings (Smith et al.2022). The methodology of IPA was chosen as it is an established method within the disciplines of health and social psychology, which requires detailed, rigourous and systematic engagement with transcripts of interviews (Flowers et al., 2011). IPA

interpretation in this research study is conveyed through descriptive narrative reports of the participant's experiences, understandings, and perceptions of the phenomenon of coping.

The study approach holds a theoretical commitment to the importance of language as a fundamental component of human interaction; the ability of humans to encompass the need to make sense of the world through communication, interpretation and understanding (Smith, 2015). The feminist lens was felt to be an important component to ensure that the female participant's perspectives are honored and protected and that women's voices can be heard. Respecting each person's way of 'being in the world', which has a uniqueness, but is at the same time framed within the universal nature of human existence (Boden et al., 2018).

Creating a theoretical understanding of the philosophy that underpins the research methodology was an important initial step in the research process. This together with the theoretical framework from the review of the existing literature, formed the conceptual framework and the foundation stones for the research proposal. The next steps involved the practical application of theoretical considerations through the specific research study design including: the ethical governance application processes; the design of the recruitment processes; and the development of the interview schedule.

Chapter five: Methods

"Just as one cannot find two leaves of a tree that are absolutely identical, one cannot find two human beings who are absolutely alike" (Adler, 1927,1997, p.48).

This chapter details the specific methods used for the study. Methods are the research tools that are used within the methodological approach of the study, including the data collection strategies, the development of an interview schedule and the application for ethical governance approval (Gabriel, 2011). The relationships between the methodology and the specific methods employed in the research design are critical to the integrity of the study, there is required to be a fit within the two dimensions which is able to support the central issues in the study (Clough & Nut-brown, 2012). Data collection strategies are subject to ethical accountability; this chapter describes the data collection from both practical and theoretical perspectives and from ethical perspectives, detailing the ethical considerations that needed to be put before the University Governance Body.

Study design

A qualitative approach was taken because of the desire to obtain an accurate picture of the experiential world of the participant in relation to coping as a phenomenon. Qualitative research can enable the participant's voice to be heard, in a way that is essentially a bottom-up approach led by the participant (Willig, 2013). The specific phenomenological research approach assumes that there is more than one world that can be discovered from the experience of individuals (Willig, 2013). Interpretative Phenomenological Analysis (IPA) was chosen because it is an approach that is committed to the examination of how people make sense of their experiences and has

a detailed theoretical framework and experiential knowledge that could support the research study.

This study utilised semi-structured interviews to facilitate the collection of women's spoken lived experience using an interview guide developed from the literature review process. Interviews are a method of data collection, which use people's answers in contrast to observational methods of what people do, as the data source (Denscombe, 2017). IPA aims to focus on people's experiences and understandings and data collection seeks to elicit detailed accounts; within IPA semi-structured one to one interviews are viewed as the method of choice (Smith et al. 2022). Semi-structured interviews can be approached flexibly, responding to the direction that the participants take the interview and perhaps adjusting the emphasis (Bryman, 2012). The interview questions are carefully developed to provide the participant with focus to tell her story and to support the researcher by the ability to guide the participant towards relevance and meaning (Dibley, Dickerson, Duffy, & Vandermause, 2020).

Having awareness of the potential benefits and difficulties of interviews can help the researcher navigate the process. Denscombe (2017) finds that advantages include: access to detail, depth and insight of the participants; a flexibility of application; and the potential for the experience to be rewarding for the participants. The use of semi-structured interviews within the study was felt to be appropriate to the philosophical approach. Interviews are a form of discourse and important in terms of a way of gaining understanding. Heidegger (1953,2010) describes discourse as "existentially equiprimordial with attunement and understanding", existing together as equally fundamental (p.155). Interviews are one of the most widely used methods in qualitative research, and have become prominent in feminist research frameworks (Bryman, 2012). Feminist frameworks advocate a high level of rapport between the

interviewer and the interviewee, a high degree of reciprocity on the part of the interviewer, a respect for the perspective of the women being interviewed and the intent to aim for a non-hierarchical relationship (Bryman, 2012). The use of semi-structured interviews was felt to be a good fit methodologically in this way, with the needs of the participants and the aims of the study.

Potential disadvantages of interviews can include the high requirement of time and resources; the potential for a dichotomy between what is said and what is done; and difficulties achieving consistency within the interview process (Denscombe, 2017). Holding the potential pitfalls in mind enables the planning of the study methods to be cognisant of avoiding them. The time and resources requirements were factored into the planning time scales and resource availability. The potential for dichotomy between what was said and what was done in participant's lives was viewed pragmatically and considered in the study strengths and weaknesses evaluation. Within interview research the researcher aims to become steeped in the recorded and transcribed words of the participants, so as to be drawn closer to their frames of mind (Belenky et al., 1997). Consistency was felt to be able to be supported by having the same researcher carry out all of the interviews using an interview guide to standardise the asking of specific questions and by having the same researcher carry out the verbatim transcriptions of all of the interviews.

Ethical and research governance approval

Obtaining data is not a neutral activity; cultural sensitivity, appropriateness and power issues need consideration with the intention of honoring the participants and the efficacy of the research itself (Bazeley, 2013). To gain insight into a phenomenon such as coping, it is necessary to have human participant's individual accounts of lived

experiences. From a scientific perspective, a research proposal needs to consider questions of: why the research is being done; what new knowledge is to be gained; how the proposal is respectful of human dignity and integrity; and how research credibility and trustworthiness is to be addressed (Dibley et al., 2020).

Independent ethical approval was sought and granted from the university governance body, the Research Ethics Committee, College of Human and Health Science, Swansea University on 25/08/2019, Reference Number 150719. The application for ethical approval was a thought provoking process, the initial application required 25 additional points to be addressed, there was an attention to detail that was supportive to the research process and protective of the participants and the researcher. The process was experienced as challenging but important in building researcher confidence in the robustness of the research proposal. It was a significant part of the preparation of the research proposal, which facilitated the proposal to become an actuality.

Brinkmann & Kvale (2015) detail questions that the researcher needs to ask prior to the start of an interview study including what are the consequences for participants, how can informed consent be obtained and how can the study contribute to knowledge. Ethical issues are unable to be ignored as they relate to the integrity and validity of the research itself (Bryman, 2012). Multiple considerations are necessary for the application for ethical approval. Brinkmann & Kvale (2015) emphasise the craftsmanship of qualitative research and view the moral conduct as closely linked to the situated judgments of the researcher. The research interviewer needs to comprehend the powers and vulnerabilities that are present (Brinkmann & Kvale, 2015). People with mental ill-health would be considered vulnerable; there is a tension between exerting absolute respectfulness of the person and obtaining worthwhile

empirical material that has value and can contribute knowledge to practice (Brinkmann & Kvale, 2015).

In preparation for the process of obtaining informed consent, which is based on individual autonomy, participants were informed by a participant information sheet (see appendix b.) of the nature of the research: how they were selected; who was undertaking the study; how long it would take; of their ability to withdraw at any time during the study; of plans for dissemination; and any potential risks to participants such as psychological or emotional distress resulting from disclosure of personal information (Moule & Hek, 2011).

It was proposed to share examples of the questions in the interview schedule with participants at the initial stages to ensure that they were able to fully consent and were able to prepare for the interviews: it was hoped that this would add to the quality of the data as the participants had the opportunity to think about what they would like to talk about. The Patient Experience and Evaluation in Research group (PEER) who met monthly to look at research proposals and give a participant perspective, recommended only sharing examples of the questions that are included in the interview schedule, as to share the interview schedule in its entirety might be rather overwhelming for some participants. However sharing examples of questions with participants prior to consent is considered to contribute to having an open shared agenda, which demonstrates commitment towards leveling the power playing field between researcher and participant, in line with feminist research philosophy (Leavy & Harris, 2019).

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision, all adults are presumed to have sufficient capacity, unless there's significant evidence to suggest otherwise

(NHS Assessing Capacity, 2019). Even in the case of a severe mental health condition, such as schizophrenia, bipolar disorder or dementia, a person may lack the capacity to consent under the Mental Health Act 1983, however may still consent for unrelated matters if the other conditions apply, specifically that it is voluntary, informed and the person is able to understand the information on which the decision is based (NHS Assessing Capacity, 2019). When submitting to the Research Committee, College of Human Health Science, Swansea University, it was necessary to provide additional information as to participant's mental capacity.

Mental capacity is defined as the ability to make a decision (Mental Capacity Act, 2005). Decision making is the ability to understand relevant information and to appreciate the reasonably foreseeable consequences of a decision (Etchells et. al., 1999). Capacity is decision and time specific, the question must be asked each time "what is the specific decision that needs to be made at this point in time" (Etchells et. al., 1999). The presumption that a person has capacity is fundamental to the Act, the person has to prove nothing; the burden of proving a lack of capacity lies with the person who considers it necessary to take a decision on the person's behalf, or will invite a court to take such a decision (Community Care, 2019). There are two stages to assessing capacity, asking the following questions –

Stage 1

- Is there an impairment or disturbance in the functioning of the mind or brain of the person, permanent or temporary?

If the answer is yes then stage two is completed.

Stage 2.

- Is the person able to understand the information relevant to the decision?

- Is the person able to retain the information long enough to make a decision?

- Does the person have the ability to weigh the information as part of the decision making process?

- Is the person able to communicate their decision?

(Community Care, 2019, Five key steps for Assessing Capacity).

It was not considered appropriate to conduct a formal capacity assessment as part of this study as the Mental Capacity Act 2005 clearly states that a person must be assumed to have capacity unless it is established that they do not, a person is **not** to be treated as unable to make a decision unless all practicable steps have been taken without success to aid capacity. However it was recognised that the study was recruiting a potentially vulnerable subject group.

Some advice on identifying risks to capacity include the use of red flags for example-

- Memory loss
- Disorientation about simple concepts for example time or place
- Drastic mood swings
- Difficulty with abstract thinking
- Poor judgement, irrational behaviour
- Lack of awareness of risks to self or others

Sweatman, J. (2011). Red flags for Incapacity.

The use of open-ended questions, rather than questions that can be answered 'yes' or 'no' or 'I understand' can be an effective way to ensure understanding when concerns arise as to capacity (Sweatman, 2011). The researcher was aware of the need to be observant for risks to capacity and intended to encourage participants to seek support from their own GP or support agencies listed in the participant information (see appendix b.), if any of the red flag signs were observed, however in the event this did not transpire. The researcher was also aware of the responsibility to ensure that the participants had been able to read the participant information, ask relevant questions to facilitate understanding, were able to reasonably confirm that they have understood the implications and give voluntary informed consent by the use of a written consent form (see Appendix d.).

The researcher was cognisant of the need to be conscious that the openness and intimacy of research interviews could lead to participants disclosing information that they could later regret sharing, and the need to be aware that when working with vulnerable people to maintain respect for the unexpected (Brinkmann & Kvale, 2015). Josselson (2013) recommends that from an ethical standpoint, informed consent also requires asking the participants at the end of the interview, whether they are happy to give consent for what they have disclosed, to be used in the study. This study intended to uphold this principle and was in the event able to do so.

It was hoped that any distress could be minimised by the salutogenic focus on factors that support well-being, IPA interviews are intended to be participant led and conducted with sensitivity and modified according to participant need (Smith et al., 2012). The researcher for this study had experience of discussing issues around mental health and motherhood and was committed to being supportive of women in this position. The role of the researcher is critical to the quality of the quality of the

data, as a person the researcher is required to be knowledgeable, experienced, honest and fair (Brinkmann & Kvale, 2015). Additionally the researcher is required to present findings in a way that accurately represents the lived experience of the individual participants within the specific context, which is related to the phenomenon (Farr & Nizza, 2018).

Brinkmann and Kvale (2015) discuss the ethical issues surrounding the empathetic researcher, warning against being a 'Trojan Horse' by creating rapport to get inside a participant's defenses, but conclude that empathy cannot be dismissed. Empathy holds efficacy by demanding that respect is shown to each participant as another human being. Josselson (2013) states that although we are doing research, we are entering a human relationship and it is important that at the end of the process the participant has a sense of being valued.

Researchers need to be mindful of the 'do no harm principle' and be skilled enough to manage the human interaction, being non-judgmental, giving encouragement, reassurance and empathetic responses without influencing the participant's narrative as independent data (Cerwonka, 2013). Cerwonka (2013) finds that in order not to do violence to another person by speaking for them, it is important that their experiences are not reduced to perspective, but are represented authentically. The voice of women within IPA can be heard through the use of direct quotes, using direct quotes can aid transparency (Moravcsik, 2014). Transparency is required in the processes by which data is collected, validated and analysed to be able to demonstrate that the data analysis is valid (Brinkman & Kvale, 2015).

In a qualitative research interview where the participant's words may be quoted or used in a public way, steps to protect their identity have to be taken (Brinkmann & Kvale, 2015). The confidentiality and anonymity of participants in this study was

maintained by changing personal details such as names and or any identifying factors such as place names. Steps to assure anonymity and protect confidentiality included; keeping transcripts in a locked file without the names of the participants attached, changing proper nouns, names, place names or company names: and at all times holding in mind the potential consequences of publication (Josselson, 2013).

Deontological principles were considered important, in that the 'act' is required to be ethically beneficent. The researcher was aware of the importance of having knowledge and understanding of ethical issues so that when engaging in the research interviews, the ethical needs of participants was able to be considered. The importance of concluding the interview process with the needs of the participant in mind is an ethical consideration. It is sometimes termed as de-briefing the participants and includes the interviewer thanking the interviewees for their contribution. It is important that the participant does not feel that their contribution is judged as good or bad, but can be viewed as valued and enlightening (Josselson, 2013). A participant de-briefing letter was also utilised (see appendix f.) for this aspect, which included written thanks for their participation, a reminder of anonymity precautions and sources of support contact details.

It was also important to acknowledge the potential risk to the researcher. The researcher for this study was able to follow lone researcher policy by always letting someone know where they were going and when to be expected back and actions to be taken if they did not return on time. The researcher had a health professional training and was able to carry a mobile phone and had received specific training in lone working and safe practice. A mobile phone was be used specifically for this research project, which was not a personal phone. In the case that a participant became distressed during the interview, the plan was for the researcher to allow the

participant to pause and recover, and stop the interview if necessary. If assistance was needed the researcher would offer to phone for support to the relevant agency, for example GP or family member, in the event this was not necessary.

The interviews were all arranged to take place at a time and place of the participant's convenience. The interviews were audio recorded and the recordings were transcribed by the researcher, Bryman (2012) estimates five to six hours to transcribe one hour of speech. Following completion of analysis to allow for verification requirements, the recordings were deleted in accordance with the ethics requirements. Post-interview reflections of observations were also taken as a record of researchers appreciation of subtle factors such as perception of atmosphere, how difficult it was for the participant to talk about the subject, environment, and understanding of any contradictory elements in the transcriptions. Post-interview reflexivity can act as part of the ongoing accounting of the role of the researcher in the research process and be a valuable part of reflexivity (Leavy & Harris, 2019).

All confidential data was stored on a secure, password-protected computer, which was only accessible to the researcher. Participant codes were used on transcripts and field notes and the code and any identifier participant information were kept in a separate secure locked cabinet. Data will be preserved for accessibility for ten years after the completion of the research in accordance with Data Protection legislation; date for destruction will be 2032.

Participant sampling strategy

The sampling strategy was based on the research methodological requirements. Purposive sampling was chosen because it can be utilised for obtaining a particular sample that would be difficult to select using other methods (Moule & Hek, 2011). The

use of this non-probability sampling, which uses subjective, non-random criteria, does not allow the researcher to generalise the research findings to the general population, but permits logical inference and development of theories that can be later tested (Bryman, 2012). The use of purposive samples recognises that participants are sought and selected by virtue of their capacity to contribute data that is richly textured and relevant to the phenomenon under investigation and that they are able to provide a perspective on the phenomena being studied (Smith et al., 2012; Vasileiou, Barnett, Thorpe, & Young, 2018).

Researchers seeking a homogenous sample of participants can use defined demographic characteristics to seek out a probable shared perspective on the phenomenon of interest which is of value in applied research (Larkin et al., 2018). Larkin et al. (2018) point out that the aim of idiographic data collection and analysis is to bring understanding to particular experiential perspectives, however this can involve achieving important insights, which may have a more limited capacity to significantly influence within the wider context. They recommend that multi-perspectival dimensions which can demonstrate commitment to presenting important insights from more than one point of view, thus strengthening its representativeness (Larkin et al., 2018).

Within IPA sample size is dependent upon the capability to provide new and textured understanding of the phenomenon, whilst being small enough to permit in-depth case orientated analysis (Sandelowski, 1995). IPA studies are typically conducted with small sample sizes; there is an acceptance that larger findings can produce broader findings, whilst smaller samples can result in deeper findings (Smith et al., 2012; Spiers & Riley, 2018). It is this idiographic focus, which requires the smaller sample sizes (Spiers & Riley, 2018).

An important concern was that the information that was gained in the interview process was representative, whilst also developing a strategy to ensure that the sample was inclusive of the target population (Moses & Knutsen, 2012). The inclusion criteria was debated within the supervisory team and developed to meet the needs of the study.

Inclusion criteria were developed that included-

- Presence of a self reported mental health difficulty including anxiety and depression or self reported mental health diagnosis included in the DSM-5 (American Psychiatric Association, 2013). Diagnosis is not required, the main focus is anticipated to be anxiety and or depression but other diagnoses will be considered
- Have children aged 0-2 years
- Have the ability to communicate in English
- Aged over 18 years old
- Have the ability to give consent

The use of specific criteria in the sampling strategy was undertaken to positively recruit-

- Mothers who have had self-reported mental health difficulties prior to the birth
- Mothers who have had self-reported mental health difficulties following the birth
- Mothers who have had self-reported mental health difficulties following a difficult birth experience

Exclusion criteria

- Major physical health problems that could have a significant impact on mental health in early motherhood that could impact the data, for example a cancer diagnosis
- Any person who indicated that they were posing a severe risk to themselves or others

An age range for the infants of 0-2 years was considered based on the 1001 Critical Days report by Leadson et al. (2013); the report points to the importance of the period from conception to age two for infant development, in terms of the developing brain and the ability of the infant to form secure attachment relationships. The report emphasises the importance of the earliest experiences that shape a baby's brain and have life long impact on mental and emotional health: during the first 1001 days the infant is at risk of setting response base lines at high alert if they experience high levels of fear or tension from maternal stress, parental mental illness, maltreatment or exposure to domestic violence (Leadson et al., 2013).

It was decided to seek participants with and without diagnosis, the mothers would be able to self-report that they had experience of mental health difficulty. Diagnosis would not be able to be verified without NHS ethical approval and seeking participants with and without diagnoses, would immerse the research within the 'lived in' world, where 'being a mother with mental health difficulties' does not occur only in those with a medical diagnosis. Diagnosis is a process from seeking help through to receiving assessment and diagnosis and the decision to use self-reported mental health difficulties places the research within participant's lived experiences, which is phenomenologically appropriate, relating to the awareness of the experience rather than the thing itself.

Additional insights from points of congruence or divergence may be found through these differing perspectives; this is important in applied research, which hopes to contribute to understanding within service provision (Larkin et al., 2018). We all have mental health; it refers to our emotional, psychological and social well-being and affects how we cope, our relationships and our daily functioning (Hampshire CAMHS, 2022). A mental illness or mental health disorder is an illness that affects the way

people think, feel, behave and interact with others that reflects significant distress: the difference between poor mental health or mental health difficulties and a mental illness is generally viewed as one of degree (American Psychiatric Association, 2013; Hampshire CAMHS, 2022).

Recruitment and procedure

A presentation of the research proposal was made prior to recruitment to the Patient Experience and Evaluation in Research group (PEER). The group met monthly to look at research proposals and give a participant perspective. This encourages researchers to consider the question 'What would it be like to take part in your research'. The participant information sheet (see appendix b.) was further developed through the support of this group; it was hoped that this would provide reassurance that the information sheet could convey information in a way that would be informative, understandable and comprehensive to participants, and in a way that would guard against the use of jargon, or technical language.

The PEER group was supportive and engaged with the process, they offered several suggestions regarding recruitment, information sharing, interview schedule content and consent form development. Presenting to the group was a really positive experience and was greatly valued as a supportive perspective on the development of the research proposals. The PEER group recommended the maximum use of positive sampling criteria and the inclusion of this information in the recruitment flyer/letter so that potential participants would understand why they might be recruited or excluded from the study. The recruitment flyer (see appendix k.) was designed in accordance with this.

Participants were also intended to be sought from Voluntary Sector Support Groups, including local baby groups and social media networks. Relevant groups would be identified and the group leader approached to seek consent to present the research proposal to the group. The researcher was to attend the group and briefly explain the study, leaving the study information leaflets behind with full details of what would be involved and how to contact the researcher if necessary. Interested participants could then contact the researcher to arrange a suitable time for the interview. However due to the onset of Covid-19 this did not happen and access to participants was through the use of social media networks alone.

The media networks were utilised through a poster advert using the recruitment flyer (see appendix k.) that was shared on the researchers own personal social media and also the research supervisors' networks. This initial recruitment of participants was based on the simplified criteria of mothers of a child aged under two who had-

- Experience of mental health difficulty prior to becoming pregnant
- Experience of mental health difficulty during pregnancy
- Experience of mental health difficulty following the birth
- Experience of mental health difficulty following a difficult birth

When mothers who were interested in taking part in the research project contacted the researcher, the mothers who met the inclusion criteria were given information about the research through participant information sheets and valid consent was sought (see appendix b. & d.). Mothers who did not meet the criteria were contacted via e-mail to thank them for their interest and explain that the study was unable to include them at this time.

Informed consent required that the participants were given information on the study and had time to read the information and ask relevant questions (Bryman, 2012). Participants needed to know that the study would involve being interviewed and that the interviews would be recorded and transcribed (Bryman, 2012). It also required that participants understood that their words could be quoted in publications, reports and web pages and what measures would be taken to ensure anonymity (Bryman, 2012). Lastly participants needed to be made aware that they were able to withdraw from the study at any time that they wished, without being asked to give a reason why they wished to withdraw (Bryman, 2012). Given the sensitive nature of the interviews, it was proposed that time was given to allow participants to think about taking part, rather than requiring them to 'sign up' on the spot.

Participants were to be excluded from the study for two main reasons. Firstly if they had a major physical health problem, for example a cancer diagnosis, which could influence their ability to consider 'coping' as a phenomenon in terms of mothering and mental ill-health; and secondly if they at any time indicated that they were posing a severe risk to themselves or others. The confidentiality limitation around severe risk was addressed within the participation information (see appendix b.).

It was proposed to offer a shopping voucher to participants to thank them for their time and contribution; the value of this voucher was £15 per interview plus a small gift for the baby. This can be perceived as controversial in that it could be regarded as an incentive, but it was felt to be important to convey to participants that their contribution was appreciated and valued. Incentive payments to finically disadvantaged groups are at risk of being seen as coercive (Researcher Development Initiative, 2019); the value of the shopping voucher and gift was purposively kept small to mitigate this risk to participants. In the event all but one participant accepted the offer of the shopping

voucher and small child's gift of a book and comments were received that it had not been expected but that it was a lovely and welcome surprise.

The second share of the study recruitment flyer specified additional criteria to widen participant diversity and targeted mothers who met the original criteria and plus specifically inviting non breast feeding mothers, unmarried mothers and encouraging ethnic diversity. This share resulted in only one further participant and the subsequent third share of the study information flyer did not stipulate additional criteria.

Development of interview schedule

The interview schedule for the semi-structured interviews (see appendix c.) was developed from the literature review process, by examining qualitative questionnaires for inspiration and example. In particularly a study by the Mental Health Foundation (2011) *Recovery and Resilience: African-Caribbean and South Asian women's narratives of recovering from mental distress*, which used a semi structured interview process with 27 women on a one to one basis was examined. The study was found to be inspirational because it was about survival, it enabled women to tell their stories of recovery and many of the women found the process empowering as the act of telling their stories became part of their sense making. The interview schedule facilitated the women to tell their stories by moving gently from the general to the specific, from the specific to hopes for the future and a gentle closure of the interview.

Within IPA the researcher sets the scene, which enables the participant to talk and give access to the phenomena (Smith, 2019). The interview themes were developed from the literature to include themes around: being a mother; comforting your baby; coping; and what mothers' would like to pass on in terms of coping skills to their children.

The questions were developed around the research question-

What can women's lives tell us about surviving adversity and developing coping mechanisms, with particular reference to mental illness and being a mother?

The incorporation of the sub-questions concepts within the interview schedule was able to refine the inquiry. Smith et al., (2022) explains that sub-questions are not hypothesis, they engage with theory but do not test it: they can only be answered interpretatively and are grounded in the phenomenological account.
The sub-questions were-

- What are the lived experiences of coping for mothers with mental health conditions?
- How are mother's experiences of coping affected by motherhood and mental illness?
- What ways of coping come out of past experiences of coping, where does strength come from?
- What supports coping for mothers with mental health conditions?
- What coping strategies do mothers with mental health conditions want to pass on to their children in terms of being strong and resilient?

It was important to link the questions to the literature and ensure relevance, focusing on the gap that was identified in the literature review.

The interview schedule was further developed by the integration of an IPA approach focusing on open questions, which do not limit experiences to one event. IPA interviews aim to invite participants to offer detailed, first person accounts of their experiences, and aim to enquire about experiences of a personal world (Smith et al., 2012). Interviews are considered to be a complex process for the interviewer because; it requires attentiveness to the process as well as the interview content (Josselson, 2013). IPA requires rich data and it is suggested that participants are

given opportunity to tell their stories freely and reflectively, with opportunity to develop their ideas at length (Smith et al., 2012). Participants may develop their thinking about the phenomenon under investigation during the interview process.

The interview questions are intended to provide the participant with a focus which enables her to tell her story and reflect upon the phenomenon under investigation: this in turn supports the researcher by providing the framework to support facilitate analysis (Kalathil et al., 2011). Josselson (2013) explains in-depth interviews as a special kind of conversation, where content is affected by process and the interviewer has a responsibility to listen carefully and intently to participant's experiences. This respectful listening and sharing of participant knowledge, leads to a feeling of authenticity for participant and researcher alike (Josselson, 2013).

The initial questions were aimed at setting the scene and obtaining background information, the questions then developed to introduce the core elements of the research around being a mother and mental health and coping (see appendix c.). Boden et al. (2018) describe the interview structure as providing 'touchpoints' that help the participant through the interview journey. It was intended that all the questions were to be asked in a similar way in each interview, to allow the researcher to collect data in a comparable way from one participant to another (Bryman, 2012). The process involved asking open questions that allowed the participant to explain their understanding of issues and what they view as important in explaining forms of behaviour with relevance to the phenomenon of coping (Bryman, 2012).

Open ended and non-directive questions are considered to enable participants to share their personal experience of the phenomenon with the researcher, while focused or specific questions are held for picking up what has already been said to provide clarity or elaboration (Willig, 2013). The interview schedule was examined for

'usability' and ethical qualities, for the way that it could enable, help and protect participants from harm: the focus on a salutogenic approach was considered to create a positive environment for participants during their recollections, which would be protective (Antonovsky, 1996).

A further refining of the interview schedule was completed in order to bring the core questions about 'coping' back to the research question. The emphasis in the research question on the development of coping mechanisms from surviving adversity was placed more firmly in the core of the interview schedule. The suggestion by Josselson (2013), which advocates placing a large 'Q' by the conceptual question, to prevent getting lost in the need to investigate the wholeness of the person was employed. To maintain the focus on the particular aspect of participant experience the 'Q' question acts as a road map bringing back the focus to the core question that connects the literature to the research (Josselson, 2013). The 'Q' question in the interview schedule was identified as Question 5. *What 'ways of coping' for you, do you think came out of your past experiences of coping?*

A pilot interview was arranged to ascertain that the interview schedule was in fact user friendly and was able to collate the data that was required for the study.
Before beginning the interview process the interviewer was aware of the need to ensure that they had explained the study and the interview process, the consent form was signed and the recording devices were switched on. It was also considered important to remind the interviewee that they did not have to answer any questions that they do not want to and that they were able to terminate the interview at any time. The interviewer was also able to reassure the interviewees that there was not a right or wrong answer, but it was about their experience.

The interview schedule was developed to include 10 main questions with 40 possible extending questions or prompts. Smith et al. (2012) find that between six and ten open questions with discretionary prompts will occupy between 45 and 90 minutes of conversation. Josselson (2013) advocates that the researchers default position is one of "not understanding" and approaching "with a benign curiosity and a readiness to learn" (p.81). She recommends a prompt for long pauses within an interview of " Were you having some other thoughts about that?" which indicates that thinking is also important as part of the process of the interview (Josselson, 2013, p.67). The semi-structured interview schedule was designed to contain different types of questions (see Table 04.).

Table 04. Types of questions in semi-structured interview schedule.

Descriptive questions	Please can you tell me about yourself and your current life?
Narrative questions	Can you tell me about having children and being a mother?
Structural questions	How old were you when you had your first child?
Contrast questions	What do you find easy or difficult about caring for your baby?
Evaluative questions	Can you think about what happened in the moment that helped you to cope, move forward, be strong?
Circular questions	What do you want to pass on to your children to help them be strong and resilient?
Comparative questions	What do you think you would have recognised as a coping skill or strategy at the time? What would you recognise in retrospect, looking back, as a coping strategy?
Extending questions to initiate more depth	How did you feel about being a mother?
Probes to clarify participant's responses	Can you tell me a bit more about that?

To facilitate drawing the interview to a close, the question *Is there anything else you would like to tell me about your experiences of being a mother?* was incorporated. The interviewer ended the interview by thanking the interviewee and asking if they would like to receive a copy of a summary of the research findings, in the event all the participants requested this. The interviewer was also able to ask how the interviewee was feeling about the experience of being interviewed, that if they were happy for the interview to be used in the research, and ensured that the interviewee had the contact information sheet with details of their supportive contacts and of the researcher if they want to talk with someone.

The interview style was intended to consist of a dynamic of reflection, followed by clarification of what the participant has said. Clarification questions included asking *why* and *how* questions for example; *Can you tell me more about that? How did that make you feel? Can you remember what you were thinking?* or *Where did you learn that?* (Smith et al., 2012). The interviewer was aware of the need to establish rapport with each participant and actively manage the interaction within the interview to elicit first person detailed accounts of specific events (Flowers et al., 2011). The role of the interviewer was to make the participant feel comfortable to discuss personal accounts of her experiences as a mother with mental health difficulties. It was intended to maintain a consistent interview style across the different interviews, with a view to enhancing the quality and consistency of the research, which with the use of a single researcher interviewer was more potentially achievable.

IPA has an intellectual history that is interested in subjective experience that has particular significance to the person involved, but it also understands that the researcher is also participating in the experience of listening and relating to the

participant and this is also part of the process (Smith et al., 2012). Hoshmand (1999, p. 15) describes the researcher as exercising “intentionality” and having “particular research agendas”. This requires skillful attention by the researcher to be able to recognise the effect that they are having and to be able to value their own interpretation, whilst not confusing it with the participant’s interpretation (Smith et al., 2012).

The researcher’s orientation in the interview, is to what is transpiring within the conversation, however non-verbal exchanges can be as important as what has actually been said and this will not be recorded by the recording device: embedded within the individual narratives are “the markers of what the experiences mean to the person” (Josselson, 2013, p.81). It was therefore recognised as important that observations of smiles, signs of discomfort, or other responses were recorded by the researcher after each interview. For this the researcher needed to keep a post-interview reflection about each interview, which would be able to support the analytic phase, giving clarity and understanding to the text; this was done and proved to be a useful source of context and clarity of nuance such as when a participant was emotional or distracted. This post-interview reflectivity acted in a process which facilitated reflection on the content of the interview, the requirement or not for any alternative responses than that which were given; a safety net of reflective thought focusing on the content of the interview and the well-being of the participant.

It became part of the analytic process where immersion in the data was supported by re-visiting the detail of immediate recall of the interview: containing elements of meta-cognition, thinking about how we think and construct knowledge, guiding, legitimizing and supporting knowledge construction as a professional activity and creating

Gadamer's shared horizons of understanding (Gadamer, 1960, 1998; Von Kardorff, 2004). There was also an element of the diary acting as a decompression and personal de-brief that was able to support the researcher's ability to maintain a calm reflective position in regard to the data. This is supported by the feminist perspective which understands that as researchers, we need to engage in processes of emotional reflexivity, especially when we are listening to traumatic stories (Leavy & Harris, 2019).

The interview schedule for the follow-up interviews (see appendix g.) was designed to be more open to enable the participant to expand and give detail to their initial interview contributions. It aimed to seek clarification, identify and explore consistencies or developments in mother's experiences of coping since the initial interview. The use of follow-up interviews with the same participant was intended to capture depth, to clarify any longitudinal change and explore any dynamic effects involving the phenomenon (Farr & Nizza, 2018). Participant quotes are identified as particularly useful when showing dynamic trajectories from follow-up interviews (Farr & Nizza, 2018).

All of the initial six phase one participants agreed to take part in a follow-up interview. The participants were offered a brief summary of points from their initial interviews; all participants chose to have the summary. The summary was pre-prepared by the researcher by re-reading the initial interview transcript and presenting in point form the main components of the interviews. The researcher read the individual summaries to each participant at the beginning of each follow-up interview.

A typical summary would be similar to this example starting with-

We discussed or you mentioned-

- Coming to terms with having a child
- Losing your sense of identity
- Feelings of distress
- Needing a tribe
- Singing, painting swimming
- Healing self
- Finding child fascinating
- Child as a motivator
- Enjoyment of comforting her
- Practical coping and problem solving e.g. on line shopping
- Emotional coping- self talk, breathing, time off, calming, contextualisation, boundaries
- Self care

For example in this extract from Ava's follow-up interview where the use of 'R' signifies Researcher and 'P' signifies Participant and the series of '....' denotes a short pause-

> R- *I don't know if you remember what we talked about last time? Or if you'd like me to give you a couple of little summary points?*
> P- *Yes just a little reminder would be good, it was a while ago wasn't it*
> R- *It was a while…. It was a bit longer because we had the lock down and everything stopped so....Ok so we talked about.… you said that becoming a parent was like having to grow up*
> P- *Yes (laughs)*
> R- *And you felt there was a need to focus on the mum not just the baby*
> *You enjoyed going to classes, we talked about support networks quite a bit*
> P- *Yes*
> R- *um we talked about feeling guilty, and we talked a bit about trauma, around the birth particularly*
> P- *Yup* (Ava, p.17).

On one occasion the summary contained potentially painful items for example-

- Feeling that you wanted to hurt child
- Feeling that you made a mistake in having a child

However these more difficult points were omitted by the researcher interviewer, in a judgment decision made during the follow-up interview itself, as the participant disclosed that she was pregnant again and it was decided not to risk bringing up these particular painful memories in light of the pregnancy and possible distress it could cause. All other points were included. All of the participants joined in the discussion around the sharing of the summary and commented saying that they remembered or just acknowledging that it was an accurate summary.

The follow-up interview guide contained only six questions with an additional Covid-19 related section. The questions were aimed at establishing elements of consistency and change in distinction to their initial interviews.

The interview guide was as follows-

- How do you feel about what we talked about previously?
- How do you feel that things have changed
- What do you feel has been more consistent or stayed the same?
- Do you think that you have discovered anything about surviving difficult experiences and coping from focusing on it as part of the study?
- What would you like to say to other mothers who are going through mental health difficulties?
- If you were being completely compassionate, what would you say to yourself? If you were like your own best friend?
- Would you like to add anything further about your experiences of coping, being a mother, or mental health difficulties?

Post Covid-19 questions-

- How did you cope during lock down?
- What strategies did you use?
- What effects have the Covid crisis had on your mental health?
  Do you think that your previous experiences of coping have helped you cope with Covid-19? (see appendix g.).

The questions in the semi-structured interview guides were used dynamically, so that if something had already been discussed the question would not be repeated, or if a subject came up during a response to another question, then a related question might be asked out of order. The process was intended to be flexible and to follow the lead of the participant and in this way be participant led. The researcher brought the interviews to a close by asking if there was anything that the participant wanted to cover that had not already been mentioned and then finally a brief summary of what to expect from the research in the future was given. All participants requested to receive a final summary of the research findings.

Brinkmann and Kvale (2015, p.3) describe the research interview as talking to people "because we want to know how they describe their experiences or articulate their reasons for action". It was also intended to have a feminist perspective within the research approach, which can help recognise power imbalances within the research relationship (Clifford et al., 2018). A feminist approach was felt to compliment the key aspects of IPA by acknowledging the impact of wider structural aspects of the research process (Clifford et al., 2018). Leavy and Harris (2019) explain that many feminist researchers use interviews to document women's experiences and perspectives as interviews are useful for gaining detailed data directly, where participants can use their own language to respond. During the interview itself, Levy and Harris (2019) emphasise that the most important aspect in data collection is active listening, using gestures, giving eye contact, using probes to demonstrate accurate listening, and picking up markers where participants may indicate they are speaking about something else. The placing of importance on these skills of active listening demonstrates respect towards the participant, who is giving of their time and sharing their knowledge, experience and understanding and facilitates the building of relationship between the interviewer and participant.

Data collection changes due to Covid-19 pandemic

The onset of the Covid-19 pandemic was not predicted or accounted for in any of the study planning or ethical applications. There was a level of not knowing what the next day would bring or what the consequences would be short or long term. Table 05. explains the timeline of Covid-19 in Wales. There were big changes in daily life and everyone was having to accommodate the new challenges entailed in a world pandemic. The implications for research began to emerge and needed thoughtful consideration.

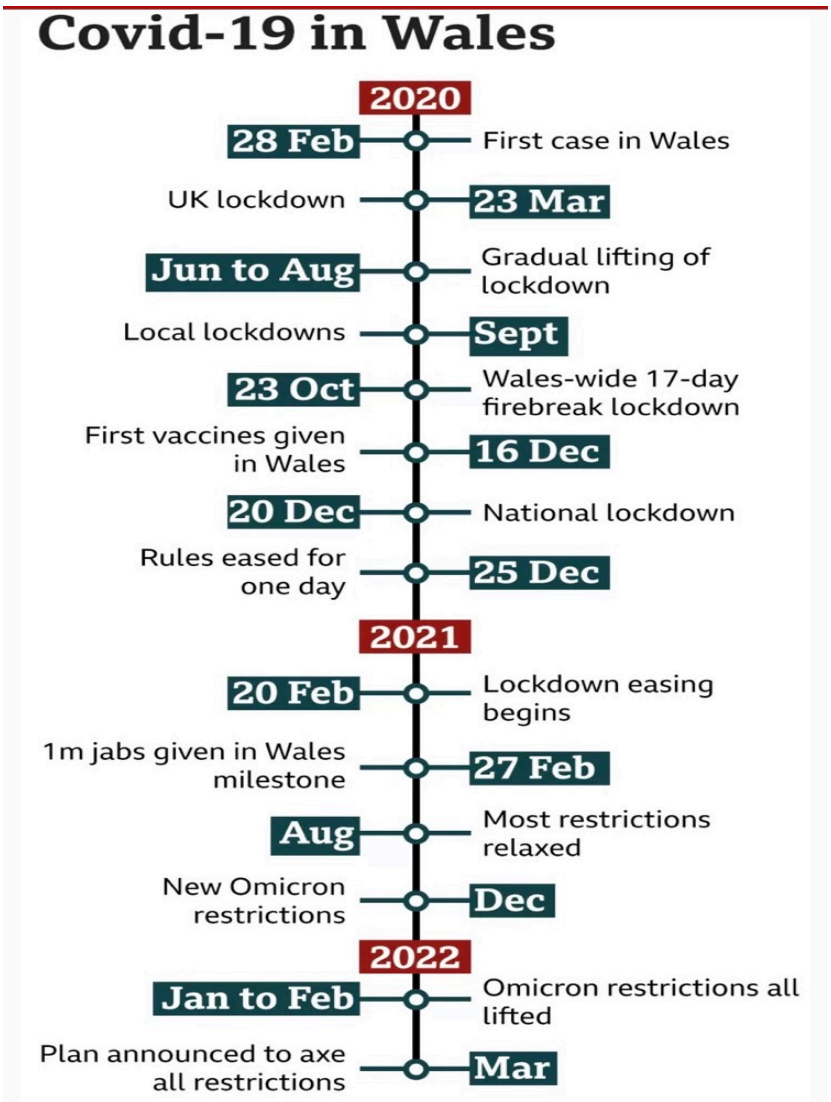


Table 05. Covid-19 in Wales, 03/03/22, bbc.co.uk.

The pilot interview and the first five interviews were conducted prior to the Covid-19 lock down in 2020, during the lock down the interview process was suspended. The sixth interview was an exception, it took place three days into the initial Covid-19 lockdown in March 2019 and had been pre-arranged to take place in person at the participant's home; the participant was keen to continue and because of the Covid-19 restrictions the interview was completed through a virtual medium. Following this no further interviews were scheduled and all face-to-face research was suspended.

In consideration of the risk and anxieties produced by the pandemic, it was decided to re-commence all the interviews using virtual medium. A couple of the previous interviews had been conducted virtually due to distant travel considerations and the researcher had found the forum effective and non-problematic. However it needed to be considered in the light of Covid-19, what were the ethical and pragmatic implications of conducting virtual interviews. An amendment to the ethics application was sought with the additional considerations of conducting all subsequent interviews virtually within the Covid-19 pandemic.

In practical terms the advantages include achieving interview convenience for the researcher and the participant by including evenings, which would not have been the case with face-to-face interviews due to safety restrictions. The participant group were young mothers who are conversant with the technology and this also proved to be an advantage. Brown (2018) found that interviewees could find virtual interviews less intimidating than face to face, however this may not be the case and researchers require a strong reflexive position. The potential difficulties of the researcher and the participant being physically separated include: technical issues with technical quality variation with sound or picture, time lag in the audio feed;

ethical considerations including the considerations of confidentiality and assessment of safe environment for the participant when the researcher is not physically present; the possibility of missing physical aspects of communication, body language and gestures, eye contact, atmospheres; and the potential of greater difficulty in building rapport (Chiumento, Machin, Rahman, & Frith, 2018).

The researcher used checking questions with the participant at the commencement of the interview to increase confidence in security of participant and confidentiality on the researchers end. The researcher was able to collaborate with the participant to ensured that the room used for the virtual interviews was secure from interruption and secure from loss of confidentiality and was able to maintain an awareness of the participant environment and any changes of circumstances that would warrant further checking questions such as *Are you ok to continue?*

The potential loss of data from failure to interpret more subtle participant non-verbal communication for example, when the intricacies of body language might be outside of eyeshot, less noticeable or more difficult to attune to was accepted as a potential reality; the interpretation of pauses and silences was also more difficult in some interviews when a small time lag was present. However, Krouwel, Jolly and Greenfield (2019) in their study comparing Skype (video calling) and in-person qualitative interview modes, found that technical issues could be a bonding experience for participant and researcher as the difficulties were ironed out.
In the phase one study three of the six interviews were carried out face-to-face in person, two in the participant's homes and one at an agreed location; and three interviews were carried out face to face on a virtual medium. All of the subsequent interviews due to the Covid-19 restrictions took place on a virtual face-to-face medium. An interval of approximately four to six months between the initial

interviews and the follow-up interviews was planned, however in the event due to Covid-19 restrictions the gap between initial and follow-up interviews was longer. The follow-up interviews eventually took place between seven and eight months after the initial interviews, when the additional ethical requirements had been sought to take the Covid-19 situation into account.

The occurrence of the Covid-19 pandemic lock down during the data collection year resulted in the initial group of six interviews being arranged prior to the initial lock down. The data collection was suspended during lock down and the amendment to the ethics application was sought to re-commence all interviews virtually. Subsequently the initial six interviews were succeeded by follow-up interviews of these first six participants. Three further initial interviews had been completed and it was at this point that an ultimate decision as to sample size needed to be made and it was considered in the following way-

- An IPA study at PhD level may contain three self-contained but related studies (Smith et al, 2012)
- 6 interviews looking at coping as a phenomenon arranged before the initial Covid-19 lock down
- 6 Follow-up interviews on the initial six participants looking at longitudinal elements and Covid-19 related factors related to coping
- 3 interviews post Covid-19 initial lock down looking at Coping as a phenomenon
- Looking at overarching emergent themes across the three groups

Therefore it was decided at this point to aim at three more post Covid-19 onset initial interviews that would make a group of six that would balance with the initial six interviews and result in a sample size of 12 participants in total; this meant one further share of the research flyer. It was decided to limit the follow-up interviews to

six, totaling 18 interviews in all. The timing of the study which traversed the Covid-19 pandemic period was instrumental to the decision to divide up the study into three phases or sub-studies (see Table 06- The three phases of the study).

Table 06. The three phases of the study.

Phase one	Phase one of the study was determined by the of the Covid-19 pandemic, all of the interviews arranged with participants pre-Covid-19 initial national lock-down in 2020, numbering six in total were assigned to the pre-Covid-19 sub-study. The sixth interview could have been included in the post Covid-19 initial lock down group of interviews but was kept with the phase one study because of the timing, which led to the interview being predominantly pre-Covid-19 in content. The interviews were purely focused on coping without any questions on coping and Covid-19 and took place between January and March 2020.
Phase two	The phase two study consists of follow-up interviews with the initial six participants; the interviews took place between September and November 2020, after the initial Covid-19 national lock down. The semi structured interview questions focused on longitudinal factors and Covid-19 related factors.
Phase three	The final third phase study included a further six initial interviews on participants post the initial Covid-19 national lock down that took place between March and June 2020. These subsequent initial interviews were conducted using the same interview guide as the pre-Covid-19 initial lock down interview group with the addition of Covid-19 related coping questions; these interviews took place between August and December 2020.
Finally	There would then be an overview that would consider overarching emergent themes across the three groups.

Each subsequent study phase was able to build on the previous phase in terms of perception, understanding and conceptual development: the themes across the

phases were considered as one analysis and did not re-start each phase at theme one, but continued on to the next study phase.

It was apparent that there are diverse opinions, as to whether concepts around data saturation are fundamental within IPA. In some ways when considering coping as a phenomenon, it was considered that 100 or a 1000 individuals could have their own particular set of coping skills or strategies. The main essence of IPA is the enable the participant to narrate the research findings through their lived experiences (Alase, 2017). In light of this it was considered that the relevant criteria is the ability to shed light on the phenomena and explore the meaning for a specific group of people in a specific time and place. This provided for an analytical structure as well as a plan for further data collection.

The study was not designed to be about Covid-19, however it was recognised at this point that interviewees might bring up the subject of Covid-19 in reference to coping as a phenomenon. This issue was on-going and the researcher was aware that coping in the Covid-19 setting was problematic for many people. The salutogenic approach, looking at factors that support human health and well-being within coping as a phenomenon was felt to be supportive of women at this time. Explanatory e-mails were used to cover the changes and checking questions were also be used to assess the need to signpost interviewees towards support agencies referenced in the participant information and de-brief information which was shared with the participant.

Any concerns around the building of rapport did not present as a recognisable reality, the mothers were often enthusiastic about the research and presented with positive engagement in face-to-face interviews and virtual interviews. In terms of dominance Krouwel et al. (2019) found that the researcher was less dominant in the virtual setting taking up less of the word count. Researchers also did not find consistent differences

between the nature or character of interview modes and differences were acknowledged as modest, with mixed modes possibly being the most efficient balance (Krouwel et al., 2019).

A favourable ethical opinion was given in June 2020 in respect of the amendment to the ethical application and the interviews were re-commenced at this point. In October 2020 the UK Research Integrity Office published a report with further guidance for research during the Covid-19 pandemic (UK RIO, 2020). Aspects that were considered included the accuracy, honesty, transparency and replicability of data findings obtained within the pandemic, and the potential limitations of the study that need to be considered in light of the pandemic (UK RIO, 2020). The report was reviewed in detail by the researcher and the proposal was felt to be in overall accord with the recommended checklist, with on-going considerations to be deliberated on regarding limitations of the study.

This chapter has outlined the complex ethical considerations and the theoretical aspects that relate to data collection strategies. The development of the interview schedule was something that occurred over time and strongly related to the methodological aspects of IPA itself and the existent literature on the phenomenon of coping. There were practical aspects to the development of the research that occurred in consequence of the onset of the Covid-19 pandemic that influenced the emergent structure of the research, which were considered pragmatically in a response to circumstances. The ethical issues that permeate interview research, come from the interviewer's concern to obtain authentic knowledge and ethical respect for the integrity of the interviewee; it requires the researcher to be, cognitive of the

power asymmetry of the interview situation and committed to the moral responsibility of research behaviour (Brinkman & Kvale, 2015). In the next chapter the theoretical frameworks that support the stages of data analysis are introduced and the importance of the authenticity and trustworthiness of the study is considered.

Chapter six:

Data analysis approach, reflexivity and trustworthiness.

"I think, I feel, I experience" (Wolf, 1988, p.11).

This chapter describes the theoretical frameworks supporting the stages of data analysis, which are congruent with Interpretative Phenomenological Analysis (IPA) methodology. The practical application of these stages is discussed in relation to this study's data that was collated via the semi-structured interviews. A hierarchical model of adaptive processes and families of coping (see Table 08) is introduced as a theoretical framework in the initial analysis phase of all the interviews, which is used to identify the ways of coping that the mothers utilise and to provide evidence of the researchers understanding checking and orientation.

The concepts of reflexivity and trustworthiness are examined in this chapter. Reflexivity is addressed through consideration of the researcher as immersed in a continual process of engaging with and articulating the place of the researcher within the context of the research. Two of the dominant processes used for this study were firstly: the carrying out of a bracketing interview with another independent researcher described in this chapter; and secondly the writing of a reflexive analysis of the process of knowledge formation, which is included in Chapter Eleven in the discussion.

Data analysis

Within IPA analysis involves immersion in the interview data, by actively engaging with the data and appreciating the flow and rhythm of the interview as it moves from the broad or general to the specific details, through to the concluding and ending of the

interview (Smith et al., 2012). It involves a systematic examination of participant interview transcripts through processes of reading and re-reading to engage actively with the data (Smith et al., 2012).

The first stage of analysis involves the analysing of the transcripts in their entirety, one at a time, making initial notes, which can be developed into emerging themes that capture the key elements of the participant's experience (Spiers & Riley, 2018). Initial noting is aimed at examining the semantic content of the language, exploring the individual participant's understanding and ways of expressing their experiences (Smith et al, 2012). The transcripts are approached employing inductive and iterative processes, going from the specific to the general, moving backwards and forwards within the transcript, exploring, noting, reflecting, interrogating, integrating and thematising (Flowers et al., 2011).

The exploration of semantic content requires the examination of language: the descriptive content which captures participant's subjective experience; linguistic content which concerns the use of specific language and its potential significance; and conceptual content which identify more abstract thought and meaning making (Smith et al., 2012; Willig, 2013). This is carried out whilst holding the phenomenological focus and examining the participant's explicit meaning (Smith et al., 2012).

The text is deconstructed for critical examination of underlying assumptions and key words, phrases or explanations are recorded (Hoshmand, 1999; Smith et al., 2012). The text is then examined specifically looking for similarities, differences, repetitions, re-enforcement or contradictions (Smith et al., 2012). Interpreting can involve the use of de-contextualisation, which can reveal the embedded nature of the participant's experiences (Smith et al., 2012). Patterns of meaning are identified from the

transcripts, which aim to demonstrate shared understanding of participant's experiences and individual accounts (Flowers et al., 2011).

Smith (2019) advocates a flowing typology of meaning to review the analysis: what does that mean in a literal sense; what does the person mean pragmatically; what does it mean experientially; what does it mean in terms of self identity; what does it mean existentially in the persons life; what is the purpose. The third level of experiential meaning is at the core of IPA; however it is necessary to understand all levels to be able to access experiential significance (Smith, 2019). Focusing on perceptions, IPA analysis aims to gain understanding of participant's view and experience of the world (Willig, 2013). The participant's search for meaning transforms an event or occurrence in their life into an experience (Smith, 2019). There is acknowledgement of a dual order process where participants represent their unique idiosyncratic qualities while also displaying shared higher-order qualities and aspects of meaning (Smith et al., 2009).

The second analytic phase is the identification of themes, which are usually expressed as phrases and the search for connections from these themes to develop the emergent themes (Smith et al., 2012). Looking for emergent themes involves managing the data to reduce the volume whilst maintaining the complexity within connections, interrelationships and patterns identified within the hermeneutic circle (Smith et al., 2012). The aim is to identify patterns of meaning (themes) within the participant's narratives that reflect a shared understanding of the phenomenon of coping, but also is able to give a sense of the individual distinctions of experience (Flowers et al., 2011). Themes are labeled in a way ideally that can capture the experiential quality of participant's descriptions (Willig, 2013).

A three-column approach, suggested by Smith et al. (2012) was used in this study, with original transcript quotes in the middle column, exploratory comments to the right and emergent themes on the left (see appendix I. example of interview transcript). Colour coding was used in the transcripts in the following way (see Table 07.).

Table 07. Colour coding used in transcription analysis.

Yellow	Notable or interesting data relevant to coping as a phenomenon, descriptive key words or explanations, thoughts or experiences.
Blue	Insight from participant or understanding of things that are important for the participant.
Pink	Painful or difficult experiences related by participants.
Red	Severe trauma experiences related by participant.
Green	Ways forward identified by participant or positive coping strategies identified by participant, positive learning experiences achieved following experiences of adversity.
Grey	Grey was used when significant quotes had been identified that were referenced within the Spread sheet to be considered for inclusion in the results section.

The colour coding provided a landscape to the transcripts that aided the analysis of the data by providing instant physical and emotional clues to the content of particular components of the data. The transcripts became in this way living documents of participant experience that the researcher could react and interact within the hermeneutic circle of interpretative analysis. The interviews in the study were analysed by looking for patterns across cases. Working with the transcripts, initial exploratory comments, emergent conceptual themes and relevant transcript extracts from each case, were placed on a spreadsheet. Each interview was worked through systematically, looking for convergence and divergence across the interviews.

The emergent sub-themes were then drawn up into the spreadsheet table, with reference to the transcript initial comments and quotes, which could facilitate comparison across cases, looking for convergence and divergence. This was initially carried out by hand across two cases and then five cases and then using a computerized Microsoft Excel spreadsheet table (see appendix h. & appendix i.). It was completed across the data set in each study phase, and finally across the complete data set of all participants in accordance with recommendations from Spiers & Riley (2018) and Smith et al., (2009). There were 47 sub themes drawn from the three phases of the study, which comprised 24 more general sub-themes, 12 related to longitudinal factors and 11 related to Covid-19.

The emergent sub-themes were then able to be examined for patterns and connections and be grouped into the significant main themes (Smith et al., 2012). The clustering of sub themes into a main theme was part of the interpretative process; for example in theme one *Mothers lived experience of coping* the following sub-themes were incorporated-

- Avoidant coping
- Emotion focused coping
- Cognitive coping
- Emotional intelligence
- Ethics
- ACEs

Aspects of personal experiential sub-themes could be incorporated into more than one group experiential main theme. The process of refining the group experiential themes involved returning to the research question and the phenomenon of coping, searching for aspects of the phenomenon, moving back and forth iteratively through the transcripts, looking for individual experiences with shared meanings. Within the horizons of

understanding suggested by Gadamer (1960, 1998) the personal experiential themes are from the understanding of the individual, where as the group experiential themes are formed through identification of shared understandings or interpretations of experiences, which can be grouped together in a theme.

The resultant recurrent themes that are identified are written up as a narrative, giving examples of participant lived experiences through selected transcript extracts. The transcript extracts are chosen to demonstrate the range of views expressed by the group of participants and the richness of the data. In this study the emergent 47 sub or lower level themes were clustered into 14 main themes across the whole study with: five main themes in the phase one study; four in phase two of the study; and five in the phase three study. Finally there were three super-ordinate themes that relate with the study as a whole entity which are more abstract and presented independently directly in relation to the literature.

It is recognised in this second analytic phase that some themes may be subsumed by others and polarisation is able to occur (Willig, 2013). It is part of the interpretative process within IPA, where the researcher organises and interprets the data: developing themes from the shared experiences of the participants, looking for convergence and divergence. Themes can be examined in different ways, using contextualisation, numeration, function, patterns and recurrence (Smith et al., 2012). Emergent and recurrent themes are required to be present in a minimum of a third to a half of participant interviews to be accepted as valid (Smith et al., 2012). The master themes capture shared participant experience; analysis is regarded as complete when all subordinate themes have been integrated into the main master themes or have been dropped from analysis (Willig, 2013).

Smith et al. (2018) discuss the use of a single case study for initial detailed examination: followed by moving on to detailed examination of two cases; and lastly by increasing to examination of the larger sample of participant interviews, for examination of connections, patterns and emerging themes. The first case analysis as a case study aims to incorporate explanatory, descriptive and exploratory elements (Yin, 2009). This use of an initial case study approach facilitates an understanding of the participant's life story in context, so that the participant's attempts to make sense of her world can be examined in detail.

In this study early analysis was initially written up using a case study approach on the first participant in each study phase, an example is included in the appendix (see appendix m.). This involved getting to know and becoming immersed in the individual's "unfolding" of the phenomena (Smith et al., 2022, p.25). This was followed by moving on to a cross case comparison with the second participant's data (see appendix m.), then moving on to cross case analysis of five and then six participant's transcript data (see appendix h., & i.). This was a really useful early approach in terms of being a novice researcher as it enabled a drilling down into the ideographic detail. The case study approach was not included in the final results chapters as the results chapters were eventually written up thematically whilst drawing on the narrative detail from the early case study approach.

The results chapters were developed by structuring them around the master themes, which are introduced and their manifestations discussed with illustrative participant quotations as recommended by Willig (2013). Within IPA the results sections can typically be weighty as they contain substantial transcript extracts and analytic interpretation of the texts (Smith et al., 2022). The participant quotations are of varying lengths related to the interpretative discussion, longer quotes are sometimes included

when it is necessary to give the participant recollections proper attention. Relationships between themes are addressed, reflexivity being utilised to differentiate between participants comments and researchers interpretations (Willig, 2013). The analysis of the data forming a co-construction of interpretation by the participant and researcher together which focus on perceptions (Osborn & Smith, 1998; Willig, 2013).

A defining point of IPA is that it is concerned with the meaning of what is being said by the participants rather than just the content; the ideography of individuals experience is then exposed to the hermeneutic circle of interpretation; the double hermeneutic conceptualising the meaning making of the participant, and also the meaning making of the researcher (Smith, 2018). The philosophical commitments within IPA create a layered approach to interpretation that uses existing knowledge for example existing theory to support the results presented with participant's voices (Kirn et al., 2019).

Analysis can be presented as a narrative within IPA, representing the dialogue between participant and researcher that is interwoven with analytic commentary and extracts from the raw data (Smith et al., 2012). In this study the participant's words were interpreted in relation to the phenomenon under study, which was 'coping'; the writing up of the three sub-studies was completed interpretatively, predominantly without reference to the existing literature. This is in accordance with IPA methodology, which holds the researchers connection to the data and its interpretation as pre-eminent, with the researcher in this study holding in mind the particular focus on coping, motherhood and mental health difficulties.

Phase one of the study presents the six initial interviews arranged with participants pre-Covid-19 initial national lock-down in 2020. The interviews were purely focused on coping without any questions on coping and Covid-19 and took place between January and March 2020. The second phase study presents the six follow-up interviews on the

initial six interviewees. These interviews were completed between September and November 2020, following the initial Covid-19 lock down of March to June 2019. This section focuses on longitudinal factors that address coping as a phenomenon, and Covid-19 significant effects upon coping as a phenomenon. The third phase of data collection includes the six post Covid-19 onset initial interviews that took place between August and December 2019, which were analysed as a section on their own (see Table 06.).

Introducing a theoretical framework

Skinner and Zimmer-Gembeck (2011) hierarchical model of adaptive processes and families of coping was used as a theoretical framework in the initial analysis phase of all the interviews, to identify the ways of coping used by the mothers (see Table 08). Crawford (2020) explains that a theoretical framework can provide evidence of a researchers understanding checking and provides transparency with regards to the orientation of the study. The theoretical framework in addition to the researchers experiential background and wider knowledge of the literature together, form the conceptual framework for the research (Crawford, 2020). The Skinner and Zimmer-Gembeck (2011) model was found to be supportive to the researcher's ability to analyse the data by keeping the focus on coping as a phenomenon.

The framework was not exclusive from other sources of understanding of coping as a phenomenon that were explored in the literature review. The ability for the researcher to be able to identify coping efforts was seen as imperative for analysis of the data in relation to coping efforts made by the participants and provided part of the researchers conceptual framework.

Table 08. A hierarchical model of adaptive processes and families of coping.

Adaptive process 1. Co-ordinate actions and contingencies in the environment

Family of coping	**1.Problem solving**	**2. Information seeking**	**3. Helplessness**	**4. Escape**
Family function in adaptive process	Adjust actions to be effective	Find additional contingencies	Find limits of actions	Escape non-contingent environments
Ways of coping	Strategizing Instrumental action Planning Mastery	Reading Observation Asking others	Confusion Cognitive inter-ference Cognitive exhau-stion Passivity	Behavioural avoidance Mental withdrawal Flight Denial Wishful thinking

Adaptive process 2. Co-ordinate reliance and social resources available

Family of coping	**5. Self-reliance**	**6. Support-seeking**	**7. Delegation**	**8. Social isolation**
Family function in adaptive process	Protect available Social resources	Use available Social resources	Find limits of resources	Withdraw from unsupportive contexts
Ways of coping	Emotional regulation Behavior regulation Emotional expression Emotion approach	Contact-seeking Comfort-seeking Instrumental aid Social referencing	Maladaptive help-seeking Complaining Whining Self-pity	Social withdrawal Concealment Avoiding others Freeze

Adaptive process 3. Co-ordinate preferences and available options

Family of coping	**09.Accommodation**	**10. Negotiation**	**11. Submission**	**12. Opposition**
Family function in adaptive process	Flexibly adjust preferences to options	Find new options	Give up preferences	Remove constraints
Ways of coping	Distraction Cognitive restructuring Minimisation Acceptance	Bargaining Persuasion Priority setting	Rumination Rigid perseverance Intrusive thoughts	Other-blame Projection Aggression Defiance

Skinner and Zimmer-Gembeck, 2011, p.41.

Transcription and data context

The transcription of the interviews was carried out by the researcher, to facilitate the immersion of the researcher within the data. This process was found to be immensely valuable as it really enabled the familiarisation of the researcher with the transcripts; it was a time consuming process but one in which the outcomes in terms of knowledge of the transcripts was found to be very worth while. The use of the columns on either side of the transcription for initial exploratory comments and noting of conceptual emergent themes was carried out immediately following transcription. All transcriptions and initial noting were carried out sequentially and completed prior to the next interview.

The analysis was approached through the reading and re-reading of the transcribed interviews, using initial noting with descriptive comments, exploratory comments, linguistic comments and conceptual thematic comments. De-contextualisation of the data, interpretation and social comparisons were examined in the analysis, including looking at metaphor and micro-analysis looking at the small details. There were a total of 18 interviews included in the combined study, with 12 participants. The length of interviews ranged from 45 to 115 minutes for initial interviews with a mean of 79 minutes. The follow-up interviews lasted between 25 and 60 minutes with a mean of 42 minutes. All interviews were transcribed verbatim amounting to 145,795 words of transcript data.

The mothers participating in the study had an age range of 26 to 37 years; they were all in legally officiated marriages; they all had at least one child aged two years or under at the time of interview; the age range of the children of participants was 9 weeks to 11 years old and collectively amounted to 19 children, with 13 children aged two or under. There was a diverse geographic spread of participants across the UK, five from Wales, six from England and one from Scotland, with one participant originating from Northern Ireland but living elsewhere.

All participant transcripts were anonymised by removal of any identifiable information, for example, names, place names and job titles. The main participant mothers were given a pseudonym to allow for the particular participant data to be followed across the study. Children are referred to as M for a male child and F for a female child, H represents husband. Where there is more than one child, they are referred to as first, second, third child. Verbatim quotations are reference by page number in the specific participant transcript. Where quotes include researcher and participant, they are signaled 'R' and 'P' respectively.

The development of the themes in the phase one study provided the building blocks for the subsequent phases of the study. It provided the grounding of the 'unknown' in the participant's lived experience of the phenomenon of coping and the examination of the meaning making of the phase one participants. The phase two study comprised of the follow-up interviews on the initial six participants, all of whom were willing to take part in a further short interview. The aim of this sub study was to focus on the longitudinal factors that are apparent in relation to coping as a phenomenon and to draw out any coping efforts that are specific to coping within the situation specific Covid-19 pandemic. The focus was on depth through the examination of dynamic effects, looking activity at apparent changes or consistencies, progress and patterns of meaning, which constitute temporal triangulation.

The identification of the phase three study themes was a development in the thought processes of the researcher following on from the phase one themes. It was an instinctive interpretative development to investigate different dimensions of the phenomenon of coping, which was enabled through the first phase analysis. The themes are interrelated aspects of the phenomenon that are examined from different perspectives, but are similar and connected in subject matter.

Triangulation and integration of data

The analytic phase was completed by the triangulation and integration of the data from phase one of the study with the themes from phase three and vice versa. This was a complex decision to go ahead with the rounding of the study and the integration of the themes and was taken after prolonged consideration. The supporting considerations of this decision included-

- The ability to add more detail to each theme
- The integration of the study phases in to one complete study
- The ability to enhance clarity of themes
- The ability to demonstrate that the themes could be supported by the different phases of the study or not
- The ability to compare and contrast a wider data set
- The ability to unify the study

Triangulation entails the use of more than method or data source that can operate within or across a research strategy (Bryman, 2012). The process of triangulation, by the amalgamation of the additional data to each phase was in reality not problematic and did result in an additional representation of the themes across the phases of the study. The supporting considerations were felt to be enhancing of the study as a whole. It enhanced the ability to triangulate findings through mixing the data from another phase of the study.

Data sources for triangulation can come from the qualities of time, space or person (Thurmond, 2004). The inclusion of follow-up interviews in the phase two study, was regarded as a form of time triangulation. However the main source of triangulation for this study was the adding of additional data from a different study phase for example, adding the stage three study data to the phase one themes, and the phase one study

data to the stage three themes. This incorporation of a different phase of data collection facilitated the inclusion of further diversity of viewpoints and enabled validation of the chosen themes for analysis.

In the phase two study there was only one theme that was triangulated with the phase three interview data, which was *Children as motivators*. The remaining three themes were not triangulated with the phase three data, as they expressed aspects specific to the longitudinal inquiry that emerged as a part of participant development, for example *Maintaining self care needs and identity*.

An interesting theme that was specific to the phase one and two cohort was the *Rebalancing through Covid-19 lockdown*. This theme was not amalgamated with the phase three mothers because the interviews of the phase three mothers took place towards the end of 2019 and there was a normalization of the Covid-19 situation apparent in their accounts where they did not differentiate their pre-covid coping to the post-covid coping styles in the same way as the phase one mothers. The supporting data was therefore not present for this theme in the phase three mothers and therefore not included. The experience of mothers who only knew mothering within the pandemic was different to the mothers who had experienced both pre and post pandemic situations, and they did not have the same re-balancing understanding. This is significant in terms of coping and indicated an element of habituation for these mothers.

Following the interpretative narrative writing up of the themes in each phase of the study, each study phase results chapter is concluded by discussing the themes in relation to the existent literature. This places the study within the context of the wider research base. Finally in chapter ten, the over-arching analysis is presented, incorporating the three sub-studies of 18 interviews into a cross case analysis to identify three super-ordinate themes. The super-ordinate themes are examined for patterns and connections and

presented in the context of the existing literature. This abstraction of higher-level themes was completed, by dealing with ideas rather than events, with some themes being subsumed by others.

Assessing validity and quality

Yardley (2015) describes four principle considerations in the assessment of a qualitative research study: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. Sensitivity to context was demonstrated through the selection of verbatim quotes, which linked directly to the interpretive processes. Interview quotations were able to communicate authentically the voices of the participants and ensure a clear trail from analysis back to the data aiding validity in the study. The quotes selected were intended to be relevant to the general text, contextualised and clearly presented in a way that was able to give light or understanding to the research question as recommended by Brinkmann & Kvale (2015).

Commitment and rigour was addressed at the interview stage by attending intimately to what the participant was saying, picking up on cues and following up on important ambiguities as guided by Smith et al. (2012). Lincoln and Guba (2007) emphasise the importance of concepts of trustworthiness within rigour in naturalist research. Trustworthiness encompasses authenticity through an understanding that there can be no single reality, and that there are multiple realities, which are socially constructed (Lincoln & Guba, 2007). In this way rigour was addressed through ensuring that the participant was interviewed safely, and that the transcript rigorously protected with reliability and accuracy being held as an ethical principle. The transcript data was

examined for divergence and convergence and pre-assumptions were examined through reflective processes.

Transparency of the research processes was communicated within the written record of the research. Transparency is viewed as an obligation on social scientists, which requires that data, theory and methodology on which conclusions rest are able to be examined, scrutinised, critiqued and debated (Moravcsik, 2014). Transparency was addressed in the way recommended by Moravcsik (2014) through three dimensions of the research process: data transparency which allows access to the richness and nuance of what participants say; analytic transparency which assures understanding of the precise interpretative process; and production transparency which provides access to cited evidence and methods.

Just (2011) finds that the process of writing is part of the development of understanding, aiding comprehension and mapping unconscious processes. However if understanding and the communication of understanding are different as suggested by Schleiermacher (1838,1998); the question of how we ensure authenticity arises. The reader of an interview-based study requires information about methodology in order to be able to evaluate the trustworthiness and credibility of the studies results and conclusions (Brinkmann & Kvale, 2015). Questions about study design, interview procedures, transcription, analysis and verification were addressed through the detail in the writing up of the study. Analytic transparency, which assures understanding of the precise interpretative process, was addressed through detailed methodological description. Production transparency, which provides access to cited evidence and methods, was addressed through the use of verbatim quotations.

Data transparency was addressed by the reviewing of the initial analysis of a single transcript by an independent researcher for methodological authenticity in regard to the

drawing of appropriate themes from the specific data. The feedback was positive with a suggestion to focus on the meaning making interpretation that could be supported by direct quotes of words and phrases, looking at their specific symbolism. The supervisory team also were able to comment on the initial transcript analysis on a sample of participants, their advisory comments were around adding more detail into the initial noting and explanatory comments and this developed somewhat naturally as the process was repeated with each new interview transcript and as a novice researcher I was able to gain in experience and develop my interpretative stance.

Assessing the reliability of the research findings within the study allows other researchers or health professionals to make a judgment as to the soundness of the research, the application of research method and integrity of the research findings (Noble & Smith, 2015). The independent checking of researchers competence within the prescribed method is part of the assessment of quality and validity within the study and is intended to demonstrate rigour: validity referring to the integrity of the application of the method and reliability to the consistency of analytical procedures (Noble & Smith, 2015).

Carrying out the follow-up interviews involved giving the 6 initial participants verbal summaries of their first interview to enable them to reflect and focus on the longitudinal aspects of the phenomenon of coping within the follow-up interview. Although the purpose of this was not validity and authenticity of the research data, the participants reported that they found the summaries helpful and did not disagree with the content of the summary. This is a quality aspect that is able to act as an authentication of the data reported with clarification by the participants of the content of their initial interview data. The quality of the data is an extremely important aspect within the credibility of the study (Alase, 2017).

Maintaining cohesion between the study's aims, design and methods can demonstrate the attention to consistency and neutrality (Noble & Smith, 2015). The adherence to rigourous methodology is hoped to provide transparency within the research process. Smith et al. (2009) suggests coherence is addressed through the presentation of a coherent argument that is able to deal with ambiguities and contradictions and that can be logically understood. Validity can be viewed as subjective in some respects, Bruner (1990) asserts that it is an interpretative concept and it is the plausibility of the conclusions that are significant. Validity can also be addressed through relevance, impact and importance: Yardley (2015) suggests that the reader discriminates what is of impact and importance for them, thus continuing the hermeneutic circle.

Smith et al. (2012) cites Yardley's (2000) principles for assessing quality and validity: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance. Rigour within IPA is accomplished through: the demonstration of the thoroughness of the study; the appropriateness of the sample participants; the quality of the interview; and the completeness of the analysis (Smith et al., 2012). Bryman (2012) finds that in terms of study validity the minimum that needs to be established is that the study reflects the concept in question. The focus on the phenomenon of coping was held throughout the study, with the participants providing the context of motherhood and mental ill-health.

Reflexivity in research appraisal

Reflexivity considers the specific ways that the researcher has influence in the study and is an important part of critically enhancing the quality and transparency of the study (Barrett, Kajamaa, & Johnson, 2020; Smith, 2015). Bryman (2012) expands the conceptualisation of reflexivity to include wider considerations of the implications of the

methods employed in the research, values, biases, cultural, political and social contexts. The requirement for reflexivity can be what distinguishes qualitative research from positivism and can be a part of methodological rigour (Barrett et al., 2020; Rennie, 1999).

Bryman (2012) considers that any research that involves the participant's life story experience, must implicate the researcher and will require the researcher to be reflexive. When data involves transcription of live interviews, the text itself is can be considered reflexive (Rennie, 1999). Linge (2008) explains that within the hermeneutic conversation the interpreter opens themselves up to the text by listening and allowing its viewpoint, confronting the otherness of the text; making reflexivity of the researcher a vital component of methodological requirement. Reflexivity is connected to issues of representation and the inclusion of information about the researcher and the research process can contribute to the reader's ability to evaluate the research (Merrick, 1999).

Reflexivity is a continual process of engaging with and articulating the place of the researcher within the context of the research; it can challenge that status quo through questioning and examining attitudes, assumptions, perspectives and roles (Barrett et al., 2020). Reflexivity for this study was addressed in several ways including the writing of post- interview reflections after each participant interview discussed in chapter five and the keeping of a diary of progress and the passing emotional journey. Both of these were more personal tools and were felt to be supportive to the context of the researcher within the study. Two dominant processes used for this study were firstly: the carrying out of a bracketing interview with another independent researcher described here below; and secondly the writing of a reflexive analysis of the process of

knowledge formation using Belenky et al., (1997) *Women's Ways of Knowing,* which is included in Chapter Eleven in the discussion.

The bracketing interview

Malterud, (2001) proposes that the background of the researcher is pivotal to the chosen topic of investigation, the approach chosen, the methods chosen and how the results are identified and communicated. Barret et al. (2020) suggest that every researcher has an agenda, including: the choice of the research question itself; why it was chosen; how the researcher views knowledge in the world; and their understanding of reality as absolute or relative to individual experience. The importance of reflexivity within the research process is therefore pivotal to the authenticity of the research approach and bracketing can be considered as a form of reflexivity. Malterud (2001) suggests that preconceptions are not the same as bias, unless they are not declared. Within qualitative research and IPA in particular, the researcher is the primary instrument for data collection (Chan, Fung, & Chien, 2013). The researcher needs to be aware of their particular cultural framing and how that applies to the phenomena that they are studying (Gould, 2010). Concepts of emic, studying from within, and etic, studying from the outside, need to be considered; does the researchers understanding cause areas of blindness or areas of understanding (Gould, 2010).

It is recognised that the undertaking of bracketing is able to demonstrate validity in terms of transparency: the researcher needs to have an awareness of and be able to put aside their own knowledge, beliefs, values and experiences, in order to accurately describe participant's life experiences (Chan et al., 2013). Bracketing has mathematical roots within equations of separating out the contents of the brackets (Smith, 2007). However within hermeneutic phenomenological research, it is acknowledged that the pre-understanding of the researcher cannot be eliminated and is in terms of IPA

hermeneutically incorporated within the analysis framework (Chan et al., 2013). Morrow, Rodriguez and King (2015) set out Colaizzi's (1978) descriptive phenomenological method which describes the researcher identifying meanings relevant to the phenomenon that arise from careful consideration of the significant statements in the interview transcripts, whilst bracketing the pre-suppositions to facilitate adhering as closely as possible to the phenomenon experienced by the participant.

Although it was not necessary within IPA methodology to bracket all fore-knowledge, in order to engage with the researchers fore-knowledge and pre-conceptions, it was decided to take part in a bracketing interview. Bracketing interviews can be used to explore how a researchers assumptions and experiences may be influencing the construction of knowledge; exploring the researchers professional and personal experiences in a research focused relationship that is similar to a clinical supervision framework (Rolls & Relf, 2006). It can enable the researcher to manage the duel processes of investigating the participants experience whilst holding their own experience (Rolls & Relf, 2006).

De Cruz (2010) identifies the role of a bracketing interview as enabling the researcher to explore their own responses to the phenomenon, to bring awareness to the researcher of their own subjectivity, assumptions and vested interests in undertaking the research and how these may impact participants. This will enhance the researchers capability to perform a thematic analysis and form a further data set, whilst demonstrating reflexive practice for transparency that will aid rigour and credibility (De Cruz, 2010).

Past knowledge can then be used in a restricted way to integrate the meanings that are drawn from the data (De Cruz, 2010; Finlay, 2008). The task remains dialectical, acting through two opposing forces: the challenge being to access the participants lived

experience and meaning making, rather than purely just reflecting upon it (Finlay, 2008). Finlay (2008) explains that the questions that need to be asked by the researcher in terms of data are based around how the world appears to the participant; what does the participant mean by certain phrases; and what the participant understand to be the difference between their own and other's experiences. The researcher needs to have the ability to reflect upon their own world view and how this might influence their analytic capacity.

The full bracketing interview is included in Appendix j. Extract quotations and short summaries of the bracketing interview are included here, to give an indication of the nature and content of the interview. The interview quotations are indented and italicised, the use of a series of full stops e.g. "….." denote a pause for thought and not the use of an ellipses to indicate that words have been omitted. The questions asked in terms of the researcher were written out prior to the bracketing interview so that they could be shared with the person included in the interview.

The questions were-

- **Why did you want to do this?**

The researcher reflected on her past work as a health visitor-

> *That…. sometimes when I was listening to women talking about their experiences, I was like I don't think I would have survived that, if I'd have had to be there, because these women had been raped as children and um lived with violence and you know…. and then resorted to substances to alleviate their pain and I'm like I don't think I'd be there…. if that was me…. so I just felt that there was something there that made them strong enough to survive, but I wasn't sure what it was* (see appendix j.).

- **What influences do you think your past work will have on your research?**

That ordinary people have extraordinary things happen to them (see appendix j.).

- **What could be a negative impact of your experience?**

Potential difficulties were felt to be around the researchers ability to sit with pain and discomfort and a prominent early theme from the participants was "It's ok not to be ok". (see appendix j.).

- **What could be a positive impact of your experience?**

Strengths recognised by the researcher included authenticity and genuine interest in what the women being interviewed had to say about the phenomenon. Also the ability to be comfortable when talking to mothers with small children present was felt to be an advantage.

> *I'm in there with them and I can't take myself out, I don't want to take myself out, I just need to be aware of leading, or not leading I guess.*
>
> (see appendix j.).

Having prior knowledge and experience of the phenomenon was considered and the process of immersion in the data; the reflexive stance was found to be important when considering the iterative hermeneutic circle, where a complex relationship occurs between the interpreter and the interpreted (Smith et al., 2009).

- **How is your research affecting you in a personal way?**

The need to bracket off a personal journey was discussed-

> *Yes that has surprised me it has been quite difficult at times…. but it has thrown up quite a lot of thoughts and feelings in me, about how I've dealt with things or coped with things, or not and the way that my psychological make up has developed. Which I have sort of bracketed off as a separate um journey, but it has been much more than I ever anticipated.* (see appendix j.).

- **What are your concerns about you as a person doing this research?**

Crossing the interviewers boundaries was considered and the Bracketing interviewer pointed to a paper she had read-

> *Isn't that in one of the papers that she thought she crossed a boundary into therapy and actually they said well actually you did cross a boundary but if you had stuck to your research agenda it would have been insensitive, to not kind of talk openly and honestly and acknowledge what they had been through and you are offering a supportive listening opportunity which is what they most need at that time, so you just cross a boundary into supportive listening.*
>
> (see appendix j.).

This was helpful because sometime the interviewees discussed difficult and painful memories and it was important that the experience was a supportive one following the salutogenic and feminist approaches to data gathering. It was felt that it was ok to be a part of the participant's attempts to form a coherent narrative, as this could be a positive thing in the way that they processed past events (Cozolino, 2017).

The bracketing interview experience was felt to be a valuable one and consideration was given to the motivations, assumptions and difficulties within the research process. Both the researcher and bracketing interviewer partner were surprised about how immersed they actually were and how good it was to be able to talk about their research. The ability to be strongly reflexive was felt to support the researchers ability to complete thematic analysis and then go on to form a further data set.

In conclusion the bracketing interview process was felt to be supportive and brought attention to the need to remain strongly reflexive throughout the research process. It did have a feel of clinical supervision within the research process. The researcher was

aware of having certain emic perspectives, being a woman, being a mother, having life experience that was relatable to participant experience in certain circumstances whether first or second hand; but also having an etic perspective of outsider not currently experiencing any of the things that the participants were. Gould (2010) concludes that interpretative etic insights can be infused with informed critical perspectives and applying a critical emic can consider how the two cultures of researcher and participant might frame the results.

The importance of transparency is key, with the laying out of fore-knowledge, motivations and pre-conceptions as within the systematic approach to analysis and interpretation: this is integral to the hermeneutic circle within IPA, that understands the researcher is engaged in making sense of the sense making of the participant (Smith et al, 2012). This double hermeneutic conceptualizes the meaning making of the participant, and also the meaning making of the researcher; the insights generated are a product of the relationship and interaction between the researcher and the data (Smith, 2018; Willig, 2013).

This chapter has described the theoretical frameworks that support the stages of data analysis, which fit with IPA methodology. The practical application of these stages has been discussed in relation to this study's data that was collated via the semi-structured interviews. The approach to data analysis involves immersion in the data and active engagement with the data. The analysis is in the form of interpretation by the researcher in an interlinking of transcript data and interpretative comments. Within IPA the researcher's interpretation is the central analytic tool used to study the data. The researcher engages in an interpretative relationship with the transcript, which allows for the capture and recognition of the meanings

relevant to the phenomenon in the participants mental and social world (Smith & Osborn, 2004).

The important aspects of assessing the quality and validity of the study have been addressed through the use of Yardley's (2015) four principle considerations of: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. Authenticity and trustworthiness were considered as an aspect of methodological rigour, highlighting the importance of communicating sufficient information about methodology, in order for the reader to be able to evaluate the trustworthiness and credibility of the studies results and conclusions. Finally the importance of reflexivity within the study design has been discussed through the bracketing interview and as a continual process of engaging with and articulating the place of the researcher within the context of the research.

Chapter seven: Phase One study results from data analysis

"I learned to appreciate how important it is to listen to a variety of discordant voices- and to be especially careful not to distort them, not to reduce them to one uniform harmonious choir" (Stadlen, 2004, p.9).

Overview of results presentation

This chapter lays out the presentation approach to the three data analysis results chapters. The results from the data analysis in each study phase are presented with illustrative verbatim quotes from individual participant's interview transcripts, which are interwoven with interpretative analytic commentary. Lastly the themes in each study phase are discussed within the context of the existent literature.

Chapters seven, eight and nine respectively present the study results in the three phases of the study (see Table 09).

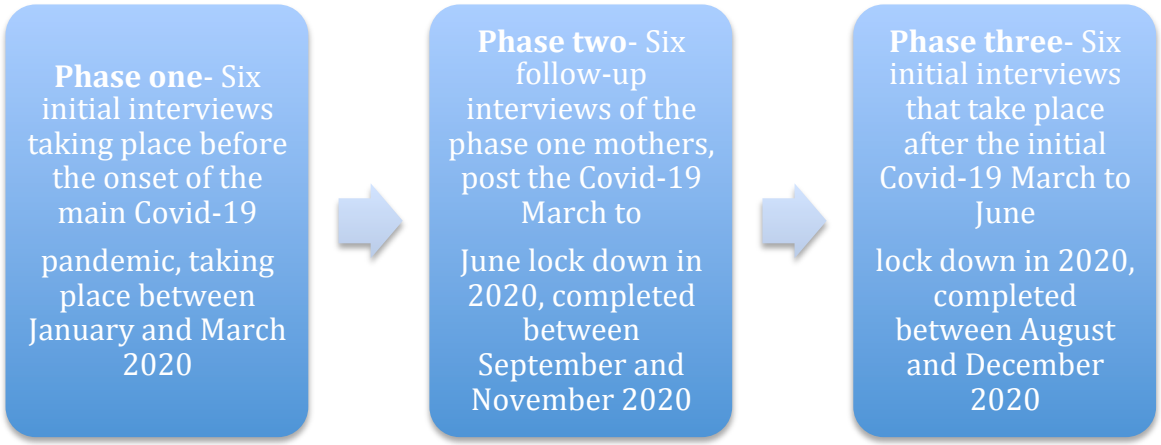


Table 09. Flowchart indicating the timings of the three phases of the study and the Covid-19 circumstances.

The data was analysed as described in the previous chapter through engagement with the interview transcripts, reading and re-reading the transcripts, following which initial noting and further experiential description was developed. The analytical process was continued by the development of individual emergent themes followed by moving into generating group generalised experiential themes through cross case analysis. The emergent 47 sub or lower level themes were clustered into 14 main themes across the three study phases; with five themes in phase one, four in phase two, and five in the phase three study. There are three overarching super-ordinate themes, presented independently in chapter ten, which are more abstract in nature and relate to the three phases of the study as a complete entity.

In the results chapters quotations from the participant's transcribed interviews are indented and italicised. The use of a series of four full stops e.g. "….." within the participant transcript extracts, denotes the participant pausing for thought and not the use of an ellipses to indicate that words have been omitted, longer pauses are also noted in brackets. Where participant quotations also contain dialogue from the researcher, they are labeled 'P' for participant and 'R' for researcher respectively. Skinner and Zimmer-Gembeck (2011) conceptual model of hierarchical adaptive processes and families of coping was used to identify the ways of coping used by the mothers and is integrated into the analysis (See table 08). A table of themes is included for each study phase: detailing the participants included in each theme; whether the theme is present in over half the sample; and examples of key words and phrases pertinent to each theme (see Table 12, 13, & 14).

The background information for the six participants in the phase one study are detailed here in Table 10 using pseudonyms to protect participant's identities, details include

participant age, geographic location, marital status, children's age and gender, and self-reported mental health difficulty.

Table 10. Participant background information for phase one study.

Participant number and pseudonym	**Age**	**Location**	**Marital status**	**Children age M= male F= female**	**Self reported mental health difficulty**
1- Ava	28	North West England	Married	M aged 22 months	Anxiety
2- Beth	27	North East England	Married	F aged 18 months	Pre-natal depression, Post-natal depression
3- Chloe	28	West of England	Married	F aged 2 ½ years M aged 5 months	Obsessive compulsive disorder
4- Dawn	37	Wales	Married	M aged 2 years	Bulimia, anxiety, depression
5- Ellie	29	Wales	Married	F aged 3 years M aged 18 months	Post-traumatic stress disorder, Post natal depression
6- Faye	26	Wales	Married	F aged 11 months	Depression

The analytic phase was completed by the triangulation and integration of the interview data from phase three of the study with the themes from phase one and vice versa. The participant background of the six mothers in the phase three study are included in Table 11. below.

Table 11. Participant background information for the phase three study.

Participant number and pseudonym	**Age**	**Location**	**Marital status**	**Children age M= male F= female**	**Self reported mental health difficulty**
7- Grace	32	Scotland	Married	F aged 3 ½ years F aged 22 months	Depression
8- Hazel	34	Midlands England	Married	F aged 2 years	Anxiety
9- Isla	34	Midlands England	Married	F aged 5 months	Anxiety
10- Jinny	32	Wales	Married	F aged 11 years M aged 9 years M aged 2 years	Pre-natal depression, Post-natal depression
11- Kelly	34	North of England	Married	M aged 4 years M aged 9 weeks	Pre-natal depression, Post-natal depression
12- Lynne	32	Midlands England	Married	F aged 7 years M aged 5 years F aged 10 months	Depression, Anxiety

In the first phase of the study, the main areas that have been drawn together in the cross case analysis of themes were: an examination of the lived experience of coping as a phenomenon; the relevance of concepts around self-care and identity to coping; an exploration of what constituted effective support in terms of their coping for the mothers; and how the mothers were able to talk about their hopes and intensions for passing on to their children strategies for coping and building resilience. Three of the six interviews in this phase were carried out face-to-face in person, two in the participant's homes and one at an agreed location; and three interviews were carried out face to face on a virtual medium.

Table 12 introduces the themes and illustrates each theme with key words or phrases from the participant transcripts.

Table 12. Table of themes in phase one study.

Study Phase	**Theme**	**Participants**	**Key words and phrases**	**Present In over half of total sample**
Phase One	1. Mother's lived experience of coping	Ava Beth Chloe Dawn Ellie Faye Grace Hazel Isla Jinny Kelly Lynne	"You can do this" (Beth, p.14). "Riding that wave" (Chloe, p.212). "It will get better" (Dawn, p.22). "I have to go on" (Faye, p.14). "Hold it together" (Grace, p.11). "Survival mode" (Isla, p.12). "Auto pilot" (Jinny, p.6).	Yes
	2. Learning the importance of self-care	Beth Dawn Hazel Isla Jinny Kelly Lynne	"Bottom of the pile" (Beth, p.7). "I looked like shit" (Dawn, p.8). "So much pressure" (Hazel, p.9). "Empty cup" (Isla, p.15). "So exhausted" (Lynne, p.7). "At the bottom" (Jinny, p.8).	Yes

	3. Losing selfhood: Reclaiming selfhood	Beth Dawn Ellie Faye Grace Hazel Isla Jinny Kelly Lynne	"Sacrifice" (Beth, p.17). "I've lost who I was" (Dawn, p.8). "Just a full time mum" (Faye, p.1). "Lost myself" (Lynne, p.3). "Changed the essence of who I am" (Hazel, p.1). "Lost my own identity" (Kelly, p.5).	Yes
	4. Identifying effective support	Ava Beth Chloe Dawn Ellie Faye Grace Hazel Isla Jinny Kelly Lynne	"Tough love" (Ava, p.12). "Acceptance" (Beth, p.10). "A really small act" (Chloe, p.19). "Checking in with me" (Faye, p.8). "Cleaning" (Grace, p.10). "Cooked meals" (Hazel, p.14) "Washing" (Kelly, p.8). "No judgement" (Lynne, p.8).	Yes
	5. Passing on coping	Ava Beth Chloe Dawn Ellie Faye Grace Hazel Isla Jinny Kelly Lynne	"It's OK you can cry" (Beth, p.16). "What ever they need to talk about" (Chloe, p. 24). "Big breath, calm down, let me know what's wrong" (Ellie, p.16). "All we can do is our best" (Faye, p.15). "Its Ok not to feel 100 percent all of the time" (Jinny, p.19). "Quiet time to kind of calm down" (Grace, p. 15). "Acknowledge it and say I know you are upset" (Lynne, p.25). "Stopping and pausing" (Kelly, p.16).	Yes

Theme one- Mother's lived experience of coping

The mothers included in this initial phase one study were able to discuss and describe their engagement in a broad spectrum of coping strategies. Ava describes using rationalising self-talk to help her cope with her child's behaviour. She explains how she often reminds herself that her child's behaviour is normal and not something to worry about.

> *I still say it to myself sometimes now, yes he should know a little bit now but he's still a child, he doesn't understand and that's ok* (Ava, p.11).

Ava's use of cognitive reasoning to draw meaningful conclusions, shows her ability to be reflective, this appears to be calming for her and assists her with regulating her emotions. Beth similarly uses self-talk to help herself rationalize that the intensity of parenting is time limited and this is helpful to her in terms of motivation and manageability.

> *I used to just repeat things to myself in my head, you know like 'it's not going to be forever'* (Beth, p.11).

Dawn in the same way uses self-talk, to emphasise the time-limited nature of early parenting. In this extract, Dawn's use of repetition accentuates the message that she is giving to herself, allowing it to stay in her mind and perhaps creating less opposition with successive suggestions.

> *I just keep telling myself it will get better, it will get better….* (Dawn, p.22).

Chloe similarly shows her ability to think about things and motivate herself using cognitive self-talk. Chloe is able to remind herself that she is doing ok by appreciating her children.

> *I kind of go I can't be that bad, this isn't who I am because look how I've done, you know and look how well I've done it because they're pretty cool* (Chloe, p.22).

For Beth, the ability to be organised is important for her, she see's her ability to strategize and plan as a coping mechanism. Beth is clear that the realistic approach for her is paramount, so that she is able to achieve mastery, even if its only a small thing and in this way she is not self-destructive by trying to do too much and possibly prompting failure by then not being able to do it.

> *I think that being organised is one of the key things, but soft organisation, like being realistic about the amount of tasks that you can get done in one day, and you know, even if it's just one thing, like if you need to get the shopping, on any day of the week, plan that one day and make that your one task for the day* (Beth, p.13).

Faye also mentions this 'realistic' element in her organisation and her expectations; she wants to feel that she has achieved something, even if it is only one thing, she can achieve a sense of mastery, rather that attempting many things and feeling a sense of failure with things being unachievable.

> *If I set myself a realistic expectation of doing one thing a day rather than getting overwhelmed thinking I've got to do this, this, this and that…. then I feel like I…. that really helps me mentally* (Faye, p.19).

Chloe also discusses the ability to be organised, in her parenting strategy she gives her older daughter something to do whilst she is feeding the baby. This enables the three of them to enjoy their respective experiences and not be distracted or stressed.

I'm really good about being organised and saying, right ok I'm going to get this out so that I can start a game and she can carry on the game so that she's got something to do whilst I'm feeding him and she doesn't get jealous (Chloe, p.15).

Faye shows a development of this style of coping by recognising her responsibilities. In this longer quote Faye tells herself that things are time limited but also that they will get better. In a delightful way she looks forward to her child's happy interactions.

I think it's the fact that I have to…. I have this responsibility now in life, um I have to get up and I have to go on, I have no choice um which sounds horrible but it's actually not it's a really nice no choice.... um and also I can tell myself this isn't going to last forever, you know something good and positive is coming around the corner whether it's her laughing at me tickling her belly or something, there's always going to be a positive with her….(Faye, p.14).

Faye is able to appreciate her interactions with her child and this helps her think more positively about the day ahead.

In this next exert Beth focuses on her ability to regulate her emotions: it is emotion focused and self-reliant in nature and emerges through a sense of self-discovery.

I kind of found a way to cope with it, by just walking away sometimes, just to go actually, I just need to go and sit in the bathroom for five minutes, like or even just 10 seconds to just breath…. and calm (Beth, p.11).

Beth describes how she learnt to be able to comfort her child even in times of stress and exhaustion by calming her own emotional responses and regulating her emotional expression towards her child. This is protective for her child, and demonstrates a parental protective capacity in her.

Chloe also talks about attempting to regulate her emotions, but recognises that she finds it challenging. She uses the phrase “riding that wave” (p.21), the wave of intense emotion, it is difficult for her to do.

> *On a really bad day it’s about riding that wave and it does help eventually it’s just that that wave is pretty horrible to ride. Um but I do find that the more that those coping mechanisms work the more good days I have* (Chloe, p.21).

Chloe expresses this in a metaphorical context that implies going with what is happening in that moment, for her the more she is able to do this the more effective she finds it as one of her coping mechanisms.

Ellie describes being able to seek emotional support, she values the experience and understanding of someone that has been through something similar to her and she feels able to talk about things when she is having a bad day.

> *My sister, my sister is really good because she’s done it all, she’s been through counseling, she’s been on medication, she’s been off her medication now for three years, so she really gets it, so she’s really good to talk to on a bad day* (Ellie, p.12).

Ellie deliberately seeks support from someone that she is confident will understand her situation. It is implied in this extract that talking to someone who had not the experiential understanding would be more difficult or less helpful, Ellie has no fear of judgment from her sister because her sister has “done it all” (Ellie, p.12) and can therefore be a trusted source of emotional support in this respect and can assist Ellie in regulating her emotions.

Faye describes the hope that she will be able to pass this form of emotional coping ability on to her daughter, the ability to express emotions leading to the ability to process what is happening.

> *...and if she is ever feeling down or anxious she can always express that and if we can express it we can talk about it, that's the way to kind of process.…*(Faye, p.7).

The use of the word 'process' implies a cross over with cognitive forms of coping, which could include: forming a narrative by organising thoughts and managing outcomes.

The cross over cognitive and emotional styles of coping include further examples of coping self talk. Faye reminds herself that she chose to have a child, it is what she wanted, no matter how distressed she feels.

> *You know it's my choice, it's what I want to do* (Faye, p.1).

This sense of taking responsibility for life choices is a type of acceptance and helps give meaning to the experience that she is having.

Beth finds strength from listening to her positive thoughts, but she has to pick them out from her more negative thoughts.

> *I just wanted to, to run away, but, there was all these things in the back of my head saying 'you can't do this', 'you can't do this', 'you've got to work on this bond because one day it will be worth it'. And it is worth it now, but at the time like it was absolute hell (laughs)* (Beth, p.14).

Beth here is expressing thoughts that were helpful to her in her struggle that came from another part of her being, a part that was able to encourage and motivate her.

Her description of “absolute hell” (Beth, p.14) leaves no doubt about the depth of her feelings at the time. Her laugh indicates the level of difficulty for her; it is possibly an acknowledgement of her pain, a recognition of the juxtaposition of “hell” and “worth it” in her account (Beth, p.14).

Chloe describes her coping strategy of saying things out loud.

> *To hear it out loud can actually make it really funny, because it’s such a silly thing to worry about that’s not going to happen* (Chloe, p.20).

Having a tiny, vulnerable baby to care for can raise all kinds of anxiety and fear for mothers, which are often protective in nature; however when spoken out loud they may not all sound rational and this enables Chloe to emotionally regulate her fears. It examples self-directed emotional regulation, Chloe points out that she can see the funny side when she says it out loud, it does not sound like a realistic concern to her; but it feels like a sad form of laughter, a way of normalising her fears, convincing herself that things are actually ok. Her use of the word “silly” could imply that she feels foolish for having some of her fears, she is not confident in her own judgement (Chloe, p.20). This is not positive in some ways, in that there is an element of self-denigration: however in terms of re-negotiating her anxieties it is an effective coping strategy for her.

Moving on to the inclusion of the data from the phase three study into the phase one study themes, the data from the phase three study shows similar diversity in the wide variety of ways of coping that the mothers employ. In terms of coping Grace is able to identify many sources of resilience.

Probably in the most difficult times I would have got…. tried to hold it together until H got home, and then quite often just gone out by myself, like on a walk or something like that and kind of tried to clear my head, umm quite often planned things that were going to help me (Grace, p.11).

This behavioural coping includes some passive coping as in self-control and but then positive emotional coping finding time for self and some space to think and restore. The cognitive coping skill is also present on the holding on in the sense of time 'holding it together' in the awareness that it is time limited and that relief will be available at a later time.

Hazel identifies that spending time outside is helpful to her, she is able to identify that being in the quiet of nature she is able to find a sense of balance.

P- Yes being outdoors, it always balances me so getting outdoors as much as possible is a coping strategy I think....
R- What is it about being out doors that is so helpful?
P- ahh.... the quiet I suppose, the fresh air, I'm not from a city, so I grew up in (place name) so I'm I would spend a lot of time outdoors I would spend a lot of time at the beach by the sea, in the woods, things like that, so um I think that kind of…. I think there is just something about being in nature I guess that kind of balances me (Hazel, p.22).

Hazel in a similar way to Grace is able to appreciate this as a coping strategy; this recognition of the effectiveness of a coping strategy enables it to be used purposefully to facilitate coping. The recognition of coping strategies also enables the development of a coping repertoire that can be consciously accessed in times of need. Hazel is also able to identify 'being organised' as a conscious coping strategy.

> *Although having a baby and being organised is kind of hard, they kind of don't go together really well, it makes me feel like I'm coping better, if I know if things are in order* (Hazel, p.21).

Having a sense of mastery is enabling for her, she is able to strategize, plan and take effective action that makes her life more manageable. This is essentially problem solving in nature.

Isla talks of being in survival mode-

> *I think we were both just in survival mode* (Isla, p.12).

This for some might indicate her not coping, however the managing of moment by moment, surviving each day may resonate with many parents in the early days of caring for a new born infant. In a similar way to Isla's "survival mode" (p.12), Jinny describes how at times she faced the world on what she describes as 'auto-pilot'.

> *That was obviously auto-pilot I was quite emotionless, because I got upset about a lot of things so I just turned my emotions off to the world, I would get up sort (the children named) out to go to school, send them to school, get ready for work, go to work* (Jinny, p.6).

This is potentially mal-adaptive in style, but it is protective in some ways, it is an escape, a mental withdrawal, a break from the distress and possibly a way to survive until things improve for her. Here Jinny relates a complex aspect of her coping.

> *When I have my GP reviews it's… yes never been suicidal thoughts it's always just that I can't cope, that I need to be able to want to cope* (Jinny, p.7).

The needing to want to cope is hugely significant because without that what do you

have? It is an aspect of her depression that is creating a difficulty with motivation for her. The way that she copes with this stagnant state is really inspiring; she describes being able to do something different that could break the stagnation.

> *That was the biggest thing to do something that was out of our routine* (Jinny, p.5).

In terms of coping this is taking instrumental action, it is problem solving and strategizing. It did not have to be any thing big, but just breaking the routine and shaking things up a bit.

> *I do like to be in control and I like to have a set routine and when things are out of my control then I do feel that I can't cope, but I can't remember what the thinking was behind having that change in the routine then, it was mainly just to snap me out of my way of thinking* (Jinny, p.6).

There is a high level of self-awareness here, Jinny recognises her need to be in control and stick to her prescribed routines; she also recognises that when this does not happen she feels unable to cope. The likelihood of feeling out of control when caring for a newborn is possibly fairly high as the levels of need and manageability in caring for new-born babies are fairly unpredictable. However the changing up of the day's activities was really helpful for Jinny, enabling her to accommodate in a more flexible way the levels of difficulty that are present for her.

The use of logical thinking is useful for Kelly when she is tipping in to catastrophizing thought patterns.

> *You tend to find like five things go wrong you know in a row and it's hard.… sometimes I will ring my mum then, in a bit of a tis and she tries to remind me that you know it's not necessarily.… like those five things aren't necessarily connected, they just happened to have happened together and you know it doesn't have to be a negative rest of the day just accept that they were all a bunch of bad co-incidences kind of thing* (Kelly, p.15).

Kelly is able to seek support from someone that she trusts and with her help is able to dispel the feeling that everything will go wrong because a few things have gone wrong. The seeing of a negative pattern for Kelly is predictive of the rest of her day, but when her mother points out that these may not be connected occurrences, this enables her to emotionally regulate and calm her thinking so that she is able to cope better. With her second child, the changing of priorities for Kelly is a positive coping strategy.

> *I think first time round that would have just stressed me out that I would have sort of noise and clothes all over the floor and things like that but then I just kind of flipped it on its head this time and thought well managing to feed a baby and look after a four year old and have a shower that's sort of quite an achievement rather than just being sort of a nightmare*….(Kelly, p.10).

This re-negotiation of her priorities enables her to be more accepting of her limitations and be able to appreciate what she is able to achieve. It feels a really positive focus for her, rather than the focus on the unachievable.

Hazel has been able to identify activities that she can do that are calming for her-

For my quiet down time I do a lot of sort of sewing, cross-stitching and sewing and things like that and I guess and reading, I think I mentioned that to you, but I suppose sort of developing…. I think there is something about doing things with your hands, quite often that for me will certainly calm me down (Hazel, p.26).

It is a recognition of her own needs in this respect: a time for self; a time for calm; the physical repetitive craft that can aid the physiological calming of the body; and doing something that she enjoys. It leads by example for her children, the ability to pursue calm activities that are productive or meet the needs of self.

Lynne is able to reflect on her self-talk and realise that she needs to be compassionate towards herself.

There have been times where I've said to.... like I've internally said stuff to myself and I've had that realisation of…. what are you…. kind of like what are you saying that for.... or what because you wouldn't dream of saying that to someone else in that situation…. (Lynne, p.23).

In terms of coping this reflective functioning is valuable, she realises that she would not speak to another person in such a negative way and she is able to challenge herself to be kinder to herself.

The lived experience of not coping can be experiences as difficult and unhappy, as Ava describes-

I had, had a really bad day, everything just made me cry (Ava, p.8).

Where as coping described here by Faye is a kinder happier experience-

> *I've achieved something and also I'm not overwhelmed, you know like that's a big achievement* (Faye, p.19).

The experience of not coping can also impact the maternal infant relationship, as Beth relates here-

> *When I was at a bad time, I absolutely hated her, I really did* (Beth, p.6).

Beth describes the experience of not coping and how it impacted how she felt towards her daughter, she continues here to comment on how she feels that society has expectations of motherhood that make it hard for her to comprehend how things could have been different for her.

> *I just felt completely overwhelmed all of the time and it was really really difficult.*
> R- *It was a very hard time*
> P- *And it was really hard not to blame her for it even though it was me that did it, cause I decided to bring her into the world, but I don't think (pause) I don't think, I don't think it would have been any other way if I had a different child or if I did things another way, because I think it's quite natural for women to put all this pressure on themselves to do it right because society expects them be independent and not to be expecting other people to drop in all the time and to make them meals and….* (Beth, p.7).

Beth highlights the expectations that the society around her place on mothers to be independent, to the detriment of mothers' coping abilities. This challenges the status quo in some ways and shows her insight into her own situation.

This first theme is able to give examples of an extraordinary range of coping resources that the mothers are able to call upon that demonstrate the real and effective strategies that they are using on a daily basis. The inclusion of adaptive and potentially mal-adaptive strategies is significant in that the mothers are doing what they need to do in order to cope.

Theme two- Learning the importance of self-care

The mothers in the phase one study describe an internal journey for them in terms of self care and coping; involving initially finding themselves low down on the hierarchy of needs, and then realising that they are unable to manage caring for their child, if they do not meet some of their own needs. Beth describes finding herself at the "bottom of the pile" (p.7) when she is using all her energy to try to be a better mother than her own.

> *I always promised myself I will be a better mother to my child than I had, and I feel like I wanted to do absolutely everything to ensure that we had a stable and perfect connection and I was so hell bent on that, that I caused extra pressure on myself, like I, for the first maybe five or six months of her life she spent it in my arms, which was what I thought you were supposed to do, because you know, my heart beat will calm her, what in fact that did was put me at the bottom of the pile* (Beth, p.7).

The recognition that she is at the bottom of the pile is then pivotal to enabling Beth to make changes to meet some of her needs. Beth is exhausted by her attempt to be a better mother than her own mother; she is desperate to remedy what was broken for her in her own experience. It feels as if this could make it better for her as well as her child if she can create the "perfect connection" with her child (Beth, p.7): there is a

sense of righting a wrong almost, re-writing the past for her. Beth is thoughtful about self care and challenges the thought that you can buy self care-

> *I think that like, people think self-care, self-care is kind of this thing that you buy, but actually I think self-care is like choosing a course to do, or paying a bill, and making sure you are on top of life you know, not distracting your self from it* (Beth, p.12-13).

This is sophisticated thinking in terms of coping and self-care; if she makes her life more manageable, she will be caring for her self in terms of her equilibrium, her life balance, and this will enhance her coping abilities.

She later describes how she has learnt to prioritise her own needs.

> *I'm developing as a human, and my highest level I have ever done, and part of that is because I'm a mum and that has its own stress, but part of it's because I'm doing something for me, like this evening I'm going to a singing lesson* (Beth, p.16).

Beth is taking some time for herself, to do something that she likes to do; this is valuable to her in terms of her own mind, finding time for her own joy and supporting her mental and emotional health.

Dawn describes her experience of being "last down on the pecking order" (p.3) she later explains further about not being able to look after her-self, whilst still maintaining high standards for her baby.

Well I just looked like shit all the time, you know and I would always make sure that M's clothes were um…. I put something on insta-stories.... instagram the other day you know I got his little folded cardigan out and I got the little de-bobbling machine and everything making sure its looking perfect and my own clothes I just…. pick it up off the floor, I just like…. I…. it's just covering my body and that will do, as long as he's not going… as long as he's clean and brushed and he's got all the things he needs and his needs met then I can just…. (sigh).... you know sometimes you feel like as a mother (pause) you are the child's shadow, that's how I felt like, and not actually…. sorry I'm going to start crying…. (Dawn, p.8).

Dawn's account of caring for her child's clothes to the utmost extents, even making sure there were no bobbles on his cardigan is in contrast with her attitude to her own clothes, which are picked up off the floor. The phrase "child's shadow" (p.8) presents a feeling that Dawn feels that she is concealed from view, not noticed or not good enough; her needs are hidden and she is less worthy of care. Dawn is insightful in her reflection, but it visibly distresses her to hear it out loud and she has to stop. Dawn feels that she had to break before anyone recognised that she needed help.

But I feel like I had a breakdown I feel that I've had a breakdown before it got…. before we got.... I got….(Dawn, p.7).

She struggles to express what she is trying to describe and her speech becomes dysfluent. The terms that the mothers use of 'being broken', 'last down on the pecking order', 'bottom of the pile' are strong and desperate, crying out for recognition of their needs. They come to a realisation that they themselves have to take action and meet their own needs. Dawn tells how she has learnt to act as her own friend in this respect.

> *I just keep going through what I would be telling a friend, um I'm listening to happy things just trying to be practical and doing the leg work, going to the gym, yoga, reading, that all the people say you need to be doing, a healthy diet, getting out for fresh air, listening to happy things, just do all the stuff that people tell you to do* (Dawn, p.19).

For Dawn these activities that she undertakes to become well are work "doing the leg work" (p.19), she is working at wellness and shows her ability to adapt, and develop positive coping strategies. The ability to be your own friend appears incredibly positive for Dawn, and relates back to positive rather than negative self-talk and the ability to be reflective of how we speak to ourselves.

The mothers from the phase three interviews also express similar struggles with self-care; in a similar way to Dawn when she was unable to attend to the clothes she was wearing. Lynne also recognises a lack of interest in herself and how she looked-

> *I just didn't take much interest in how I looked particularly, I was just so so exhausted with (second child) when he was a baby, I just didn't have time to even consider how I looked half the time….*(Lynne, p.7).

The exhaustion she felt limited her ability for self care, her energy is focused on caring for her baby. Isla also reflects that she was so concerned with providing care for her daughter that she did not look after herself "at all" (p.13).

> *I don't think I did, I really don't think I did look after myself at all, I think it was really um I was just much much more conscious of making sure she was ok* (Isla, p.13).

Isla contrasts her attentiveness to her self before and after having her child.

> *Before I had F my hair would always be done, I had my make up on, now it like nah (laughs) scrape your hair back I've got no make up on, if my clothes have anything less than poo on them, you know that's a win* (Isla, p.13).

There is a feeling of either/or here, it is not possible within available resources to care for the self and the infant; so in the mother's protective stance, the infant becomes the priority to the detriment of self.

This pressure to be a perfect mother resonates with Hazel's account; there is a development for Hazel from trying so hard to be a perfect mum, to realising that she needs to develop kindness towards herself.

> *Learning to be kinder to myself um which I didn't in the beginning I really like I said for the first few months sort of two months at least I felt like I needed to be perfect, I was putting so much pressure on myself* (Hazel, p.9).

For Hazel the transition to motherhood brings a realisation of the need to care for herself.

> *Definitely becoming a mum has taught me to kind of look after myself* (Hazel, p.18).

The risks of not doing so are a loss of self, a feeling of being used up and not replenished.

> *I can't put everybody else first before myself all the time because there will be nothing left of me….*(Hazel, p.18-19).

The act of self-care in effect acts to restore the self, enabling the self to function: the lack of self-care affecting overall well-being, to the point of loss of self where there is "nothing left of me" (Hazel, p.19).

Isla reflects on something she was told by a family member-

> *Well my granddad always used to say…. you can't pour from an empty cup…. so there is no point running yourself into the ground repeatedly* (Isla, p.15).

Isla is able to rationalize that she will be better able to care for her daughter if she is able to take care of her own needs.

> *Actually I'm going to come back and be a happier, nicer person (laughs) a more patient person, um and that's better for her*….(Isla, p.15-16).

This recognition is protective of the child, providing a more balanced ability to provide care for her child; and also acknowledges her limitations as a person.

The placing self at the bottom of the hierarchy of needs is an ongoing issue for Jinny.

> *Right at the bottom, yes it was always…. it was always the children first, my partner, then me and I think that's still the case now actually*….(Jinny, p.8).

However in some way Jinny knows that self-care is important if only to be able to continue caring for others.

> *I think as we get older it definitely becomes more clear to us that we need to be ok ourselves before we can look after others* (Jinny, p.9-10).

There is a feeling that having a sense of well-being in herself, enables Jinny to endow well-being in her children. This demonstrates a sophisticated reflexive reasoning that is something Jinny attributes to her life experience.

Kelly reflects on attitude to self and showing self-appreciation for the mental and physical challenges of bringing up children for both parents.

> *It's a really big thing, it's a big life style change and it takes a lot out of you both physically and mentally, um it's a positive thing like you are bringing up a child but you know some people probably underestimate that and definitely I think mums make themselves feel worse by the fact that you know apart from your own family a lot of people around you don't really appreciate that it's a massive thing that you're going through* (Kelly, p.19-20).

This mental attitude of self-appreciation is supportive and benefits from being non-judgmental and acceptant of the struggles that are common to motherhood and fatherhood. It is obvious that motherhood is 'normal' but the strains are interpreted as unappreciated by others here, and giving self-credit for what you can is self-caring in this respect. It lessens the need to strive for the unachievable perfection.

Lynne recognises that she needs to monitor her 'self-talk' in a light of recognising the need for self-compassion.

> *Because there have been times where I've said to…. like I've internally said stuff to myself and I've had that realisation of…. what are you…. kind of like what are you saying that for…. or what because you wouldn't dream of saying that to someone else in that situation….*(Lynne, p.23).

This is also recognition of the need for self-care; it is emotional care-taking of the self, as you would for someone that you loved. The journey from elements of self neglect and being bottom of the hierarchy of needs for the mothers appears to be one of self-

realisation that they can not function in a balanced way of coping, without the ability to meet some of their own basic needs.

Theme three- Losing selfhood: Reclaiming selfhood

For the mothers, the ability to be able to 'take care of yourself', appears to be wrapped up in identity. Identity was a difficult issue for them and one in which they predominantly expressed a sense of loss. The concept of selfhood is based around the quality of self that constitutes individuality as a person (Oxford Essential English Dictionary, 2011).

Beth expresses a loss of aspects of her personality that were positive.

> *I think, I've always been quite a positive person, but motherhood made me incredibly negative all of the time* (Beth, p.12).

However we can question if this is motherhood or the mental ill-health that came with motherhood for Beth. She later returns to this sense of loss, of "losing' who she is and having to re-invent herself.

> *I've always been absolutely fine with who I am, but, I really struggled with, because you don't know who you are when you are a mum, for the first time, you absolutely don't, everything changes, every part of you that you enjoyed before disappears for some reason. Then it takes such a long time for that to come back, because you have to re-invent yourself, you have to say goodbye to the person that you were before, completely and then re-build your life* (Beth, p14-15).

Beth assumes that her experience is felt by others, “you don’t know who you are when you are a mum” (p.14) and this raises a lot of questions: why does motherhood obliterate who she feels she is beforehand; is this a common experience for mothers; why has everything changed for her; what do mothers need, to be able to maintain a sense of coherent identity that transitions childbirth?

The re-building of her life and identity is a positive feature in her narrative, but she is cautionary to herself for the future; she does not want to go through the experience of losing herself again, this loss for her is serious and risky.

> *I never want to sacrifice myself like that again, it’s not worth it really, but the journey that I’ve been on, and however much I’ve come out of it and developed, it could have quite easily gone the other way, you know and I don’t want to put myself at risk like that…. we just sometimes seem to forget that your mental health is incredibly important and it can be the choice like between life and death or completely suffering or not* (Beth, p.17).

Through this experience of losing herself and suffering, Beth seems to learn that she needs to be able to prioritise her mental health needs. For Beth the experience was life threatening and the knowledge she gains is of the importance of her ability to maintain her mental health.

Ellie remarks that when she is asked who she is “I always go ‘M and F’s mum” (Ellie, p.6) and at the time this seems to be enough for her. However motherhood is demanding of time and energy and creates difficulties for mothers in terms of remembering who they are and that their needs are legitimate.

Faye uses the word “just” as she explains that she is a full time mum, the word is queried by the researcher.

P- *I'm just a full time mum and obviously stuck in the house…*

R- *That's the interesting word there 'just'?*

P- *Yes I know, um it's a bit of a weird one, I think…. I think people put a lot of um merit on having a job rather than staying at home, as a mum…. so I find that hard....* (Faye, p.1).

Faye implies that merit is given to paid work and that motherhood does not attract this same merit, the significance is in the self concepts that ensue from this, of being less meritorious, even though Faye communicates that she thinks this is unfair. The consequences however are that she feels that her identity as a stay at home mother is not as valued as other working mothers and she feels "stuck" (Faye, p.1); we can question if this is a physical or metaphysical reality for her.

Dawn differentiated between losing her identity and losing who she was as a person, but it is unclear whether it is motherhood or poor mental health that is causing this feeling, although both appear interlinked for Dawn.

I feel like my um I've lost my…. not my identity but I've lost (pause) who I was, um the laid back, chilled sort of person, I feel like I'm always pretty uptight just waiting for the next bad thing to happen (Dawn, p.8).

Dawn goes on to describe herself as her baby's shadow, indicating the lack of self-worth that she feels; she is there to make sure things are done for her baby, but you get a sense of her loss of self.

You're existing but um he is my life now and I'm just a sort of a shadow, attached to him, making sure that everythings, everythings done (Dawn, p.8).

For Dawn her ability to return to work was critical for a return to a sense of individuality and her rights in her world. It suggests a memory of a more certain time for her, when she knew who she was as a person and when she was able to be self-sufficient financially.

> *I should have gone back to work sooner and insisted…. so then I'd have had money and I'd have been working as well so I wasn't just yes I wish I'd got the balance back sooner, and I think that would have helped my mentality….my mentality…. my state of mind as well, I deserve my space in the world….* (Dawn, p.21-22).

This use of the term "deserve my space in the world" is loaded with meaning, there is a sense that she feels that this has been denied her, there is a feeling of inequality, a feeling that she needs to be heard and that she has a right to be heard. Then she would be able to re-balance, re-establish equanimity for herself and heal. The need for financial independence is evident here in connection with her understanding of balance in her own life. Dawn says she should have "insisted" (p.21), fought for her right to choose to work if that's what she needed. There is a feeling that the expectations of society around her, was that mothers do not return to work in the first few months after having a baby, and that this was restrictive of her free choice to make her own decision in the matter.

With regard to coping, it seems that being able to maintain or re-create an identity that provides a sense of coherence is important for the mothers, in terms of having the ability to meet their own needs.

The theme is maintained with the phase three study participants, terms around the 'loss of self' are predominant.

I just completely lost myself I just wasn't the person that I used to be (Lynne, p.3).

The self that belongs to me, 'myself', not the part of self that relates to others, the part of self that relates to self.

I just felt like I didn't have any interests myself, that's the only way I can describe it, I think literally…. I think particularly after (second child) it just felt like an existence, that's the only way I can describe it as just getting though the best I could (Lynne, p.8).

The loss of activities and interests that would have been pursued prior to motherhood appears significant here. It feels like an existence "just getting through" (Lynne, p.8), not living a life fulfilled; a separation from mindful living.

I describe that feeling of when I'm feeling really detached and I had that feeling with both (Lynne, p.6).

This feeling of detachment suggests a feeling of emotional numbing or cognitive exhaustion, protective in some ways in terms of coping but passive and helpless to some extent too. Later Lynne is able to pursue some interests for herself and this is helpful for her need to regain her sense of self.

I did do two courses when I was on my maternity leave with (children named) that probably helped because it gave me um something for me (Lynne, p.16).

The doing of something for 'me' helping to replenish the sense of selfhood that had been lost.

Grace describes an absolute clash of expectation versus reality. She explains with humour how her expectations of early motherhood were not grounded in reality.

> *You don't actually understand the kind of…. what you do all day long, like I remember planning to paint the house whilst I was on maternity leave and now that seems completely insane to think that that would have been something that you would have been able to do, I don't know where I pictured the children were (laughs) do you know? Erm so yes it was probably a bit…. I don't think I realised how erm intense it maybe was and I think especially when they are very young, it's quite um it can be quite boring as well,* (Grace, p.2).

The reality of her parenting experience are clearly expressed here as all absorbing, intense, time consuming, boring at times with repetitive tasks and not in accord with her pre-parenting expectations. The humour she expresses feels healthy in response to the dramatic clash in expectation, but there was also distress and a loss of self.

> *I feel like I'm coming back to feeling more like myself now but um yes because I think that I've always been somebody who has been quite confident um and um very decisive and I've always had quite a good memory, and those three things were quite significantly impacted, and that was very strange.... I think the real…. the kind of judgments you get really knocks your confidence and then just the tiredness just really knocks your memory and then I couldn't make a decision to save my life* (Grace, p.2-3).

The confident, decisive person who was able to remember important details was then unable to make decisions, and became self doubting and not confident in what she was doing: there is a real sense of loss here and disintegration of the personality. Tiredness appears as being debilitating and making it hard to manage daily life needs; but the loss of self is most significant, the person who is known to the self, being no longer there.

For Hazel there are massive changes felt in her sense of identity, but they are more positive for her.

> *I feel like she's changed the essence of who I am really like how I feel about myself, how my priorities in life changed, it kind of all….not made sense, but kind of shifted into a much kind of…. I think calmer pattern for me rather than being all focused on work and studying and everything like that* (Hazel, p.1-2).

This change in the "essence" (p.1) of her being indicates something abstract but self-determining, a powerful shift of priorities and peaceful in its 'calming'. There is a sense that her life has become more understandable for her with the birth of her child. We do not know if these shifts in life priorities are permanent or flowing with the changing needs of her infant.

For Isla there is a challenge of her confidence in her own abilities and competencies-

> *I think because of the perfectionist issues that I have, nothing I ever do is ever good enough, um and I think that regardless of what your personality is like I think being a mum makes you question everything that you do, um you know…. am I doing it right….* (Isla, p.10).

This feels like a loss for her and there is a need to re-balance her sense of coherence, that her life is manageable; she seems to do this by doing things that interest her that are not about being a mum.

> *I would give my last breath for her if that's what she needed…. but I also am me um I have things that I'm interested in that don't link to being a mum* (Isla, p.14-15).

This statement “I also am me” (p.15) is profound, she is a mother to her child but there is a feeling that she is struggling to integrate her motherhood with her self-identity. The part of her that is a mother is more of a generic sense of motherhood and not specific to her as an individual. Isla develops this thought later-

> *You can’t be everything to everyone, and you need to…. to be something to yourself sometimes* (Isla, p.16).

The word “be” (p.16) in this context may infer ideas around existence, to live and breath, to consider self; if you meet everyone else’s needs you leave nothing left of yourself. This need to meet her own needs in terms of her identity and the integrity of her personality seems clearly stated here.

Jinny recognises a need in herself to return to work-

> *I imagined I would be so in love with this baby and I would want to do everything with…. with this baby, but in reality I just wanted to get back to work, because that was my norm and that was where I ....where I was comfortable I think* (Jinny, p.2).

It feels as if work for Jinny is a safe place where she is able to understand her role and feel at ease; she has confidence in her work identity and her abilities, to meet the expectations of her as a person. Later in Jinny’s story, she relates that the key phase for alerting her partner when she is not ok is “I’m not feeling myself” (Jinny, p.6). The statement implies that this is when she is not able to feel or behave in a way that is normal for her, or in a way that she recognises as her usual self. This reflective ability to recognise this changed internal state is pivotal to her coping abilities. It is this ability that enables her to seek support appropriately to meet her needs and return to an internal state of equilibrium where she is able to recognise herself again.

The experience resonates with Kelly's description of losing her sense of identity, and feeling a need to return to work where she knew who she was and had a support network of friends.

> *When I got the post-natal depression, I think I had sort of really lost my own identity I felt like I was just a mum, I didn't do any of the things that I used to do, obviously you know, the big thing was that I wasn't at work any more and that a lot of my life and probably a lot of my social life did center around my colleagues and things* (Kelly, p.5).

Kelly describes post-natal depression with the preposition "the", as if it is a generalised illness not specific for her: there is a sense that she does not wish to identify herself with it. If Kelly had difficulty feeling valuable to her own child at times, it could in the same way make it more difficult for her to value herself as a mother: however for Kelly the loss of identity appears in some ways to be a symptom of her post-natal depression. She is able to identify the loss of doing the things that she used to do, that feel bound up with her identity before motherhood. The phrase "I was just a mum" (p.5) resonates with Faye's (p.1) description of "I'm just a full time mum" and signifies a feeling of loss, maybe a loss of status, maybe a loss of social and financial security, possibly a feeling of not being valuable? For Kelly there is a need to reclaim all of these elements of her life, in order to reclaim her identity.

The complexity of maintaining identity through the transition to motherhood is evident: who you are, the way that you think about your self and the way that others view you are all essential characteristics of identity and are essentially bound up with coping. The additional burden of mental ill-health is significant in the struggle to maintain a

coherent sense of identity for these mothers; the necessity of meeting some of their own needs as individuals in their own right, outside of motherhood appears pivotal for them.

Theme four- Identifying effective support

For mothers losing a sense of selfhood as their horizons expand and transition to incorporate their children and re-balance into a new sense of selfhood is a challenging process, in which the importance of engaging with others within supportive contexts cannot be underestimated. Effective support in this context can be considered to be any action by a person that is successful in providing mental, physical or emotional assistance to another person in a time of need. In this passage Beth describes how her husband was able to support her emotionally through his acceptance of her. She takes a long time to think about her answer at the beginning of the passage and then describes beautifully what it is that he does that helps her.

> R- *What made you feel cared for?*
>
> P- *(long pause) erm probably acceptance from my husband more that anything, I know that sounds silly but, I think I was really angry all the time and I was really exhausted all the time so, just having somebody that just didn't get offended by that or just didn't take it personally that you know sometimes that I was going to struggle and that means more than anything, that helps more than anything, to know that I am secure, and to know that I am safe, and that, even though I am going through a hard time I've still got somebody that just accepts me for who I am and whatever happens you know that underneath it all, that it's ok, he's still going to be there for me* (Beth, p.10).

Beth articulates her feelings of anger and exhaustion interposed with feelings of safety that come from her husband's ability to communicate acceptance of her as a person;

he is non-judgmental of her struggle and does not make it about himself by taking it personally or getting offended. This acts as an emotional 'holding' for her and supports her from descending into more negative realms; giving her this emotional support lifts her sense of coping in terms of 'my world is understandable'. The feeling of safety that Beth receives from her husbands ability to communicate acceptance to her, helps her feel that her world is manageable in this way and supports her sense of coherence.

Ava describes the effective support that she received from her partner, when she is starting to get back to doing normal things like driving the car after having her baby. It might sounds like gentle encouragement to an outsider, but for her it is "tough love" (p.12) and it is the push that she needs.

> *I remember being worried about driving him in the car, the first time, 'just go out and do it, do it while you can, just go round the block that's all you need to do'. But I think if I didn't have that bit of a push with those little things, I'd have really struggled and it would have turned out to be bigger problems and bigger things, that tough love helped* (Ava, p.11-12).

This must be a difficult line to draw for partners, it is obviously scary for Ava to drive the car, with her baby in it, for the first time, a feeling that would resonate with many parents, the enormity of responsibility that descends with the birth of a child, perhaps with a first child in particular. The line between effective support and being overbearing might be relationship dependent and takes sensitivity on behalf of Ava's partner. He supports her sense of coherence in her life in terms of its manageability.

For Ava being able to manage and get on with the little things in life that loomed large for her helped her cope in a wider sense. It achieved a sense of agency for her that

brought with it a feeling of mastery that can contribute to well being. It was important that the "tough love" was loving however, and that it came from a supportive stance from her husband and was therefore not perceived as undermining or unhelpful.

A small act of kindness by her husband is recounted by Chloe, she describes it as "really valuable" (p.19). The "small act" (p.19) appears to signal to Chloe that she is being thought about: when she herself has to spend so much of her time and energy on thinking about others and in particular the needs of her children throughout the rest of the day.

> *It's a feeling of I was thinking of you, you know, and he does things like he brings me a cup of tea every morning, and its just a really small act but its something that, is really valuable to my day, it's a really lovely way to start my day, with somebody saying this is something that I can do for you* (Chloe, p.19).

There is another element in effective support for Chloe as her husband shows that he is able to hold her in mind when he goes to work.

> *I think he is very good at acknowledging how I am feeling and asking me about that rather than dismissing it or ignoring it. So he can sort of sense that I've had a bad day or a bad day is brewing and if I've had a difficult morning before he's left, he'll message me later on and say' how are you doing' and that makes me feel cared for* (Chloe, p.19-20).

He is able to acknowledge her difficult emotions and offer support through his remembering and inquiring about how she is 'doing'. There is a sense too that she is feeling accepted and not judged in this account, and she feels cared for in this respect.

Chloe identifies that being listened to, for her is helpful; she does not like it if someone jumps in to help her when she has not asked them to.

> *So it terms of being helpful, I think one of the most helpful things is when people ask what they can do to help, or ask how you are feeling and listen, rather than jumping in and trying to fix the situation or offering advice that hasn't been asked for in the first place* (Chloe, p.19).

Dawn identifies the difficulty of not being on the same page as her husband in terms of childcare and how this impacts her regarding effective support.

> *My husband will just keep giving him milk, so we are not quite on the same page as to what to try and do, my husbands getting better, um because now he's doing night shifts as well* (Dawn, p.13).

Dawn's baby was waking "15-20 times in the night" (p.3) and until her husband was taking a turn at childcare at night, they were not able to parent in a joined up way. In her narrative she describes repeatedly that she had to 'break' before it was noticed that she needed help.

> *Yes but it's taken…. for me to have a breakdown.... but I shouldn't really have to have a breakdown for people to go.…*(Dawn, p.9).

Her ability to cope was assumed in spite of the severe sleep deprivation that she encountered; there was an impression for her that as a mother she was expected to be able to cope, Dawn is clear about how she feels about this.

> *When a woman's had a baby, because women just push through and battle on because you think that's what everyone else is doing and you think that's what I should be doing being the bottom of the pile, you know women are cracking and imagine when women are having babies I find that women are already working the hardest they can, they are already at full capacity, between work and being expected to be this person and be that person and then you have a baby on top of that and its just oh my god you know, so yes that motherhood yes....*(Dawn, p.22-23).

The expectation is from her as a women as well as from others around her and this has implications for societies attitudes to supporting new parents. Dawn appears to accept that her husband is not different from society as a whole in his assumption that she can cope with what is in realistic terms the impossible. It takes his experiencing of the night shift for him to be able to 'be on the same page' in terms of their joint parenting and to be able to validate her need for support. For Dawn the multiple roles and demands on women in society already place women in a vulnerable position: being "this person and be that person" (Dawn, p.23) suggests that women have multiple identities that make demands on them. The recognition that she deserves for being a mother, does not appear to be an easy gain for her and there are serious losses for her in terms of her well-being before she starts her recovery. Her husband's support when it does come is transformative for her and as she is then able to develop a voice and express her own needs as she explains here "I am asking for more help now as well" (Dawn, p.9).

Ellie explains how she values her husband's encouragement to get out and do something different when she has had a bad day during the week.

> *It usually ends up being that typically the bad days are a week day and then the weekend we've got H and we go out and do something and it's really good and it sort of snaps me out of it* (Ellie, p.15).

This going out and doing something different is helpful for Ellie and supports her coping abilities, she intimates that it is able to alter her mood and make her feel better in herself.

Support from others external to the household comes from multiple sources through relationships with family members, friends, parenting groups, work colleagues. Faye describes a friendship that surprises her in its ability to support her, as it comes from a woman who does not have children.

> *I've got friends, older friends who've actually been fantastic, um since I've given birth, and I think its made our friendships stronger, um and friends actually…. one of my friends doesn't even like children, and she's been fantastic, you know she's been the best one at really like checking in with me and making sure that I'm ok and asking about the baby* (Faye, p.8).

The act of 'checking in' is valuable for Faye, it is not so much about doing, but of asking the questions from a standpoint of genuine interest that is the supportive factor, and Faye has confidence in the genuineness of the support as she feels there is no other motive present.

Ellie describes attending baby groups and how this helped her to connect with other mothers, forming a close friendship with another mum that has lasted.

I went to loads of groups with F, and I kept in touch with all of them, and we've all got a second one around the same age now so I've got one that I class as a really good friend and I've got a couple of others, you know, that I'm quite happy to go out for coffee and stuff (Ellie, p.12).

Attendance of baby groups was mainly mentioned by the mothers in a supportive context, however for some mothers it was an added pressure with which they had difficulty coping.

You've got to go to groups because there is that pressure that you, you know, you are supposed to go and do that, when actually if you've got anxiety issues which a lot of people do, when they have a baby, that isn't always the best environment for them to be in. Like for me I used to go to groups and then spend half my time crying, because I just couldn't talk to anyone, and my baby couldn't talk, and I just felt like, what am I doing here, I don't like anybody really (laughs) (Beth, p.4).

This passage is deeply expressive, Beth almost finds it laughable that she can't talk to anyone and neither can her baby, so what is she doing there. She articulates that it may not be the right place for someone who is feeling raised levels of anxiety.

For Dawn also it represented a struggle and a pressure to attend groups.

P- *Mother and toddler groups? Um yes I sort of did but I just…. this ahh…. I just felt really exposed umm*

R- *It raised your anxiety rather than lowering it?*

P- *Yes and you know in all fairness my husbands friends, wives and girlfriends were saying come on come out to these groups, you know I could never relax around them and I thought no you know that's no good….*(Dawn, p.15).

Dawn was unable to relax in the group environment, feeling exposed and uncomfortable she takes the decision not to go. Dawn's baby was not sleeping and she describes how she feels as people constantly tried to advise her what to do.

> *When you are already doubting yourself, somebody giving…. my, my and it's my issue when somebody is giving me advice I think they think I don't know what I'm doing, and I…. that's always been… because I've always been capable I suddenly thought to myself I'm not capable….*(Dawn, p.15).

There is considerable dysfluency in this passage characterised by the involuntary repetition of "my" (p.15) and changes in flow and rhythm, as Dawn appears to grapple with intense emotions. These emotions leave her feeling vulnerable and not up to meeting up with people that might offer her advice, advise that makes her feel that she doesn't know what she is doing and makes her question herself. Nevertheless she is able to gain support from a social media App for mothers who are awake in the night with their babies. Dawn explains that it is able to alleviate feelings of loneliness for her when she is up alone at night with her baby.

> *There's stuff like little stories and a forum just so people can say 'hi, anyone else awake out there?' you know, its quite new because that's when people tend to feel the loneliness* (Dawn, p.16).

The feeling that she is not alone in her night time vigil is supportive to her sense of coherence, in the terms that her world is understandable and therefore manageable.

Moving on to the phase three interviews, the mothers similarly are able to identify what in terms of support is effective for them. Grace recognises that both social and practical support was helpful to her.

> *So like when people had come, but like coming and sitting and hanging around with you, and maybe like cleaning, or my dad both times, he came over when F (First child) was born for I think two weeks, and he made all of our meals for the two weeks* (Grace, p.10).

The impact of providing meals for new parents has been mentioned repeatedly by mothers as really effective in reducing the strains in early parenthood. Hazel echo's this, for her the gift of cooked meals is incredibly valuable in terms of support in the early days of caring for her baby.

> *H's parents cooked us I think a months worth of meals so freshly cooked meals to go in our freezer, I still remember it now, I think I can still remember the taste of them and they were just such a godsend to us* (Hazel, p.14).

Another practical aspect of effective support is mentioned by Jinny when her sister will take the children for a few hours.

> *So my sister, everything she does is helpful…. she'll maybe have them once a week for me and it isn't planned and its quite a nice surprise when she does it, she'll just pick them up from school for me and take them home to dinner and have them for a few hours, and maybe a sleep over on the weekends* (Jinny, p.15).

It is not everyone who has this level of family support and Jinny acknowledges it as valuable. It is enabling of rest and restore time for parents and supportive in this way of overall coping abilities.

The effectiveness of practical support is exampled by Kelly here when her close family are able to help her.

They know that what you really need is sort of the practical stuff like you know, to grab all of your dirty washing and put it in for the baby (Kelly, p.8).

This relieving of the practical burdens of child care are able to lift the burden of care away from the mother so that she potentially is able to relax and enjoy the baby. However it is a fine line between effective support and intrusive ineffective support.

My mother-in-law would kind of take the baby out of the room and say…. you need to get some sleep we will look after the baby…. and stuff but after the birth I was quite anxious for a couple of weeks, um and looking back on it now, I just didn't sleep when the baby wasn't with me (Kelly, p.9).

This well-meaning intervention was unsuccessful and it would indicate that the use of checking questions might be able to differentiate effective from ineffective support, asking 'would it be helpful if…' and not making assumptions might in this way be recommended.

In terms of ineffective support, Grace like Dawn finds unsolicited advice very difficult to manage at times.

I don't like getting advice unless I've asked for it, yes that drives me insane (Grace, p.10).

With F (second child) thankfully, I um started to have a bit of um a filter for the unwanted advice (Grace, p.13).

Grace is adamant that unsolicited advice is not helpful; however she is able in time to build resilience through the development of experience-based confidence; and by her second child she has develop a filter for unsolicited advice which is protective for her in terms of her coping. Faye similarly differentiates between asked for advise and

unsolicited advise, which she finds difficult and almost as if she is not really being heard when all she wants is to complain a little.

> *So I think if I ask for advice and it's given, I think that's really helpful, but I think when people offer advice without being asked um not so.... not so helpful, just because sometimes I just want to complain to somebody um it doesn't mean I want their opinion on how I should be doing it differently* (Faye, p.8).

Talking about what she finds hard is initially difficult for Isla in her WhatsApp friendship group, the day-to-day difficulties in caring for a tiny child, but when they were able to share these things it became incredibly helpful as a means of expression and support.

> *All the normal things that I think everyone goes through, but um I can't get her to go to sleep or you know I've had three poo explosions this week I'm at the end of my tether and I can't do any more washing, that sort of stuff.… but um kind of the important stuff* (Isla, p.5-6).

These day-to-day events are the familiar experiences of early parenting but constitute the "important stuff" (p.6) for Isla in terms of what needs to be coped with. The ability to express and share frustrations is enabling for Isla: the use of complaining, whining and self-pity in a supportive context is helpful here. There is a sense of humour here as well "poo explosions" (Isla, p.6) which is able to keep perspective for the mothers as a group and It feels like a letting go of the small repeated frustrations that can occur when caring for a small child.

The qualities that make her friendship group supportive are described by Lynne-

> *There was just no judgment there, you know just really supportive the days where I would cancel last minute because I just couldn't even face going out of the house, um there was no …. oh gosh she's cancelling us again…. you know that sort of attitude* (Lynne, p.8).

The absolute acceptance and lack of judgment that she feels is innately supportive for Lynne: it is effective because it does not prevent her joining the group another day when she is feeling more able to. It also returns to the concepts around acceptance and non-judgmental attitudes highlighted by Beth and Isla that are effective in terms of support because of their enabling quality that validates the mother's experiences. In essence the practical assistance with food provision or washing is similar: it validates the experiences of the mothers by accepting their struggle and need for support. However in terms of coping, the mothers appreciate having a choice in the support that is given to them, support that is implemented upon them does not engender feelings of being supported and can be experienced as undermining.

Theme five- Passing on coping

All the mothers were able to articulate in terms of coping and resilience, what they wanted to pass on to their children. This presents as a protective factor within their parenting; the desire to equip their own children with abilities and strategies that will help them cope in the face of adversity in their own lives is apparent. Ava stresses the importance for her child of being able to ask for help and that it is fundamentally acceptable to need help sometimes.

> *But definitely I would like to pass on to M that it's ok not to be ok, if there is any point that you need something, or need some help, it's ok* (Ava, p.16).

It could be interpreted from this that this is something that Ava is able to accept for herself in her own life, or at least places enough value on to want to pass it on.

Chloe expands on this theme, and introduces concepts around emotional competence; the ability to identify emotions and having the emotional confidence in being able to communicate them.

> *I think I just want them to be able to talk to someone when they need to, when it's important and about whatever they need to talk about and not have any fear with that and I think that that's about them having confidence in their own thoughts and feelings, and that's what I would like them to be able to do* (Chloe, p.24).

There is a tacit knowledge in this extract from Chloe about what it is like not to have confidence in your own thoughts and feelings. Chloe does not want this for her children; she wants them to be able to communicate their feelings without "fear" (p.24): this implies that for Chloe herself, communicating your feelings can be fearful.

In this next extract Beth specifically relates her desire for her child to be able manage their emotions to her own life experience, where she did not have anyone to help her in this way. Beth seeks for her child what she did not have herself, the ability to recognise and manage her emotions. Beth feels that there is something lacking in her own personality, which dates back to her childhood, when she had no supportive adult that was able to help her manage her own emotions.

I don't want to discipline her for being angry, you know how some people do they're like 'stop crying, why are you crying!' you know it's like actually just recognise that they're upset and just be there for them and be like 'oh I see that you are upset, what's upsetting you' or 'it's ok you can cry, it's ok', because I don't know if I got that as a kid and that might have been a key part of my development that's missing and why I act the way I do, is because I lack that part of my emotional intelligence because I never had anyone to tell me how to do it because my situation as a child was difficult…. (Beth, p.16).

Beth demonstrates her acquired knowledge of how she hopes to help her own child, she is able to break down the aspects that she feels can support her child's understanding: recognition of distress; acceptance of feelings; identification of emotions; and showing attentiveness to the hurt. For Beth being able to view something from the needs of a child, communicates value to her as an adult about what is necessary for a healthy emotional life for all people.

Dawn similarly seeks to help her child to be able to recognise when the emotions are his own, and to be able to be strong and sensitive to others without taking on others emotions.

I want him to erm to know that he is not responsible for other people's emotions, um I want him to stand strong and have his space in the world, um to be sensitive but be um (pause) not let people walk over him really to um yes be strong and fair….(Dawn, p.22).

Dawn explains that this is something that has affected her in her life; she has felt burdened by other people's emotions.

> *I absorb other people's emotions too much and um I don't want M doing that, I want him to be supportive but he doesn't have to take them on, they don't need to weigh down on his shoulders* (Dawn, p.22).

This is a complex issue that Dawn is exploring, her insight into this emotionally protective stance coming from difficulties that she has gone through, that have led her to this conclusion. To be able to maintain the ability to be supportive of others, whilst understanding emotional boundaries of the self is insightful reflection on Dawn's behalf. It communicates a painful learning from adversity for her as she endeavors to pass on to her son this learned knowledge, in order to protect him from the emotional pain that she has experienced.

Ellie recalls her own mother helping her to calm down-

> *My mum was always really good at like coming down to my level, and going 'big breath, calm down, let me know what's wrong'* (Ellie, p.16).

This simple phase includes so much: the getting down on the same level indicating the giving of attention and the ability to listen; the instruction to take a breath engaging the calming systems of the body; and the last request to "let me know what's wrong" (p.16) giving permission and space to share the reason for distress. The fact that Ellie is able to give a word for word memory shows the significant impact that the approach had for her and is clearly valued and transferred from one generation to another in this way.

Faye includes in this extract concepts around validation of her child's emotional responses. In a similar way to Dawn and Beth, she draws on her own adverse experiences from childhood and wants better experiences for her own child.

P- *(pause) I just want her to be confident in herself, every part of herself, um and to know her own worth um*

R- *Is that something you feel you didn't know?*

P- *No, definitely not*

R- *So how do we do that?*

P- *Validating her emotionally, physically, yes you know all we can do is our best* (Faye, p. 15).

Faye is absolutely clear on how she wants to help her child feel validated and confident in her own worth. The importance of only being able do your best and no more is protective against unrealistic demands and expectations from self and others.

The developed insights of these mothers demonstrate reflective ability and protective capacities and example why mother's experiences of adversity can be built on positively to support them and their children. It is also apparent that when the mothers reflect upon the emotional needs of their children, it can support their insights into their own emotional needs and potentially lead to resilience building capacities.

The mothers in the phase three study are also able to clearly identify what it is in regard to coping and resilience they would like to be able to pass on to their children. Hazel is able to imagine helping her child in the way that her child has enlightened her.

I think for me things that I want to pass on to her, it's sort of a bit of a circle, because the things that I want to pass on to her are the stuff that she's teaching me to do, (laughs) like to be sort of the stuff about being resilient that she teaching me about myself that I hope that I can pass back to her, so we are sort of guiding each other in a way….(Hazel, p.27).

This resonates with Beth's experience of being able to view something from the perspective of the needs of a child, which is then able to communicate its value to her as an adult. Hazel has developed a relationship with her child that enhances her coping and provides a sense of purpose for the future for them both.

For Isla, the concept that she wants to pass on can be interpreted as 'hope'-

> *That you can! Just that you can! You can always cope, you can always find a way, and whatever that is that works for her, her Dad and I will always be there, to help her with it* (Isla, p.16).

This assurance that there are solutions to be found and nothing is insurmountable in terms of coping appears to be Isla's message for her daughter: this is placed along side and together with the vow of available support. There is a sense of coming from a supportive place, a place where people will believe in you and your abilities; it is help seeking in reverse, or the assurance of availability of support. There is acknowledgement of individual solutions but emphasis is on the abstraction that solutions can be found. Hopefulness as a coping skill can be considered valid in this context, with the encouragement it engenders to keep looking for solutions to difficulties. It can be regarded as part of the family of emotional coping strategies: however potentially it could be avoidant in style as it incorporates wishful thinking and assumes that a solution can be found to every situation. It is also possible that it could be an inter-generational factor in terms of the parental influence in character or personality formation of the children.

Jinny similarly echo's this message of available support-

> *I would love them to know that its ok to not feel 100 percent all of the time, and that they've always got…. I want them to be able to come to me and P for support which I haven't been able to do with my parents* (Jinny, p.19).

It is for Jinny the experience of lacking support that she herself has had, which makes her value the importance of it as a coping strategy. She also wants her children to know that they do not need to be in top form all of the time; in some ways this is an interesting acknowledgement of the existence of negative emotions that can be admitted and do not need to be denied. It might be cognitive in its reasoning and its approach to reality; but is possibly an emotional coping skill in its core essence. Jinny is saying that she and her husband are able to bear the difficult emotions as well as the happy emotions. This is enabling in that if she is successful in helping her children understand this, they should be able to go to her when they are not feeling ok.

Grace describes how her and her husband are trying to build in support for her children in terms of the ability to emotionally regulate which is a self-reliant coping skill.

> *We give them lots of cuddles and er we've built…. not built but created a little corner of the room with like cushions which has just all the books in it, so they will quite often say that they want to go in there, like a quiet corner um I think we've always done it "do you want to read a book?" so they will both quite often bring us a book, if they are upset and want to read a book so I think that obviously we've tried to instill in them a bit of quiet time to kind of calm down* (Grace, p.15).

Grace's acknowledgement of her children's needs for cuddles here, indicates her understanding of the need of her children for co-regulation in times of intense emotion. This potentially demonstrates a passing on to the children of learned pathways for self-regulatory skills. The making of a safe calm physical place for the children to be able

to be in, with calming activities in the reading of the books, is transferring tools of coping that can be used in the long term and shows a pathway of inter-generational transfer of coping and resilience. It is self reliant in nature and it is worth noting that a created calm space for the children could be replicated for the adults as well. There is an inference that reading is found to be calming for Grace herself.

The ability to be able to understand and express emotions is for Lynne what she is trying to give her children.

> *I can remember right from when they were babies, you know like if they were crying I'd try to kind of acknowledge it and say …. I know you're upset… you know or if they are angry…. I know you are angry at that…. but or …. I know you are frustrated…. or…. Oh that's made you really happy hasn't it.… so they've always been able to um even right from when they were two and talking they have always been able to verbalize that.…*(Lynne, p.25).

Lynne is acknowledging her understanding that having an emotional vocabulary and to be able to accurately identify emotions from a young age is part of emotional intelligence and that this is significantly connected with coping and resilient behaviours. Lynne has been labeling emotions for her children and helping them to match the emotion with the appropriate vocabulary. The ability to verbalize strong emotions is seen by Lynne as a positive coping skill which is self reliant in nature.

A skill that Kelly has learned her-self is also what she would like to pass on to her children.

> *That sort of like stopping and pausing and thinking you know, is everything all going wrong or can you just make a quick change um I guess to have that kind of strength within themselves really* (Kelly, p.16).

Creating a pause, a time to think, to reflect and consider options is a response approach, which is opposing reactivity. It is essentially problem solving in its nature with the added emotional element of the internal "strength within" (p.16). It feels positive too, a real strategic approach which could be transferred to many differing situations and difficulties.

The range of coping skills and strategies that the mother's are trying to pass on to their children is intrinsically linked to their own skills and abilities. What they themselves have found to be effective they feel confident to pass on to their children in a proactive protective parenting attempt to skill their children to cope with adversity. The mothers show reflective capacity as they consider aspects of coping that they lacked and why it is important for their children to be able to have skills that they themselves were not given or did not have. There is a strong focus on helping their children to manage distress: instinctively the mothers appear to recognise that resilience requires skills in coping with distress. There appears to be a tacit knowledge that the way that they manage distress in their children in childhood, will impact their children's life long skills of managing distress.

Discussion of the phase one study results

This discussion of the themes aims to encapsulate the findings and relate the thematic data analysis back to the literature, placing the study within the context of the existing literature. The motivation of discussion is to interpret and describe the significance of the findings in the light of what is already known about the phenomenon and explain any new understandings or insights that have emerged as a result of the study (Smith et al., 2022).

There are five themes in the phase one study. In theme one *Mother's lived experience of coping*, the coping strategies used by the mothers broadly fall into emotional coping and problem focused coping. Coping was in many instances a very practical affair for the mothers, the problem-focused coping exampled by the mothers tending towards the soft- organisational strategies (Beth, p.13; Chloe, p.5; Grace, p.11; Hazel, p.21; Jinny, p.6). There is a sense of needing to achieve mastery and a sense of coherence in terms of 'my life is manageable'; this sense of coherence is integral to the belief that the person can understand and comprehend challenges and has the resources to cope in terms of manageability (Antonovsky, 1996, p.15).

The use of self-talk features predominantly in the emotion-focused strategies with the mothers using rationalising self-encouragement to support their emotions (Ava, p.11; Beth, p. 11; Dawn, p.22; Chloe, p.22; Kelly, p.15; Lynne, p.23). There have been many studies into the effectiveness of self-talk coping strategies within sport; Tod, Hardy and Oliver (2011) found in a systematic review of 47 studies that there were positive benefits of instructional and motivational self-talk on performance. Self-talk is defined as the expression of a recognisable internal position, in which the person sending the message is also the person who receives the message (Van Raalte, & Vincent, 2017). It can be an internal voice or a spoken out loud voice: it usually contains expressive, interpretative and regulatory functions for the person (Van Raalte, & Vincent, 2017).

Kross et al. (2014) suggest that self-talk is normal and the ability to engage in an internal monologue is supportive to the person, by its ability to create self-regulation through psychological distance for example when someone tells themselves that they are 'doing a good job'. Constructive self-talk is found to include comments that are thoughtful, substantive, motivational, insightful or self-reflective (Rogelberg, Justice,

Braddy, & Fleenor, 2013). Rogelberg et al. (2013) caution against self-talk which may be hyper-critical or focused on negative aspects of challenging situations, and suggest that talking to yourself as you would a close friend is more helpful.

Linked to this, other forms of emotional focused coping exampled by the mothers, include support seeking (Ellie, p. 12; Faye, p.7; Kelly, p. 15) and expressions of emotional self-regulation such as "riding that wave" (Chloe, p.21) and Beth's "just walking away sometimes" (p.11). Lazarus and Folkman (1984) describe the choice of emotion focused coping as more likely to be used when a person appraises a situation as one in which nothing can be done to change things; while in contrast, problem focused coping is more likely to be used when, the appraisal is that conditions can be changed for the better.

Additional coping strategies identified in this theme that are not included in the Skinner and Zimmer-Gembeck (2011) model, include the cognitive recognition of taking "responsibility" (Faye, p.14), recognition of personal choice "it's my choice" (Faye, p.1) and "realistic expectation" (Faye, p.19) although these are essentially self-reliant in nature and serve to rationalize emotional responses. It is an ethical response to being a parent in a way, protective of the child and effective adult functioning. Some cross over strategies like "being in nature" (Hazel, p.22) appear to be strategizing on the one hand but equally meet elements of emotional needs. There is compelling evidence available on the value of exercise for mental well-being, for example Schoenfeld and Cameron, (2015) and Tada (2017).

The reality of **not** coping for the mothers feels painful and detrimental to well-being. It is damaging to the aspect of coherence described by Antonovsky (1996, p.15) of "my life is manageable" and even "understandable" at times. Where as coping is a kinder happier experience "I've achieved something and also I'm not overwhelmed, you know

like that's a big achievement" (Faye, p.19). Lazarus (1999) describes resiliency as opposite to vulnerability and finds the dependent variable is personal resources. The mothers in their accounts of the phenomenon of coping, show high levels of personal resourcefulness in terms of their emotional intelligence and the variety of coping strategies that they have available to them.

Some of the coping strategies appear specific to being a mother, taking responsibility for choosing to have a child (Beth, p.7; Faye, p.14), and soft organisation of day to day parenting with realistic goal setting (Beth, p.13; Chloe, p.15; Faye, p.19; Hazel, p.21). These pragmatic and practical approaches ensure that they are supporting their ability to be successful and can achieve a sense of agency, which can in turn support their mental and emotional well-being.

The second theme *Learning the importance of self-care* details the journey for the mothers from elements of self-neglect and being bottom of the hierarchy of needs, to one of self- realisation that they cannot function in a balanced way of coping, without the ability to meet some of their own needs. Achieving balance in life is complicated, we require activation to be able to carry out what needs to be done in our lives and we also require relaxation: equilibrium is not the absence of either of these but rather a balancing of the two. Maslow (1954, 2011) explains "Homeostasis means coming not to zero but to an optimum level. This means sometimes reducing tension, sometimes increasing it" (p.33).

When we consider what this means for mothers, it would seem obvious that there are stressors, but these are not all negative and many may be pleasurable; however the recognition of the need for rest and relaxation does not always appear so apparent in mother's or in children's lives today. Children however can provide many opportunities for rest as they sleep more than adults; but if we are active when they are resting we

may be denying ourselves and them, opportunities for really restorative co-regulation and rest. The need to maintain high standards of order in domestic and working environments when looking after young children can negatively impact our ability to rest and restore our balance and equilibrium. Maybe at times it can appear that we are just trying too hard, doing too much, and it can be our mental health that suffers.

However Kurki (2020) suggests that self-care is an ethical duty, as individuals we are governed by freedom of choice, we have self-agency in self-helping practices. Taking care of ourselves entails listening to one self, reflecting on self needs and acting in accordance with those needs (Kurki, 2020). For the mothers the needs of their vulnerable new-born infants for a while is placed higher than their own. The role of family and community can be influential in this struggle and there may be effects on the mothers seen from the decline of family networks and cohesive neighbourhoods that can support new mothers in more traditional family systems.

Additionally Stokes (1981) suggests that self-care practices are a health resource for individuals. Some of the mothers suggest that they learnt self care practices from learning about the care needs of their children (Hazel, p.9; Isla, p.15; Lynne, p.23). Our knowledge about our own care needs may be variable, and based on individual's experiences of being cared for. The expressions of self-care through attention to a healthy diet, rest and exercise balance, mental and spiritual fulfillment is potentially a life learning curve, which is accentuated by childbirth and child-care requirements.
Acton & Malathum (2000) in their study into health-promoting self-care behaviour found a connection between self fulfillment, positive connections with others and the ability to make positive health promoting self-care behaviour decisions. Germer and Neff (2015) describe self- compassion as comprising self-kindness, a sense of common humanity and universal suffering and the ability to have a mindful awareness of suffering. The

inter-connected nature of the ability to self-care appears complex and challenging for new mothers who are at a particularly vulnerable time in their lives where the nature of motherhood involves the transfer of resources from the self to the child (Bardake, 2012).

However self-care abilities and self-compassion are found to be strongly linked to emotional well-being, with self-compassion being significantly correlated with positive mental health outcomes including lower rates of depression and anxiety and improved life satisfaction (Bogels, Hellemans, Van Deursen, Romer, & Van der Meulen, 2014; Germer & Neff, 2015; Neff, 2003). In this respect encouraging self-compassion and self-care in mothers with mental heath difficulties would be a positive mental health strategy that could support coping.

In the third theme *Losing selfhood: Reclaiming selfhood* the mothers describe a transition into motherhood that involves changing concepts of selfhood. The palpable sense of loss for some with the use of terms for self such as “shadow” (Dawn, p.8) expresses a real struggle to maintain a sense of cohesive identity. Laney, Lewis Hall, Anderson and Willingham (2015) in a study looking at the influences of motherhood on women’s identity found that women lost themselves for a while whist incorporating children into their identity, this seems to fit with the experience of the mothers in this study. There is an initial stress and inability to focus on self-care needs, followed by recognition of their need for this. Laney et al. (2015) describe the mother’s expansion of self, which develops as children are incorporated into the woman’s identity and self-boundaries. The loss of the previous self, before motherhood occurs as the mother transitions to include her children into her concepts of selfhood.

The additional complexity of mental ill-heath and motherhood may make it more difficult for mothers. Mental health difficulties also can involve a loss of self in some respects; identity theory suggests that self-concepts are constructed through self-awareness

(Hine, Maybery & Goodyear, 2018). When we think about ourselves, we become the thinker and the subject of the thought and this is constitutes self-consciousness or self-awareness (Aroosi, 2019). It is not a static phenomenon rather it changes in response to environment and social context (Hine et al., 2018).

Linked to this Coffey (2003) writes that recovery in terms of mental illness is concerned with reclaiming a sense of personhood which is able to transcend thinking of oneself as just being mentally ill. For mothers, motherhood can transform women's identity in a positive way, creating a sense of meaning and connection for them, that over time is able to increase confidence as they develop competence within their parenting (Hine, et al., 2018). Motherhood can provide a healthy life focus and sense of normality in every day life, creating meaning and a role outside of mental health difficulties (Dolman et al., 2013; Nicholson, Sweeney, & Geller, 1998).

Additionally personal recovery is found to be enmeshed in aspects of holistic life functioning, including social engagement and sense of agency for self (Hine et al., 2019). The fact of having a child to advocate for may give women a sense of agency, the ability to plan and carry out care of an infant giving that understanding of life as meaningful that Antonovsky (1996) talks of. The mothers strive to re-gain some balance in their lives that can meet the needs of their children as well as their own. Re-establishing time for their own interests is important and helps them reclaim a sense of self and individual identity.

Advocating the salutogenic focus, Allen (2005) argues that we as individuals need to devote as much energy into learning how to feel good as we do about feeling bad: pain and negative emotions are able to guide us in what we need to avoid, but in the same way our positive emotions can guide us to activities that lead to our growth and development. Making good experiences part of our daily routine and meeting our

basic needs of nutrition, rest, exercise, social, mental and spiritual wellbeing are part of valuing ourselves; “taking care of yourself implies valuing yourself” (Allen, 2005, p.269). This is probably the pivotal challenge for mothers who have mental ill-health; they are in some ways being protective of their infants by prioritising the infants needs: however the realisation of the need to meet their own needs and taking steps to do this is an absolute necessity for achieving balance and wellness and the ability to cope in their everyday lives and ultimately this protects the child.

Theme four *Identifying effective support* finds that effective support for the mothers falls into the two main areas of emotional support and practical support. The emotional support is wide ranging and includes: encouragement (Ava, p.11); thoughtfulness and checking in behaviours (Chloe, p.19); feeling accepted and believed in (Beth, p.10); not feeling judged (Beth, p.10); and a sense of emotional holding of difficult emotions (Chloe, p.19). Practical support could be anything that supports day-to-day living; cooking, washing, shopping, cleaning and supporting parental sleep deprivation (Grace, p.10; Hazel, p.14; Jinny, p.8-9 &15). Sleep deprivation has been linked with depression as a causal factor in many studies (Karraker & Young, 2007; Rahamini, Rahamini, & Razaei, 2020; Titotzky, 2016; Wirz-Justice & Van der Hoofdakker, 1999). Supporting maternal sleep deprivation has the potential to reduce the risk of depression in mothers and is an important dimension in the recognition of parental need for support in this area.

Family support has consistently been shown to be helpful to mothers living with mental health difficulties; with child-care, active listening and emotional support, and the provision of helpful information and advice being identified as being effective within a supportive context (Beard, 2019). Help with household chores and child-care has been found to be significant in helping mothers transition into motherhood (Leahy-

Warren, McCarthy & Corcoran, 2011). Close and caring relationships are linked to health and well-being through their ability to support in times of stress (Feeney & Collins, 2014; Leahy-Warren et al., 2011; Uchino, Bowen, Carlilse, & Birmingham, 2012).

Feeney & Collins (2014) suggest that support functions within relationships are rooted in attachment and are able to support through: providing a safe environment; fortification against distress; motivation; and re-framing challenges into things that are more manageable problems. In the literature review for this study, attachment relationships and childhood experiences of attachment figures were found to influence how people respond to the social support that is offered (Cherewick et al., 2015; Light et al., 2019).

Similarly the study by Light et al. (2019) identified that mother's who had early trauma experiences, reported their support networks to be less helpful and more upsetting and unpredictable than other mothers leading them to seek support less often, with the insecure attachment styles in the mothers tending to lead to more negative perceptions of social support offered (Light et al., 2019). Health and social care practitioners when supporting mothers who have experienced trauma or communicate poor relationships with attachment figures need to be cognisant of this, so that they can facilitate other avenues of support for these mothers.

However Strange, Bremner, Fisher, Howat and Wood (2015) found that mothers who attended groups were given opportunities for building supportive social networks, friendships and community connectedness. The support was found to reduce parental anxiety as experiences and knowledge are shared and normalised with others who are experiencing similar things. This is in line with the feelings expressed by some of the mothers in this study (Beth, p.4; Dawn, p.16; Isla, p. 5-6; Ellie, p.12). Having said that,

for some mothers like Dawn (p.15) groups were not a place that she was able to relax or feel comfortable, although her social media group was able to feel supportive for her. The experience of effective support is individual and assumptions about personal preference should not be made.

The dislike expressed by the mothers of 'unsolicited advice' (Chloe, p.19; Dawn, p.15; Grace, p.13; Faye, p.8) is recognised within the literature. Schaerer, Tost, Huang, Gino and Larrick (2018) in a study with 290 participants found that women are more likely to receive unsolicited advice than men. Schaerer et al. (2018) suggest that there is a power dynamic in advice giving in which the subtle interplay between power and advice can be a reason that unsolicited advice is so hard to bear. Chentsova-Dutton and Vaughn (2011) in a cross-cultural study suggest that unsolicited advice can bear costs for the giver and the recipient, carrying a message that the recipient lacks important, skills, knowledge or competency.

There is a boundary between individual's business and everyone's business; respect for individual's autonomy needs to demonstrate this (Chentsova-Dutton and Vaughn, 2011). The mothers appreciate having a choice in the support that is given to them; support that is given without the consent of the person to whom it is being given may be experienced as undermining whether it is verbal in terms of advice or practical help. Support is given within the context of relationships and if there is a lack of attunement within the relationship, the support may be targeted clumsily and lack effectiveness in supporting coping abilities.

The final theme in the phase one study is theme five *Passing on coping*. Reyes and Constantino (2016) propose that the transmission of resilience occurs by the observation of adults coping with stressors by children who go on then to have a coping repertoire to help them deal with stressors in their futures, thus creating

resilience as an enduring phenomenon. Through this process Reyes and Constantino (2016) conceptualize resilience itself as a coping strategy. The mothers use their experiences of knowing to inform their behaviour with their children, knowing what they lacked, knowing what life's challenges can bring, knowing about what coping means to them as individuals. The strong protective stance of the mother's really comes through as they demonstrate practical steps that they take to provide their children with coping strategies and pass on resilience to them in this way.

Some of the mothers talked about reflecting back and considering aspects of coping that they had lacked and why it was important for their children to be able to have skills that they themselves did not (Beth, p.16; Dawn, p.22; Faye, p.15; Jinny, p.19). It was their awareness of adversity in the lacking of essential coping skills that inspired them to help their children develop skills that they themselves had lacked.

Hazel (p.27) points to a sense of a circle of learning as the mothers teach the children what they think will help them and the children through their own lived experiences inform the mothers about what their needs are. Crittenden (2008, p.339) explains that "healing comes one person at a time as a gift from a person who cares compassionately about another", and it involves "imagining a different future". The mothers seem to imagine a better way for their children and demonstrate protective reflective functioning; this is a critical entry point for supportive services to be aware of and can be used as a motivational aspect in family support interventions. However Crittenden (2008) offers a note of caution, in that parents need to be seen as individuals in their own right and not solely in terms ability to fulfill their children's needs.

This chapter has presented the data analysis of the first six interviews in the phase one study, which have been set out thematically. The triangulated data from the six phase three study interviews that had utilised the same interview schedule, was able to provide further depth and perspective to the phase one study themes. The participant's personal experiential themes were combined into group experiential themes in accordance with IPA methodology. The themes have then been discussed by setting them within the context of the existent literature. In the next chapter the second phase of analysis is presented, which compromises of six follow-up interviews with the phase one mothers.

Chapter eight: Phase two study results from data analysis

> *"Personal growth demands courage, self-confidence, even daring"*
> (Maslow, 1954, 2011, p.82).

Follow-up interviews with the phase one mothers

This chapter details the second phase of the study comprising of six follow-up interviews with the phase one study mothers. The rationale for this phase was to look at longitudinal factors for the mothers in relation to their lived experiences of coping, expanding on their initial interviews. The follow-up interview guide contained only six questions with an additional Covid-19 related section; the questions were aimed at establishing elements of consistency and change in relation to their initial interviews. The follow-up interviews took place between seven and eight months after the initial interviews and were all completed virtually.

The participants were offered a brief summary of points from their initial interviews and all participants chose to have the summary. Below is the participant background of the mothers from the phase one study who were re-interviewed in this phase two follow-up study (see Table 10.).

Table 10. Participant background information for phase one study.

Participant number and pseudonym	**Age**	**Location**	**Marital status**	**Children age M= male F= female**	**Self reported mental health difficulty**
1- Ava	28	North West England	Married	M aged 22 months	Anxiety
2- Beth	27	North East England	Married	F aged 18 months	Pre-natal depression, Post-natal depression
3- Chloe	28	West of England	Married	F aged 2 ½ years M aged 5 months	Obsessive compulsive disorder
4- Dawn	37	Wales	Married	M aged 2 years	Bulimia, anxiety, depression
5- Ellie	29	Wales	Married	F aged 3 years M aged 18 months	Post-traumatic stress disorder, Post natal depression
6- Faye	26	Wales	Married	F aged 11 months	Depression

In this phase two study, theme eight 'Children as motivators' was the only theme that was triangulated with the phase three mothers' data as there was supplementary information present in the interview data that was relevant to this theme. The remaining three themes were not triangulated with the phase three data, as they express aspects more purely focused on the longitudinal inquiry. The participant background of the six mothers in the phase three study are included in Table 11. below.

Table 11. Participant background information for the phase three study.

Participant number and pseudonym	**Age**	**Location**	**Marital status**	**Children age M= male F= female**	**Self reported mental health difficulty**
7- Grace	32	Scotland	Married	F aged 3 ½ years F aged 22 months	Depression
8- Hazel	34	Midlands England	Married	F aged 2 years	Anxiety
9- Isla	34	Midlands England	Married	F aged 5 months	Anxiety
10- Jinny	32	Wales	Married	F aged 11 years M aged 9 years M aged 2 years	Pre-natal depression Post-natal depression
11- Kelly	34	North of England	Married	M aged 4 years M aged 9 weeks	Pre-natal depression Post-natal depression
12- Lynne	32	Midlands England	Married	F aged 7 years M aged 5 years F aged 10 months	Depression Anxiety

The inclusion of follow-up interviews in the phase two study can also be regarded as a form of triangulation, which uses time as the triangulation source. Thurmond (2004) suggests that data sources for triangulation can come from the qualities of time, space or person, the themes that were developed in this phase three study that were temporally triangulated include 'Being open and honest and asking for help' and 'Maintaining self-care needs and identity'.

A summary of the themes in the phase two study is included below (see Table 13). This table indicates where theme eight was triangulated with the phase three study data.

Table 13. Table of themes in phase two study.

Study Phase	Theme	Participants	Key words and phrases	Present In over half follow-up sample
Phase Two	6. Being open and honest and asking for help	Ava Beth Chloe Dawn Ellie Faye	"It's about being really brave" (Chloe, p.38). "I'm telling people more" (Dawn, p.29). "You shouldn't feel bad for having to have things that help you cope" (Ellie, p.28). "I am just feeling not quite ready to reach out" (Faye, p.24).	Yes
	7. Maintaining self-care needs and identity	Beth Dawn Chloe Ellie Faye	"If I don't put myself first, I can't do all of the other things" (Chloe, p.36). "Building myself up again" (Dawn, p.25). "yes I do need time to just be me…" (Ellie, p.23).	Yes
	8. Children as motivators	Ava Dawn Ellie Faye Hazel Isla Jinny Lynne	"He gives me hugs just randomly" (Ava, p.18). "Magic" (Ellie, p.30). "She'll turn around and smile and that's just enough to get through" (Faye, p.19). "I just kind of let (F) teach me" (Hazel, p.8).	Yes- Integrated phase one and phase three mothers
	9. Re-balancing through Covid-19 lockdowns	Beth Chloe Dawn Ellie Faye	"It's made me realise life was just so quick and so rushed" (Ava, p.18). "Taking it as it comes" (Beth, p.27). "It brought me and my	Yes

			husband closer" (Dawn, p.27). Take each day as it comes" (Ellie, p. 29). "It would have been worse if I'd been on my own without a child" (Faye, p.17).	

Theme six- Being open and honest and asking for help

In terms of longitudinal factors, honesty and openness was perceived as important for the mother's ability to seek and ask for help. However it can be difficult as it raises feelings of fearfulness and discomfort.

> *It is about being really brave and really honest in any way that you can, so like if you are not able to say that out loud, write it down, um and I think don't be afraid that people are going to judge you as a parent because of your mental health* (Chloe, p.38).

For Chloe it is a real indication of how hard it is for her, that she has developed a coping strategy of writing things down that she is unable to say out loud. She brings up the fear of being judged detrimentally as a parent because of her mental health, which could potentially be a reason not to be open and honest or seek help.

> *I think that that has always been a concern of mine that people will kind of listen to what I was feeling or thinking and go Huh! (Big intake of breath) This person shouldn't have children…. um and actually….people kind of go…. oh you are dealing with all of that on top of having children, that's really tough….* (Chloe, p.38).

It appears to be deeply emotional for Chloe to talk about this; the pause that occurs in this extract for an audible breath prior to the expression of her fear of judgement, may bear witness to the fact that Chloe has thought this of herself at times. However her experience in reality is more positive and she has found support and a sense of emotional attunement and positive regard, rather than negative judgments of her as a mother because of her mental health difficulties.

For Faye the process of reaching out is complex, she appears to be balancing her assessment of her current coping with her need to reach out-

> *So yes I am sort of questioning whether to or not at the moment I am just feeling not quite ready to reach out but um I might do…. I think we'll just see how long this goes on for and how well I'm coping* ….(Faye, p.24).

Faye is making an assessment of herself; of her current coping abilities and whether she is ready to reach out. It feels difficult for her to make a decision; it is a complex private decision that only she can make.

Beth describes a situation when she attended a pregnancy scan, where she was unable to be honest about how she was feeling, because of the totally opposite expectations and lack of congruence with her listeners.

> *I couldn't explain it to the midwives because they're all like…. well congratulations…. you know because everyone thinks its wonderful news there's a baby on the scene but actually they don't know anything that's gone on before and what I might be feeling otherwise* (Beth, p.25).

It is an understandable dilemma, which however leaves Beth with no opportunity to be open about how she is feeling and thereby also access support. Beth offers insight in to how she thinks about being open and honest about her feelings.

> *I think at your lowest point I think you are the least likely to reach out to someone, because it's at that moment that you feel like giving up and stopping, you're not looking at a lifeline then you are looking for someone to come and rescue you and then you're wallowing in the fact that no one's coming to rescue you but it's on the days where you feel a little bit better that you actually consider that things might actually be worth talking to someone about* (Beth, p.25-26).

At rock bottom Beth is unable to see any value in reaching out for support, but when she is slightly better she has some hope that there may be support available to her.

In her follow-up interview Dawn discusses her continuing intrusive thoughts concerning her child's safety.

> *I still have a lot of anxiety about him um being involved in a car crash, choking, dying in his sleep I suppose the cot death thing is still really high up* (Dawn, p.29).

When questioned by the researcher about how she is coping with these distressing thoughts, she pauses and then says that she is telling people more.

> R- *So how are you coping with those, what do you do about them?*
> P- *(sigh) um…. (pause) not much at the moment, um I'm telling people more* (Dawn, p.29).

There is again a sense that this is still not easy for her, there is a feeling of wanting to hide such thought away as if they are experienced as shameful. She clarifies later that "Saying it out loud to someone else" (Dawn, p.29) is helpful and makes a difference to

her in terms of coping with the thoughts. In some ways it appears to reduce their significance; she is able through social referencing to seek comfort and place her fears in a more normalised context, thereby reducing their impact.

Ellie finds that asking for help for a second time was not as difficult, when she has to go back to her doctor.

> *Asking for help the second time and asking to speak about your medication a second time is a lot easier than the initial kind of…. yes I might need a bit of help here…. So I think coping wise…. knowing about it and knowing that you should really be able to do it yourself and you shouldn't feel bad for having to have things that help you cope* (Ellie, p.28).

She is more confident here in several ways including: that she is able to make the assessment that she does need help; that she really wants to be able to do it on her own but that the medication will help her achieve this; and that she doesn't need to feel bad about needing the help.

Ava specifically recognises being open and honest and able to ask for help as a coping mechanism for her.

> *Just being honest, being open and talking with everybody, I think that's positive in itself because you are not just hiding it away or keeping it inside and letting things bottle up, so I think that for me has been a really good coping mechanism* (Ava, p.18).

The value for her is in not bottling things up inside herself or hiding the difficult feelings away. There is a feeling of discomfort and shame in the hiding and a feeling of release in the ability to reveal what she is feeling. Ava clarifies the importance of self honesty-

> *Just to talk and be honest with yourself and be honest with your closest people around you as well, and ask for help*…. (Ava, p.18).

The self-honesty is a pre-requisite of the ability to be honest with others. To be truthful with herself enables her to make more accurate assessments of her own needs and also then to communicate her needs. Ava is specific in her stipulation of the closest people around her to whom she can talk to; these are the people that she can trust the most and from whom she is able to ask for help.

There is a sense that being open and asking for help feels risky at times for these mothers, asking for but not getting help could leave them worse off. It is difficult to be honest when there are feelings of shame and lack of self-worth being experienced. However where they have had positive experiences of asking for help, it becomes a decision that is easier to make and part of their coping repertoire.

Theme seven- Maintaining self care needs and identity

This theme considers self-care from a longitudinal perspective, building on theme two in the phase one study *Learning the importance of self-care,* by looking at relevant factors within the phase one mothers follow-up interviews. It is not triangulated with the phase three mothers who only gave initial interviews.

Dawn refers back to her initial interview and says that she has tried to prioritise self-care on an on-going basis.

I've been working hard on.... on what we talked about.… working hard on um building myself up again um and um recognising who I am or who I was and who I am outside of being a mother you know…. um making that space and just um chipping away at self care, that's.… that's been high up my priority list really (Dawn, p.24-25).

Dawn had described feeling "broken" (p.7) in her initial interview; she explained, "I've lost (pause) who I was" (p.8). The ability to validate her identity again, outside of motherhood is a healthy redirection for Dawn: in terms of her coping strategies, she is rebuilding her sense of self and personhood and making a space for herself in the world. Her attempts to recognise who she was as a person and who she is now, whilst knowing that she is also a mother, suggests that she needs to integrate the different aspects of herself as a person. Dawn is re-writing her story, re-integrating parts of the whole; it is hard work for her and challenging, and it is done by making small improvements "chipping away at self-care" (p.25). She is making progress in her ability to prioritise her own needs, so that she is not "bottom of the pile" (p.8) as she had previously felt.

Chloe relates meeting her own needs with her ability to be able to parent, she realises that if she does not meet any of her own needs she will be unable to function in other ways. She talks here of burn out, resonating with Dawn's description of being "broken" (p.7).

I think I'm doing a much better job of that I think I got to a point where I really was burning myself out, and I've kind of gone …. actually …. sometimes it has to put me first…. because if I don't put me first I can't do all of the other things (Chloe, p.36).

This level of debilitation that the mothers describe signifies feelings of emptiness and mental, physical and emotional exhaustion. Like Dawn she relates meeting her needs with identity outside of motherhood.

> *Having something to focus on that was something that really mattered to me that was outside of being mum all of the time because I think sometimes it feels like the hardest job in the world being a mum, because the people you are being a mum to are not always grateful for the things that you do* (Chloe, p.33).

There is a sense of the struggle for her; parenting is hard and there is a lack of recognition of her efforts.

Beth identifies that she is maintaining the self-care activities that she had put into place

> *For self care like swimming, singing and painting and stuff because that's all stuff that I do now even still….*(Beth, p.18).

These activities relate to her needs as a person and are not specific to her as a mother. The recognition that she still does them indicates that they are valued by her and are meeting her needs in the recognition of her as a person outside of motherhood.

Dawn again describes the hard work of maintaining wellness, working at mental health and being able to enjoy her life. Dawn uses humour to help herself-

> *I am working really hard at doing as much as I can to enjoy life again really and having the stand up comedy the funny audio books ready to go so I can put them in so I force myself to listen to them to get.... to find…. to pull out a laugh or something* (Dawn, p.20).

This laughter, although hard to find helps her, perhaps in gaining perspective or maybe just a physiological boost of energy.

Ellie recognises this too, the need to do things that are meeting some of her own needs.

> *I realised why 'me' time is important so where as before I wouldn't really try and do anything by myself because I would feel guilty about it, like the kids go to bed they are asleep any way so now I might have a bath or I'm sewing again so I might do some sewing or read a book and I don't feel bad for it anymore so in that aspect my mental health is better because I understand that…. yes I do need time to just be me.…* (Ellie, p.22-23).

The fact that her children are older now and less dependent seems to have helped, Ellie is more able to find time for self-care, having a "bath" (p.22), but also activities that she enjoys for herself. These activities support her identity and in consequence of this, her mental health also. They are simple activities of sewing and reading but for Ellie it reinforces the "me" in her. The "me" is an identity outside of motherhood for Ellie who previously recalled naming herself purely in terms of her relationship to her children.

> *One of the questions they ask you in counseling is 'who are you?' and I always go 'M and F's mum'* (Ellie, p.6).

Ellie recognises a loss of the "me" that she was, but is trying to reclaim part of her previous identity.

> *I don't think I'm ever going to be the me that I was but it would be nice to be a bit of me again so.… so I can say when people say.… who are you.… I can say well I'm (name) I'm M and F's mum, I'm (name) I'm M and F's mum rather than the other way around.…*(Ellie, p.23).

The ability to name herself again is an important step in regaining her mental equanimity and her ability to express herself as an individual and to know what she wants for herself in her own life. The loss of self for Ellie has bordered on depersonalization and may have indicated a maladaptive coping for her of mental withdrawal. However the adaptive element is important as it can be acknowledged for her, that it may have helped her get through her most difficult times.

Faye is reflective about her ability to meet her own needs-

> *I don't have to be super mum all the time, that just being F's mum is enough for her and that she's happy, loved, secure and sometimes it's nice for her as well to have some downtime and not be constantly engaged um I suppose that I'm not a bad mum for allowing a little bit extra whatever it is or not constantly doing things um yes I just say the same to myself really that I'm not a bad mum for putting myself first for a little bit, because that allows me to be a good mum for her* (Faye, p.25).

Faye reflects that her daughter's needs are being met and that it is helpful to her as a mother to be able to put her own needs first at times. This complex balancing of activity time and down time for her daughter appears to bring up feelings of worthiness as a mother in Faye. However she is able to reflexively examine her own beliefs, judgments and practices and concludes that the ability to meet some of her own needs enhances her abilities as a mother.

The struggle for the mothers to be able to maintain and prioritise meeting some of their own needs appears to be ongoing in some respects: it may be mitigated to some extent by the developing independence of their children and the recognition of the difficulty in caring for others if you are unable to care for yourself. The ability to meet their own needs is recognised as supportive to coping, and protective of the children as Chloe says, "because if I don't put me first I can't do all of the other things" (Chloe, p.36). However the ability to maintain levels of self-care requires on-going effort and work (Dawn, p.24).

Theme eight- Children as motivators

Theme eight *Children as motivators* was a part of 'coping' that the mothers identified in the phase two follow-up study where they relate how the children inspire coping in a variety of different ways. This theme is an expansion from the phase one study rather than specifically a longitudinal factor, although it also transcends time with the mothers giving multiple examples of being inspired by their children at different ages. It was recognised that the phase three mothers interview data also showed insight into this theme, which had relevance and their data was therefore triangulated into this theme.

The mothers expressed a felt experience of a lack of recognition for motherhood. However they were able to feel inspired by their children in terms of the children's continuing development and the expressions of love that their children reciprocate to them. Ava describes the love that her child expresses for her-

> *You just get so much back from them like he tells me he loves me and he gives me hugs just randomly and that just brings out so much….* (Ava, p.18).

Ava is able to appreciate the love and affection that her son shows her. Ava explains that it brings out "so much" (p.18), indicating a sense that this is able to enhance her coping abilities as she is supported by her child's show of affection.

For Ellie being able to enjoy her children makes up for the lack of verbal appreciation.

> *It's little things like we will be going down the garden and they will suddenly stop and be really fascinated with a leaf because it's a different colour and I think as adults you loose that magic….* (Ellie, p.30).

Her children are reminding her of the benefits of being mindful; being able to live in that specific moment, away from worries about the past or the future, and appreciate something as small as a leaf. There is also an understanding of being needed by her children for Ellie.

> *I might not think that I'm good enough for them, but nobody else is going to be better, so it's…. and like I know them so well…. I know when it's going to turn into a paddy, when ones going to start crying and you know it's a case of…. F is quite sensitive she'll cry over pretty much anything and where as I will sit there and try and find out what's wrong and try and talk it out, a lot of people would be….. well right now F that's enough now that's silly…. And like that doesn't help her….* (Ellie, p.23).

Ellie is aware that she alone has the intimate knowledge and experience of what her children need. She recognises that even though she doubts her own value at times; she has a unique contribution to make and in this way she is needed. This signifies that she has a valuable contribution to make and in this way is motivational to Ellie as a mother.

Dawn uses her knowledge of her son's needs to guide her parenting.

> *He likes to take his time in the morning so rather than scooping him out of bed and then stuffing him into some clothes you know he's a lot happier you know I've got time to see to his toddler needs really…. (Dawn, p.28).*

This responsiveness to her child's needs makes both their lives easier and more pleasant. She is allowing him to inform her parenting and to motivate her actions as a mother. Faye describes trying to get her child to sleep, and not knowing what to do next, when her child's smile lifts her from her state of being into an easier one, where she is able to carry on.

> *F is helping me although it is hard and you know like when she is really, really exited, to go to sleep and I'm stood there rocking her and thinking…. oh my gosh what am I going to do…. But then she'll turn around and smile and that's enough sometimes just to get through* (Faye, p.19).

There is a sense of emotional regulation, a co-regulation between child and mother as her child smiles, Faye is helped by the smile and eye contact to feel calm, nurtured and safe and to have a sense that she can manage her child's needs in that moment. Later Faye describes how her child is able to live in the moment.

> *She can go from being the most upset about something you know falling over she is so upset, and she will go from that to just laughing and forgetting about it and doing something else and I think there is a lot to learn from that, she doesn't hold on to anything, she just lives completely in the moment, um whether that's being happy or sad, or angry or frustrated, she expresses that emotion and then moves on….* (Faye, p.19).

The ability of her child to express emotion relevant to the exact moment and then move on not being affected by the recent past event, not holding on to any negativity is inspiring for Faye. She recognises that there are lessons to be learnt from her child in this respect; her child is able to live mindfully in the present, in a way that can be hard for adults to do. Her child is not spending time worrying about the past or being anxious about the future and Faye recognises that she can learn from this herself.

For Ellie it is the requirement of the daily parenting tasks that are helpful to her.

> *I think because when you've got kids you can't just sit on the sofa, they have got to be fed, they've got to have their nappy changed, they've got to be given drinks you know you, I think that knowing that you have to get through the day gets me through the day* (Ellie, p.15-16).

Ellie is aware of her practical responsibilities for her children; these have a rhythm and necessity, which she finds enabling. She knows what each day will require of her, in this way there is a feeling of acceptance for her. She is able to accommodate all these practical aspects into her thinking and doing and demonstrates her abilities to adapt within her coping styles.

The phase three mothers also had reflections that were relevant to this theme and their data was triangulated in. Hazel reflects on her parenting journey with her daughter-

> *I realised that you can read as many books as you like or you can speak to as many people as you like about what being a mum is about um but I kind of just let F teach me in the end.… about it.… how to become a mum you know.…*(Hazel, p.8).

For Hazel the most important source of learning is from her own child; the becoming a mother is a joint endeavor with her daughter; finding out what works or what doesn't on a day to day basis.

Isla is captivated by her daughter and there is a sense of intimate engagement-

> *She's mesmerized by her own hands (laughs) everything is interesting, everything is new, we've started trying her on a few different foods um she's just fascinating, completely fascinating, I can't wait to see what she becomes when she's older and what interests her what makes her happy, what annoys her, all of the little things about her* (Isla, p.16).

The use of the word 'fascinating' twice in this passage suggests the strength of interest and attention that her daughter inspires in her. It is an expression of Isla's attachment and love for her daughter that in some ways is able to create this level of intense emotional focus. This focus is able to support Isla as a parent, helping her to be attentive and mindful towards her child. Jinny similarly describes how she loves spending time with her children as she can see their personalities developing.

> *When they start to develop their personalities, so when they are coming up to that 7th or 8th month mark, I do love that age and love spending time with them* (Jinny, p.10).

This development of personality is important to Jinny as she finds this interesting and it inspires her to want to spend time with them.

Kelly identifies her excitement in following her children's development.

> *Actually every stage along the way I've kind of been more excited about what they can do next kind of thing so….* (Kelly, p.6).

This focus is described as ‘exciting’ for her and able to inspire her enthusiasm in a positive sense. Lynne’s description resonates with Ava’s in the appreciation of the love that they feel from their children.

> *Just those little moments of when they reach up and touch your face and things like that yes its just um its lovely and I, the three of them now will just come up and hug me and go…. love you mummy…. And that just means everything to me really…. (laughs)* (Lynne, p.14).

The use of the word ‘everything’ here denotes the importance it has for her. There is a sense of the value that the loving actions of her children engender for her is inspiring for her as a parent.

The mothers are able to be inspired by their children’s developing personalities, which feed into their parenting understanding. There is a sense of mother and child learning together as a dyad, able to support each other in some ways through their joint experiences and as the children give love back in a way that the mothers find supportive (Ava, p.18; Lynne, p.14). Being the one that is best able to understand the intimate needs of their children appears to be able to help the mothers value their contribution (Dawn, p.28; Ellie, p.23). There is also an imperative to cope because the children have needs that have “got” to be met (Ellie, p.15). These practical responsibilities have a rhythm and necessity, which can be enabling to coping.

Theme nine- Rebalancing through Covid-19 lockdown

The experiences of the mother’s during the Covid-19 initial lock down generated a broad mixture of positive and negative emotions. However there was an element of

re-balancing that was apparent in the mothers coping. For some of the mothers, co-parenting in lock down brought some additional perspectives. Dawn explains what happened when her husband was furloughed and she was still working.

> *…. um my husband was furloughed um so he took over child care and I was working and you know my husband was full of um enthusiasm to begin with…. 'well I'll stay at home and I'll look after the boy and you'll go to work, your job is more important than.…' you know to be fair to him he was.... you know he was keen, by the end of the second day he was pulling his hair out honestly…. 'I can't do this anymore' (shouty voice).... and you know he'd only been home with him for two days (humorous tone).…* (Dawn, p.27).

Dawn's husband was full of enthusiasm to take on the role of child-care but quickly realised that it was more difficult than he had understood up to this point. Dawn understandably views this with some humor as she has struggled to be acknowledged in her efforts to care for her son in the past with severe sleep deprivation. Later Dawn acknowledges a positive factor for her immediate family.

> *It brought me and my husband closer, its brought us closer as a family bubble, just three of us it's been.… a bit of a blessing* (Dawn, p.25).

Dawn is able to appreciate this positive effect of the lock down on her immediate family, which has helped them to feel a sense of closeness with each other.

Chloe also finds that there is a re-balancing for her as her husband is working from home during lock down and is able to support her in a practical way.

> *Sleep…. that sounds like a bit of an odd one but um I find that my husband getting up with the children in the morning and me staying in bed for a little bit really helps um I think that in particular that helps because it means that I am starting the day without the sort of chaos of the children.*….(Chloe, p.33).

This extra time to be able to start her day at her own pace has really helped her feel less chaotic.

Faye describes appreciating her daughter's presence during the Covis-19 lockdown.

> *I think it would have been worse if I'd been on my own without a child or another person, um but on the other side of that coin it's difficult if that person is just 18 months old and um I'm doing everything.…*(Faye, p.17).

She feels that it was good in that she herself had company during a time when she would have been unable to meet up with friends and family, but when that person is totally reliant on her for her every need, that came with some difficulties.

Ellie describes her raised levels of anxiety during lockdown, which she copes with by using her children to help her calm and regulate her emotional state.

> *A few times in lock down I found myself getting into bed with one of them just to be next to one of them and as soon as I came out I'd be fine* (Ellie, p.26).

Ellie is co-regulating her emotions by feeling the peaceful calm of her children sleeping. It is comfort seeking and contact seeking coping behaviour that relies on the fact that her children are less stressed than her. It is an example of co-regulation in a bi-directional format, child to parent. Later she shows how she uses a positive attitude to help her cope.

Take each day as it comes because tomorrow is a new day so if todays a bit rubbish and the kids have been crying they will go to bed and as long as they know that you love them and that they are safe…. tomorrow will be a completely different day….(Ellie, p. 29).

This positive re-framing, prioritising what is vital for her children and getting into perspective minor hurts, helps her approach the new day as a new experience not a continuation of the previous days difficulties. It appears as a balanced view, not over generalising any difficulties; it could be interpreted as wishful thinking but maintaining a positive attitude is a positive coping stance that is able to support her coping efforts.

In terms of Covid-19 related coping, Ava identifies that it has been a learning element for her that relates to her understanding of the need to slow down sometimes. She describes the realisation that she comes to from having more time to spend with her son and husband.

Just actually have loved having more time, we've had so much time the three of us, so much time just me and M, and I think its made me realise that life was just so quick and so rushed all the time and it doesn't need to be like that (Ava, p.18).

This has been a positive reframing of her situation in the national lock down; Ava has managed to accommodate the restrictions through acceptance and restructuring of her values.

I think the way that I've coped is to just enjoy it and just to take each day…. I'm not getting in from work and having to rush out for a rehearsal or erm to go do the shopping ever….(Ava, p.23).

There are losses though too, Chloe describes how her extended family has been affected by the pandemic lock down restrictions-

> *My mum can't come and take the children out to soft play, because she's not allowed to do that, or she can't come because actually my Dad's not well enough, you know um and we can't really go and stay there at the moment, um you know I've not seen various members of my family in a really long time because they are kind of dotted around the country, so I've actually got people who've never met my son because he was still quite young when all of this happened you know he'd only just turned six months old* (Chloe, p.37).

This represents a significant loss of support for Chloe in terms of childcare support but possibly more importantly the emotional recognition of her as a mother and of the existence of her child. This recognition by the wider society of her motherhood could be an important part of her ability to transition into being a mother; her role is changing and could benefit from supportive acknowledgement from her family, friends and wider social groups.

Ava describes the loss of interaction with her son when she has to wear a mask.

> *I never realised how much I maybe gave him a kiss on the back of his head or he sat on my knee and I never realised how much interaction I had with him until I had to wear a mask* (Ava, p.22).

The difficulty of offering support when facial expressions are unable to be seen. However Ava is grateful that her son is at an age where she is able to give simple explanations of events.

> *We haven't really told him an awful lot about the virus or anything like that it's more just saying mummy and daddy have just got to cover for any certain germs that we might get, so we've kind of gone down with the germs side as opposed to virus* (Ava, p.22).

In this way she is able to demonstrate her protective approach in her parenting, talking to her son in terms that he is able to comprehend and helping her son cope by emotionally regulating her own behaviours. This may be effectively co-regulation as each member of the maternal/child dyad being calm, can support calm in the other.

Several mothers describe the importance for them of taking one day at a time during the lock down periods.

> *I don't know I'm just taking it as it comes I think….* (Beth, p.27).

The ability to live in the moment, rather than in past concerns and future anxieties is a positive coping strategy for the mothers. Chloe also describes positively re-framing expectations of herself as a parent and not ruminating on small things.

> *I think lowering my own expectations of my self as a parent and saying you know what…. sometimes just the other day when they watched Frozen 14 times, that's ok (laughs) that's ok because everyone is fine and it's ok* (Chloe, p.35).

This ability to live in the moment with out anxiety and fear for an unknown future is helpful to Chloe and her children, she knows it's not every day but for that day it was ok to let the children watch a film that they love. The ability to temporarily lower her expectations of herself helps her and her children regulate emotion and behaviour. There is a re-balancing of priorities in the light of the additional strain that the Covid-19

lock down has created. Faye similarly describes her acceptance of some limitations that are able to enhance her ability to manage her world.

> *I think I am embracing the toddler mess a little bit, you know I tidy away as much as I can at the end of the day but like I said I give myself one task a day to do of house work and that's enough…. as long as we don't live in a pig sty then…. (laughs) I'm happy for messy….*(Faye, p.22).

The use of mastery in achieving one task of house work a day is protective for her mental and emotional well-being, better to be able to complete one thing successfully than to fail at several. The mothers show abilities to accommodate the stressful circumstances by rebalancing their priorities and redefining their priorities.

For Beth in terms of Covid-19 related coping, like Ava she is able to find some positives, her daughter was benefiting from the increase of time with her mum and dad.

> *She was just enjoying time with her mum and dad and that was really lovely for her and her language just blossomed and she's just turned into this wonderful person, its really great to see* (Beth, p.19).

This is a positive motivating element for Beth; her child's positive development is an inspiration for her. There are losses for them though, specifically her daughter's struggle when entering nursery after not having contact with other children during the national stay at home lock down.

> *I think it was more that fact that there was lots of children there and she's not spent any time with any children for a long time* (Beth, p.21-22).

Beth also describes a distressing visit alone without her husband, to her anti-natal scan appointment, she is mentally low and unsure about the pregnancy.

Going to the scan by myself was quite tricky in that regard because the lady was there and as soon as she put the scanner on my belly I was like praying there wasn't a heart beat and there was and I found that really difficult to take by myself and I couldn't explain it to the midwives because they're all like.… well congratulations.… you know because everyone thinks its wonderful news there's a baby on the scene but actually they don't know anything that's gone on before and what I might be feeling otherwise so I don't know it was really tough but I'm glad I'm pregnant I'm.... I've got to the point where I'm quite happy with it so I'm quite adjusted and excited so….(Beth, p.24-25).

The assumption by staff that she is happy to be pregnant is natural but severely problematic in the context of Beth's previous mental ill-health and having to attend the appointment alone due to the Covid-19 restrictions. In terms of coping she demonstrates an eventual accommodation towards her pregnancy and as she says a positive 'adjustment'.

Beth also displays some practical problem solving and strategizing approaches as she finds that "getting out of the house was really useful" (Beth, p.20). There is also an element of "just get on with it" for Beth (p.21) and "I don't know I'm just taking it as it comes" (Beth, p.25) for her which examples an accommodation and acceptance of the situation in terms of her coping strategies. Later she also comments, "we've just got to not dwell on bad days.… too much" (Beth, p.28). It feels as if this has been said to her, and it is hard to know if this is a possible coping approach that Beth is adopting here, it is a looking forward rather than back for her.

There are a mixture of gains and losses for the mothers during the lock down. There is a sense of adjustment and re-balancing of needs and resolutions by the mothers

displaying in terms of coping a necessary accommodation and adjustment to their environment at the time. The losses are support based in many ways, loss of extended family contact (Chloe, p.37), loss of an accompanying partner during appointments (Beth, p.24-25).

There is a real sense of re-balancing during this initial Coved-19 lock down, with some partners able to offer support where previously this was not possible (Chloe, p.33; Dawn, p. 33). The mothers were conscious of taking more time where it was needed and of being able to appreciate the present moment, taking comfort in the little things (Ava, p.18; Beth, p.27; Chloe, p.35; Faye, p.22). This indicates some level of acceptance and accommodation in terms of coping strategies as does Ellie's use of positive reframing of her priorities (p.29).

Discussion of the phase two study results

In the phase two study, the mothers are able to return to concepts around coping. They have a firmer idea about what the research is about having already completed one interview and have had time to develop their thinking on coping as a phenomenon. In theme six *Being open and honest and asking for help* there is a sense that being open and asking for help is difficult and can feel risky at times for these mothers; asking for but not getting help could leave them worse off. It is difficult to be honest when there are feelings of shame and lack of self-worth being experienced. However where they have had positive experiences of asking for help, it becomes a decision that is easier to make.

A US survey of 1400 women, found 40% of women with symptoms of mental and emotional distress did not seek help and consequently a significant proportion of Post

Partum Depression (PPD) goes undiagnosed (Manso-Cordoba, Pickering, Ortega, Asunsolo, & Romeo, 2020). Fear of being judged (Chloe, p.38) is a recognised factor for parents not seeking help with children during a mental health crisis, particularly when speaking with support services where fear of losing custody is a concern (Khalifeh, Murgatroyd, Freeman, Johnson, & Killaspy, 2009). Factors that can increase the likelihood of support seeking include having a previous mental illness and having other reasons to visit the GP (Khalifeh et al., 2020). Influencing factors for seeking support include levels of psychological distress, stigmatizing attitudes to mental health difficulties and perceived effectiveness of professional help available (Machi, Yamauchi, & Sugimari, 2016). Manso-Cordoba et al. (2020) recommend consideration for supportive interventions that can reduce social stigma and raise awareness of PPD and the support that is available.

Ava's (p.18) recognition of the importance of self-honesty is an obvious pre-requisite, however this is dependent upon individual defense mechanisms and coping styles, with avoidant styles potentially struggling more in this area. The reaching of rock bottom as Beth suggests (Beth, p.25-26) may not be a time that enables help-seeking behaviours: Montgomery, Mossey, Bailey and Forchuk (2011) found that an intense experience in bottom can jeopardize both the safety of the mother and the infant and that supportive measures need to be facilitated before this point is reached. For the mothers there is a journey towards help seeking behaviours that involves: self-awareness; being honest with themselves; and the ability to take a risk and trust in a positive response that is able to provide them with the support that they need to cope.

Theme seven *Maintaining self care needs and identity* provides a view into the temporality and change aspects of the phase one study themes *Learning the importance of self-care* and *Losing selfhood: Reclaiming selfhood*. The struggle for the

mothers to be able to prioritise some of their own needs appears to be ongoing in some respects: it may be mitigated to some extent by the developing independence of their children and the recognition of the difficulty in caring for others if you are unable to care for yourself. However the ability to maintain levels of self-care for some mothers requires on-going effort and work (Dawn, p.24).

Becoming a mother involves significant personal, social and biological changes for women (Smith, 1998). Women are known to view their identity within the contexts of relationships and connections with others (Laney, Carruthers, Lewis Hall & Anderson, 2014; Smith, 1998). However several of the mothers express a need for identity outside of motherhood (Chloe, p.33; Dawn, p.24-25; Ellie, p.23). The ability to do all of those other things for Chloe, the things that she needs to do to know who she is as a person independent of motherhood (p.36). However there is also an element of acceptance of self, being is enough as Faye describes so eloquently her realisation that "just being F's mum is enough for her" (p.25).

Maslow's (1943) hierarchy of needs model places five tiers of needs within a pyramid: with physiological needs at the base; safety and security at the next level; followed by belonging and love; esteem and recognition of accomplishments; and at the very top self-actualization (see Figure 14.). Maslow's pyramid suggests that the basic deficiency needs of the first four levels are required to be met to some extent before the growth motivation needs of self- actualization can be realised (Maslow, 1954, 2011). He suggests that not everyone will achieve self- actualization and that at the higher levels many conflicts and polarities in the human condition are resolved: one of the features of self-actualized people is that they are "simultaneously selfish and unselfish" (Maslow, 1954, 2011, p. 76).

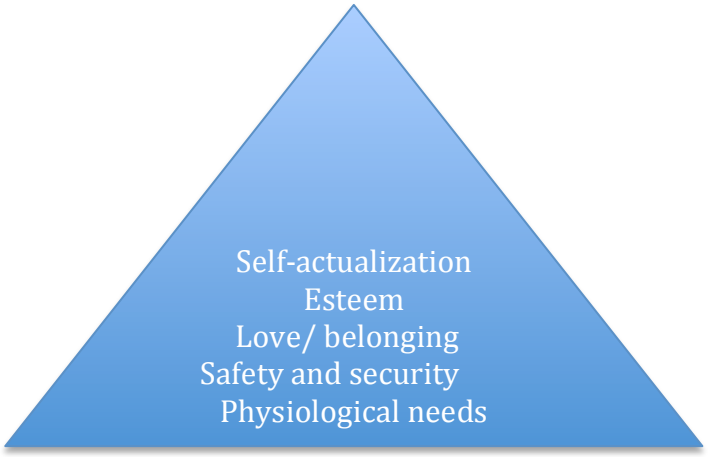


Figure 14. Maslow's 1943 hierarchy of needs.

The realisation by the mothers that to care for their children they must be able to meet their own needs to some extent suggests that they are developing as people. Some of the mothers are able to recognise a link between identity and self-care (Beth, p. 18; Chloe, p.36; Dawn, p.24-25; Ellie, p.22-23). Dugan and Barnes-Farrell (2020) in a study with 440 working mothers found that the mothers identified an inability to look after others if they were not functioning well themselves. Self-care can have a stress prevention function as it regulates personal resources to prevent depletion (Dugan & Barnes-Farrell, 2020). In this way the need for self-care supports coping, is protective of the children and accords with Maslow's "simultaneously selfish and unselfish" (1954, 2011).

Theme eight *Children as motivators* which was able to include the phase three mothers data, explores the recognition by the mothers that they are sometimes inspired by their children's developing personalities and this feeds into their parenting understanding. There is a sense of mother and child learning together as a dyad, able to support each other in some ways through their joint experiences and the children give love back in a way that the mothers find supportive (Ava, p.18; Lynne, p.14).

During positive social interactions involving behavioural synchrony such as shared gaze or touch, there is a physical hormonal attunement involving heart rate and brain EEG patterns which can provide positive experiences and promote resilience (Morris, Hays-Grudo, Kerr & Beasley, 2021). Ensor and Hughes (2008) found that what mattered for children's social understanding was the 'meeting of the minds' within conversation, where mental state references promoted children's ability to understand others. There is also an element of feeling needed that helps the mothers carry on, they have a sense that what they are able to do for their children is important and valuable (Ellie, p.23; Dawn, p.28; Faye, p.19). This helps them when they are not feeling the best or that they are the best mothers; it binds them to a higher purpose.

Some of the mothers describe finding the ability of their children to live in the moment inspiring, the interest in the color of a leaf (Ellie, p.30) or the ability to not hold on to sadness and be happy in the moment (Faye, p.19). Smith (2010, p.365) describes it as "Zen-like" when a child notices beauty in the ordinary and points to Stadlen (2004, p. 89) when she says that a mother has to "loosen her active conscious mode and sink into something older and simpler in order to get close to the world of her baby". The mothers have a joy and fascination in their children that supports their parenting, Isla describes her child being "fascinating" (p.16), Jinny says that she loves "spending time with them" (p.10) and Kelly uses the word "excited" to describe how she feels about her children (p.6).

The final phase two study theme *Rebalancing through Covid-19 lock down* was a small window of awareness where the mothers were aware of both their pre Covid-19 lock down functioning and their post Covid-19 lock down functioning, that was very specific to the moment in time. This theme was specific to the phase one and two studies and was not triangulated with the phase three study; the interviews of the

phase three mothers took place towards the end of 2019 when there was an apparent accommodation of the Covid 19 pandemic experience that was evident in their accounts through the lack of data on this theme. The distinction was that they did not differentiate the pre-covid coping to the post-covid coping styles in the same way as the phase one mothers and the supporting data was therefore not present for this theme. The experience of mothers who only knew mothering within the pandemic was different to the mothers who had recent experience of both pre-pandemic and post-pandemic circumstances.

There are many elements that signify adaptive processes and accommodation to their current circumstances, with the use of positive reframing (Dawn, p.25; Ellie, p. 29); finding new options (Ava, p.18; Beth, p.27); and priority setting (Ava, p.23; Ellie, p.29). These coping efforts appeared to be effective for the mothers and to some extent enabling of development in their capacity to be resilient. There appears to be a honing down of what is important in terms of priorities and meaningfulness, with the emphasis being placed firmly on the children and the family as a unit. The creation of an order of priorities from the chaos that is external to the mother/child dyad and the family.

In addition McCubbin (1998) finds that the well-being of families is best understood within the context of how they survive and even thrive in the face of crisis. The protective instincts of the mothers for their children are apparent and their ability to find joy in their children appeared to have been in some way accentuated by the frightening circumstances of the pandemic (Ava, p.22; Beth, p.19; Ellie, p.26; Faye, p.17). Being able to be consciously present in the moment and enjoy their children's ability to live in the moment supports more mindful parenting. Mindful parenting includes activities such as listening with full attention to the child, non-judgemental acceptance and emotional awareness of the child and parental self-regulation; in

terms of coping this has a value for reducing stress in the parent as it encourages compassion towards the self and the child (Fernandes, Canavarro & Moraira, 2021).

The mothers display a wide variety of coping abilities that they are able to access to support their coping during the pandemic. There is a sense of the adaptive abilities of the mothers as they negotiate the additional stressors that the pandemic places on them, their children and their family. The pandemic posed increased levels of stress for parents in many ways; Barbosa-Leiker et al. (2021) emphasise the role for practitioners in educating women about coping and helping women make healthy life choices during times of stress such as the pandemic, in order to ameliorate the effects of stress on maternal and infant health. Increasing levels of awareness around coping may be able to support healthy choices in times of stress (Barbosa-Leiker et al., 2021). The subject of whether the pandemic may have raised levels of coping awareness and if this will be lasting phenomena, could be a subject for future research to investigate.

This chapter has presented the data analysis in the phase two study, on the six follow-up interviews with the phase one study mothers. The follow-up interviews were able to examine aspects of coping as a phenomenon that transcended time. The mothers had the opportunity to reflect and focus in a way that was enabled by the introduction of the topic within their initial interviews and the researcher was able to build on the phase one study themes, in a way that was able to examine coping from a developing perspective. The themes were then situated within the context of the existent literature. In the next chapter the third phase of the study data analysis, which relates to initial interviews with six new participants are described.

Chapter nine: Phase three study results from data analysis

> *"A stressful life event does not occur in a vacuum, but in the context of the individuals life cycle"* (Lazarus & Folkman, 1984, p.108).

This chapter describes the analysis of the third phase of the study which involved a further six mothers, who took part in initial interviews between August and December 2020, after the Covid-19 initial March to June lock down in 2020. The interviews all took place virtually following the research guidance under the Covid-19 restrictions. The chapter concludes by discussing the themes in relation to relevant research within the field, to provide context and pursue further insight. The phase three mothers background information is detailed in Table 11. below.

Table 11. Participant background information for phase three study.

Participant number and pseudonym	**Age**	**Location**	**Marital status**	**Children age M= male F= female**	**Self reported mental health difficulty**
7- Grace	32	Scotland	Married	F aged 3 ½ years F aged 22 months	Depression
8- Hazel	34	Midlands England	Married	F aged 2 years	Anxiety
9- Isla	34	Midlands England	Married	F aged 5 months	Anxiety
10- Jinny	32	Wales	Married	F aged 11 years M aged 9 years M aged 2 years	Pre-natal depression Post-natal depression
11- Kelly	34	North of England	Married	M aged 4 years M aged 9 weeks	Pre-natal depression Post-natal depression
12- Lynne	32	Midlands England	Married	F aged 7 years M aged 5 years F aged 10 months	Depression Anxiety

The themes in the phase three study were all triangulated with the data from the phase one study interview data. The participant background for the Phase one participants are detailed below (see Table 10.).

Table 10. Participant background for phase one study.

Participant number and pseudonym	**Age**	**Location**	**Marital status**	**Children age M= male F= female**	**Self reported mental health difficulty**
1- Ava	28	North West England	Married	M aged 22 months	Anxiety
2- Beth	27	North East England	Married	F aged 18 months	Pre-natal depression, Post-natal depression
3- Chloe	28	West of England	Married	F aged 2 ½ years M aged 5 months	Obsessive compulsive disorder
4- Dawn	37	Wales	Married	M aged 2 years	Bulimia, anxiety, depression
5- Ellie	29	Wales	Married	F aged 3 years M aged 18 months	Post-traumatic stress disorder, Post natal depression
6- Faye	26	Wales	Married	F aged 11 months	Depression

The interview guide used in the phase three study was identical to the phase one study interview guide, but was able to build on the experiences of the phase one mothers, in that the identification of the phase three study themes was a development in the thought processes and interpretative ability of the researcher following on from the phase one themes. The themes are interrelated aspects of the lived experience of the phenomenon of coping, which are examined from different perspectives, but are similar and connected in subject matter. A summary of the phase three study themes is detailed here in the table below (see Table 15.).

Table 15. Table of themes in phase three study.

Study Phase	Theme	Participants	Key words and phrases	Present in over half of total sample
Phase Three	10. Things not spoken about	Beth Chloe Dawn Isla Jinny	"I didn't want to tell them" (Chloe, p.3). "I've made a terrible mistake" (Dawn, p.3). "I didn't tell them anything" (Isla, p.5). "It was never…yes…never spoken about in our family" (Jinny, p.2).	No
	11. The importance of nested support structures	Ava Beth Chloe Dawn Ellie Faye Grace Hazel Isla Jinny Kelly Lynne	"School" (Ellie, p.20). "Connections" (Faye, p.8). "Baby groups" (Grace, p.14). "My husband was quite worried" (Hazel, p.6) "Cleaning play date" (Isla, p.7). "HR (Human resources in workplace)" (Kelly, p.7). "I just remember ringing my mum" (Lynne, p.14).	Yes
	12. Owning mental health	Ava Beth Chloe Dawn Ellie Faye Grace Hazel Lynne	"I didn't realise that a lot of my behaviour was not very normal" (Chloe, p.4). Doing the leg work" (Dawn, p.19). "It really snuck up on me" (Kelly, p.3). "Making that decision to go back to the GP's" (Lynne, p.11).	Yes
	13. Learning through experience and adversity	Ava Beth Chloe Dawn	"It was the dread of my own experience of being a child that drives me as well to be better" (Beth, p.11). "If you need help you have to keep	Yes

		Faye Hazel Jinny Kelly	asking for it" (Grace, p.12). "I can't put everybody else first before myself" (Hazel, p.18). "It doesn't really matter if you don't achieve anything during the day" (Kelly, p.10).	
	14. Co-parenting and mental health	Ava Beth Chloe Dawn Ellie Grace Isla Jinny Kelly Lynne	"We are not doing this as a team" (Dawn, p. 21). "He's better than me at seeing when I need a break" (Grace, p.9). "I think he was quite conscious of talking to me, making sure he was asking me how I was feeling" (Isla, p.12). "So if I tell P that I'm not feeling myself, that's the key word" (Jinny, p.5). "Like ships that passed in the night" (Lynne, p.8).	Yes

Theme ten- Things not spoken about

This theme connects with and builds on the phase two study theme of being open and honest and asking for help, where the ability to be truthful with the self is found to enable a more accurate assessment of need and communication of need. This theme was not present in over half of the combined study mothers, however it was included as it was felt to contain some pivotal data in terms of the ability to seek help. There are things that the mothers for many different reasons struggle to speak about.

Isla described the difficult birth she had experienced with her child and her inability to tell anyone what she had experienced and how she was feeling.

I didn't tell them anything initially about things that I was struggling with (Isla, p.5).

The reasons that it was so hard to talk about are complex and multi-faceted. One of the reasons was a sense of the absolute raw intimacy of the experience; Isla had not initially been able to process the experience enough to put it into words in a way that she was able to share with anybody. The experience is intimate to her vulnerable physical body and too personal to share lightly.

> *It was humiliating, um becoming incredibly conscious that the entire world asks about your birth story, and thinking that's really personal, if I'd had an operation on any thing else, nobody would say tell me everything about it, but because you've had a baby, every ones like go on go on tell us the whole story….. no that's really personal, we are dealing with a really intimate part of my body here, if I don't want to talk about it I don't have to.…* (Isla, p.4).

Isla questions why it is expected that she should share such an experience: because childbirth is a public occurrence? Even then there is a realisation that 'the public' would only want a sanitised version of the real physical details, not the devastating distressing, disturbing and painful aspects. Isla then relates a more complicated feeling of shame that she failed at the perfect birth and shame that she is feeling bad because she has a healthy baby and has no right to feel bad.

> *Because it didn't go perfectly and that's what doesn't work in my brain, is feeling like that didn't go perfectly so that's…. I'm ashamed of that.… I'm ashamed that I didn't do it.… it's stupid because she's here and she's alive and she's in one piece so….* (Isla, p.6).

This complex mix of raw emotions of sadness and grief, the loss of the expected birth, feelings of shame bringing with it the idea that she could have done it better, even when it is clear that she absolutely did all that she could have done and it was outside of her control. The expectation of happiness at a healthy birth outcome in this case is denying Isla the ability to process her pain, her struggle and her sense of loss.

Jinny relates her difficulty in coming to terms with her experience of having depression and the relationship of this with the fact that it was something not spoken about.

> P- *….I had post-natal depression, I've had it with all three of the children, but I didn't have any awareness of it before I had her, so it was quite…. I did find it quite difficult to get my head around and to….*
> R- *So you had no expectations of having mental health difficulties before you had the children?*
> P- *No none at all, it was never…. yes never spoken about in our family*
> (Jinny, p.1-2).

Later Jinny describes a "hiding" away that has a feeling of the shame of the unacceptable, not spoken of, not presentable part of her existence.

> *I was very poorly, I had quite a lot of time just hiding at home and not wanting to do anything and just getting through the day* (Jinny, p.4).

Jinny knew how poorly she was, but her only aim was to 'get through the day', an existence but not able to live a complete life. In terms of coping Jinny had previously had to resort to extreme measures to survive and to protect the safety of her children.

Something just came over me, it wasn't me at all and I was just.… I decided that I couldn't be a parent any more, so I phoned H to come home and I packed a bag and I left.… I left (second child) with (first child) who were fifteen months and two week old and I just…. ran away (Jinny, p.5).

This use of extreme avoidance may be socially unacceptable on some levels but is merciful and enables survival at the most critical of times. The consequences of the unspeakable for individuals can be the resultant unmanageability of things that can be frightening in consequence.

I was gone for three days with no contact, I just hid away in a hotel room in (town named) no idea why, but then on that third day I think hormones had started to settle a little bit so I phoned my GP and I said what had happened, made the appointment, came back, went to the appointment with him, got straight on to anti-depressants (Jinny, p.3).

Jinny was able to use the time away to recover a sense of what she needed to do and was able to seek the appropriate help and support for her own sake and the sake of her children. The re-establishing of a sense of coherence here is palpable: my life is understandable; my life is meaningful; my life can be manageable if I access authentic care and treatment.

Some of the phase one mother's interviews also demonstrate elements of what cannot be spoken of. Beth describes the difficult emotions that emerged for her when she became a mother.

I think, I've always been quite a positive person, but motherhood made me incredibly negative all of the time (Beth, p.12).

This resonates with Isla's difficulties with sharing the negative aspects of her experiences. The unspoken assumptions about what other people are able to listen to, which may be based in reality or not, but make it hard to share negative emotions around the positive occurrence of a new baby.

For Chloe her diagnosis of ante-natal depression was something that she felt unable to talk about.

> *I was signed off work with ante-natal depression. Um so my pregnancy was really really tough, I…. so the trouble with ante-natal depression is you get signed off work for a period of time, and there is not really any dealing with it, I was told I could call 'Let's Talk', I didn't call them (laughs) um I wasn't really in kind of fit kind of mental state I didn't want to…. I was really embarrassed by feeling like that um my whole family were really really excited so I didn't want to tell them that I was feeling like that* (Chloe, p.3).

Her family is excited by the news of her pregnancy but Chloe is embarrassed by her depressive emotional state that she perceives as incongruous. The juxtaposition of these opposing emotions creates a barrier to her ability to share what she is going through.

Dawn experiences a resonating emotional reaction on the birth of her child.

> *I just looked at him and thought Oh my God, I've made a terrible, terrible mistake* (Dawn, p.3).

When everyone is full of congratulations and happiness at the safe delivery of a new baby, it becomes hard then for mothers to share their feelings of doubt, dismay and fearfulness. The desire to fit in with the majority of emotions around you and be seen

as good or even usual in this respect can potentially place pressure on mothers subliminally not to share their negative feelings about pregnancy or the new infant.

The aspects of coping behaviour can be in both the sharing and the withholding of negative emotions. The behavioural avoidance and mental withdrawal in the withholding of negative emotions may be a form of escape; however it will not facilitate the appropriate attainment of support or comfort.

The things not spoken about for Dawn are the unacceptable face of motherhood.

> *I just want women to stop being told that they will feel this rush of love and you know when they first look at their child its not always a rush of love, it might be a rush of…. what the 'f' have I done… which was my experience and I think that ahh it just needs to be more public, it needs to be said more…. It's hard it's really hard….* (Dawn, p.33).

The need to speak about the variety of responses that women can have when they give birth is emphasised here. The feeling that Dawn expresses is one of exasperation that is based on the insight of her own experience, that she felt totally unprepared for, in terms of knowledge or in terms of emotional flexibility of how she could feel towards her child after giving birth.

The things are not spoken about for a variety of reasons, it is too intimate and too personal for Isla (p.4), or not spoken of in the participants family (Jinny, p.1-2). There appears to be a strong component of the subject matter being perceived as unacceptable to others (Beth, p.12; Chloe, p.3; Dawn, p.3). It is complex for the mothers, they are vulnerable and show the use of avoidant coping strategies in an attempt to protect the self from a more public sense of embarrassment, shame or blame and the potential for further distress and discomfort.

Theme eleven- The importance of nested support structures

Bronfenbrenner's ecological systems theory (1979) influenced the formation of this theme; however it is imagined in relation to the mother specifically, rather than the child. Bronfenbrenner's (1979) ecological systems theory incorporates levels of support that include: micro-systems of the immediate environment; meso-systems of connections; exo-systems which include indirect environment; macro-systems incorporating social and cultural values; and chrono-systems which are time based.

The concepts of nested support were apparent in the participant's stories and the table below (see Table 16.) shows that all participants in this group received support from the microsystem members including partners and family.

Table 16. Table of support sources mentioned by phase three participants.

Support source	Grace	Hazel	Isla	Jinny	Kelly	Lynne
Partner	✓	✓	✓	✓	✓	✓
Family	✓	✓	✓	✓	✓	✓
Friends	✓	✓	✓	✓	✓	✓
Groups	✓	✓		✓	✓	✓
Profes-sionals	✓	✓	✓	✓	✓	
Work	✓				✓	
Society	✓					
Other	Landscape and environment	Being outside in nature	Social Media apps	Child's nursery	Child's nursery	Facebook Groups, Virtual Zoom Groups.

Concepts based on Bronfenbrenner (1979).

The mothers all spoke of their support structures in relation to their coping abilities. The significance of effective partner support cannot be underestimated when women are at their most vulnerable, coping with mental health difficulties and caring for a new baby. Isla describes the way her husband was able to support her emotionally and psychologically by challenging her negative self-talk.

> *I've definitely done a lot of beating myself up that I'm not good enough, that she deserves a better mum, um my husband's very good at challenging me on that and saying.…'well go on tell me something that you've done today that's really awful, that ruined her life, that made her unhappy?' You know reminding me that actually he thinks that I'm brilliant and that F thinks I'm brilliant and so I think I'm starting to see myself more positively* (Isla, p.10-11).

The value of this intimate partner support is so significant because he is the one who is present with her, that actually knows. The giving of positive feedback to Isla in her moments of self-doubt helps her to restructure her view of her situation and the care that she is able to provide to the baby in to a more positive light. This then enables her to carry on and be a more confident mother. The adaptation to motherhood is a complex and demanding process, which can need this intimate level of support. The ability of an intimate support individual to notice that something is different with the mother in her personhood and that they are not like their normal self, is valuable and significant in terms of the consequent opportunity to offer care or support.

> *I think my husband was quite worried in the beginning um just because there were lots of tears with all the hormones and everything, that first couple of weeks were really hard* (Hazel, p.6).

This picking up of the emotional clues by Hazel's husband led to help seeking behaviour that eventually led to appropriate professional help.

Lynne is aware of having a 'support network' and gives an example of how the practical support was invaluable to her.

> *I've got quite a good support network around me I think that's been the major thing I think particularly in those early days with (first child) I just remember ringing my mum and saying…. I can't do it any more…. You know and she raced back from work, thankfully she could, took her out for a walk so that I could just have half an hour quiet and you know* (Lynne, p.14).

The timely and responsive support given by Lynne's mother is restorative for Lynne's coping abilities; she is able to take some time for her-self, to recover and strengthen. Kelly appears to have awareness that availability of this extended family support is not always available to other mothers who may have more geographically diverse family structures.

Grace is also aware of her support circle that includes her husband, her father, baby groups, friends- inner and outer circles, extended family, work, the landscape and environment and professionals such as the GP and health visitor. She says about baby groups that at the time she did not realise that they were a part of her coping.

> *I don't think I thought the baby groups were a coping skill, I think at the time I felt like um I should bring her to make sure that she had the right things for her development, put it that way, like I felt that it was about her, but I think looking back now I think it was about me coping (laughs) rather than about her doing all these great things do you know that she could do (laughs)* (Grace, p.14).

Grace recognises in retrospect the value that attending the baby groups had for her in terms of coping; it allows her to develop friendship groups and close friends whom she can turn to for support. Isla also talks about the support that she was able to access through attending a baby group; she describes how when she eventually was able to share some of her traumatic birth experiences with the mothers in the group, it was helpful not only to her, but gave permission to other mothers in the group to open up about their experiences.

> *I told them the story and I tried to make it relatively light hearted, in the sense of, I'm ok.… I'm ok now um but this is what happened and this is how I felt um and it was amazing because they were all brilliantly supportive, which I knew they would be, but also it made some of them open up* (Isla, p.6).

Isla is protective towards the other mothers in the group and tries to sanitise her description of her traumatic birth experiences so that she does not frighten the other mothers. She expresses amazement at the level of support that the mothers were able to give her following her opening up. The sharing of difficult experiences surrounding the births of the other mothers then becomes possible for the group. There develops an ability for real practical support within the group-

> *One of the girls the other day was like…. I really feel I can't cope because my house is always a mess and I'm used to it being tidy and I can't do anything because I'm always worried about the hoovering…. And um I said, alright I'll bring F over and I'll watch yours, you do your hoovering, and it was like, we'll have a little cleaning play date and in return you can come to me and I'll do mine.…* (Isla, p.7).

This “cleaning play date” (p.7) is incredibly supporting and enabling; the practical problem solving supporting coping efficacy, emotional equilibrium and mental well-being.

The picture diversifies somewhat with the outer layers of the support systems, with two mothers feeling supported by their work place. Kelly relates how the Human Resources (HR) Department in her workplace supported her.

> *It’s quite a big company we’ve got a well established HR um I got support before I left about how to go about preparing for maternity leave and preparing to come back from maternity leave with …. keeping in touch days.… and things um and actually they were very good when I got the post-natal depression* (Kelly, p.7).

Kelly feels supported by them as she prepares to go on maternity leave and in her return to work. She points out that she worked for a larger company with an HR department on site; the implication being that this may not be the case with smaller less established work places.

Only one mother discussed support from her exo-system of state or society, she lived in a part of the country that provided the “baby box” scheme; these boxes’ contain essential items for the baby and the funding is by regional government.

> *It’s not like we couldn’t have afforded all the things that …. just all the things that were in it that were all perfectly designed for do you know you just wouldn’t have picked the right things almost, and we still use the actual box as a toy box (laughs) it’s so good* (Grace, p.8).

It feels as if Grace valued the well-chosen contents of the box and in turn this helps her feel valued herself in some way. Two mothers felt significantly supported by their childcare providers, who supported their return to work. The participants also discuss several sources of social media based support, in particular friendship groups which were used as a communication strategy: this may potentially have been enhanced by the needs of social isolation in the Covid-19 lock downs in 2020.

With the integration of the phase one interview data, the picture is similar with most mothers experiencing support from partner, family, friends, group attendance, and professionals. Table 17. below details the support sources named by the phase one participants.

Table 17. Table of support sources mentioned by phase one participants.

Support source	**Ava**	**Beth**	**Chloe**	**Dawn**	**Ellie**	**Faye**
Partner	✓	✓	✓		✓	✓
Family	✓	✓	✓	✓	✓	✓
Friends	✓	✓	✓	✓	✓	✓
Groups	✓	✓			✓	✓
Profes-sionals	✓		✓		✓	
Work	✓					
Society						
Other	Social media Groups	Child's Nursery Nature	Nature	Child care Cleaner Exercise and yoga	Child's school	Nature Exercise And yoga

Concepts based on Bronfenbrenner (1979).

Dawn is the exception as she experienced mixed levels of support from her partner.

> *My husband had two weeks off paternity, he slept for most of it and would go out to the gym, um they just have no idea, there should be some serious work shops out there for men, for partners* (Dawn, p. 23).

His lack of understanding of her needs eventually contributes to her level of distress, as she describes in devastating terms later “It broke me” (Dawn, p.22). Later the parenting does become more of a shared matter, and Dawn is able to appreciate this as supportive.

> *My husband took him to a farm where they picked apples and there was Shetland ponies and ducks* (Dawn, p.28).

However the biggest support source for Dawn together with her ability to return to the workplace, is exercise and yoga.

> *The gym had been such a pivotal point in getting out of my depression or at least um you know helping with the suicidal thoughts you know* (Dawn, p.25).

This she mentions above all else, for her as the thing that is her critical source of support.

> *I found a little corner downstairs in my work building (details omitted) and I roll out my er my yoga mat and work out there so during my lunch hour* (Dawn, p.32).

This form of support is not inter-personal, and might be excluded from many concepts of support, but to Dawn it is a self-reliant form of support that she is in control of, and is integral to her coping abilities.

Dawn contrasts the support she understands as expected for her husband's knee surgery and the support that she feels new mothers can expect.

> *My husband had a knee operation last year and he was fine, a little key hole thing and for six weeks he was recovering and now it's a big thing and it was all intense and I was looking after him and it was just a small cartilage thing and you just think there is so much you know after care done for that you know there is just not enough done for women after they… you know there is the oestrogen, the progesterone, the hormones, flooding, you know your body's going into shock, it might be caesareans, stitches....* (Dawn, p.32).

The expectations around the accepted levels of support following child-birth for Dawn are experienced in contrast to the support that was recommended following her husband's knee surgery. She questions the acceptance that she perceives of society as a whole as to whether the support directed towards new mothers is adequate.

The nested structures of support can give firm and comprehensive care to mothers, but not all mothers are able to access these. It is interesting that what Dawn lacks in the form of intimate partner support, she is able to take control of and makeup for through her work, child care, cleaner and the use of exercise. Her coping is interwoven with her environmental influences; in her own way Dawn has created nested support structures that can hold her in balance. The sources of support are strategically personalized to meet the needs of herself as an individual.

In contrast Faye emphasises the need she recognises to make connections.

> *After birth…. I think people is the biggest thing, is what I'm trying to get at.... connections and feeling like you are not the only person in the world that's staying up all night or um I think that's the biggest thing* (Faye, p.8).

Connecting with other mothers is important for her as it relieves the sense of isolation, especially at times when no one is around to help as in the middle of the night. Knowing that you are not the only one in this situation for Faye is what is effective.

> *When you can relate to other people it makes it a bit easier to talk about it as well, with other people as everyone feels anxious and down* (Faye, p.18).

The ability to share experiences with others is what is supportive for her. The school that her daughter attended was a source of support for Ellie.

> *I would call the school quite a lot in the first like two weeks that they went back and they were so brilliant…. and they'd say…. Yes she's fine she doing this…. so that helped* (Ellie, p.20).

Ellie was able to access support from the school that was supportive and enabled her to manage her levels of anxiety.

The use of Bronfenbrenner's (1979) ecological systems theory in this theme was able to suggest areas of support including social connectivity and environmental factors. The mothers show their ability to seek support from intimate and wider sources creating the structure of nested support that can provide more of a safety net in terms of effective support, rather than relying on only one or two sources.

Theme twelve- Owning mental health

The owning of their mental health emerges as important for the mothers in terms of recognition, acceptance, accommodation and adaptation. Kelly explained some of the processes she went through before getting diagnosed with post-natal depression when her baby was 9 months old.

> *I'd had depression in the past, um but it really sort of snuck up on me I didn't actually recognise any of the signs at all (Kelly, p.3).*

The inability to recognise her own mental ill-health in some ways showing the daily struggle that she was just accepting. Kelly eventually gets to a point where she feels she just can't do it anymore and acts protectively of her infant and tells someone.

> *I did ring the health visitor, one day when the baby was just playing on the floor and I just said…. I just don't think I can look after him any more* (Kelly, p.3).

Kelly describes taking the standard questionnaire used in the National Health Service (NHS) protocols which in this instance was unable to listen to her actual words and did not identify that she was significantly depressed and she had to struggle on, potentially putting both her and the baby at risk. She recounts-

> *Then a couple of weeks later, I just got really emotional and had sort of a huge argument with my husband um and I just felt like I was really acting out of character sort of like I left the house because I just needed to get away, um and I just said to my mum.… I'm just going to book myself in to the doctors, and I went to the doctors um and I think I started talking about it and I just kind of burst into tears and she pretty much sort of started writing me a prescription there and then* (Kelly, p.3).

The second experience is one of being heard; Kelly's recognition of her own need for support with her mental health and her bravery in seeking that support, demonstrates the real owning of her mental health needs. Lynne also describes a similar state of physical and emotional exhaustion and finding the limits of her coping.

> *Yes I think it just took all of my energy to look after them emotionally and physically because I was just so exhausted* (Lynne, p.7).

The reaching of the point of recognition for Lynne was influenced by her protective instincts towards her children. She describes reaching a low point and realising that her mood was affecting her children's behaviour.

> *When I was at my lowest um with my anxiety and depression I think more of that side of you comes out and your tolerance of things is a lot less um (pause) and then that kind of escalates their behaviour I think… so it was I think for me making that decision, to go back to the GP's and get my anti-depressants and stuff was the turning point* (Lynne, p.11).

The owning of and acknowledgment of her behaviour, becomes a critical point in the recognition of her own needs and her ability to seek help. The protective instincts in her mothering role providing the: motivation; the setting of priorities; and the accommodation of flexibly adjusting preferences to options. This problem solving approach involves doing what works and doing it again when necessary, even when it is not what you want.

Grace recounts a corresponding memory here, concerning the lack of recognition of her mental ill-health, and then a gradual acknowledgement, as things get worse for her.

But I still didn't recognise it when it came the first time round (Grace, p.3).

But I didn't really realise it until I was kind of six months, maybe four to six months I think, post-partum, and I kind of started to say stuff to my husband that I think F (first child) should be happier.… I don't think I really wanted to kill myself but I felt like I was the one upsetting her (Grace, p.4).

This feeling that her child might be better of without her seems significant; it appears to be a warning sign in some ways and yet again as the mother places her needs behind her child's, a protective instinct that is deeply felt. This awareness that things are not ok appears to be essential in the help seeking progression, and the owning of this knowledge to the point that it can be said out loud, is significant. Hazel puts it like this-

I think for me is that its recognising that something's a problem or something is difficult and then trying to practically overcome it or address it in some ways (Hazel, p.17).

This is self-reliant in nature, it feels self-reflective and the 'recognition' of a problem or difficulty opens up resources to be considered. However the coping options may not all be positive or protective of health and well-being, and therefore this may be a critical turning point for mothers. The surrounding support structures coming in to play in this pivotal moment.

Grace here describes how difficult it is to know what are the helpful options, as people try to make her give up breast feeding her child so she can get some rest.

I felt like everyone was just telling me that I should give her some formula and then you know…. you would get some sleep or you'd be better rested or somebody else could do it so that I could have a break but.… that actually the breast feeding was the main thing, and I always feel like its always annoyed me and it would still annoy me, that was the thing that was holding me together, because it was the only thing that she really needed, or it felt like she needed me for it…. Yes, I didn't want actually to give up the.… the thing that she needed from me.… do you know in that way…. The thing that only I could give her.…(Grace, p.7).

This cry from the heart, "the only thing that I could give her" (Grace, p.7), so powerful in conveying that giving it up was not what she needed. What is unclear is consideration of all the practical things that could be given up to attain more rest such as cooking, cleaning, laundry, shopping for example. Later Grace reflects on the times when she has been unwell.

I feel like I'm on the other side of it now, do you know and it feels like there is good days and bad days and my good days and bad days are more like everyone has probably, I think my mental health has improved quite a lot so sometimes its quite hard to think back and recognise how bad it was at times do you know that way (Grace, p.17).

The awareness of lack of awareness feels protective in some ways, not denial because there is insight present, but maybe helpful to the ability to move on. However there remains an owning of her mental health situation. Grace is able to reflect on her expectations of herself with her first child-

> *I think with F (first child) I felt like I…. I had to get it exactly kind of right and that was too much pressure* (Grace, p.14).

The realisation that she was putting too much pressure on herself is helpful with her subsequent child in her appreciation of more realistic expectations for herself as a mother. Grace is better able to judge what is achievable with her second child; this is important in terms of her mental and emotional well-being. In terms of coping it demonstrates an accommodation and acceptance, flexibly adjusting her preferences to her options; and shows her ability to consider and take ownership of her own mental health.

The phase one mothers interview data is also able to demonstrate this theme of 'owning mental health', and the importance of self-recognition of mental health needs. Ava describes a conscious awareness of her mood state as an important influence on her good or bad days.

> *I think it all depends on my mood for some reason, whether I've had a rough nights sleep and am overtired, or now I'm back at work, if I've had a difficult day at work, I've come home, I'm having to do tea, bath, bed, um, so I think it all depends* (Ava, p.8).

She is taking ownership of this in a helpful way; there is a sense of taking of responsibility. For Ava there is a necessity to "be honest with yourself" (Ava, p.8) that is enabling of the ability to get the appropriate help and support.

Understanding the significance and importance of mental health for Beth is an absolute necessity.

> *We just sometimes seem to forget that your mental health is incredibly important and it can be the choice like between life and death or completely suffering or not* (Beth, p.17).

There is no illusion here for Beth; it is a matter of life or death for her. This recognition allows for due consideration of what is required to maintain wellness and prevent illness.

Chloe speaks about the difficulty she had recognising that her behaviour was of concern.

> *So when she was born and I was so in love with her um I didn't realise that a lot of my behaviour was actually not very normal* (Chloe, p.4).

Chloe develops an acceptance towards her mental health difficulties and is able to acknowledge it.

> *I think a big part of it for me is learning to be accepting of the fact that this is probably something that is…. I'm going to have forever, it's going to be there, it might not always… it might not always be bad but it is something that doesn't just go away, it doesn't just fix itself and that is quite a big thing to come to terms with, whilst also not letting it define me* (Chloe, p.13).

She is attempting to balance acceptance with not letting it define her, it is an element of self that she needs to be attentive to but it is not the sum of her as a person, her personality, her strengths, her gifts, her motherhood.

Dawn describes how she is taking control of her mental health, by treating herself as she would a friend and doing what she needs to do to stay well.

I just keep going through what I would be telling a friend, um I'm listening to happy things just trying to be practical and doing the leg work, going to the gym, yoga, reading, that all the people say you need to be doing, a healthy diet, getting out for fresh air, listening to happy things (Dawn, p.19).

Dawn is able to listen to her inner knowledge about how to maintain her own mental health, she knows from her own experience what works for her, what is helpful and supportive for her. She has listened to advice from other people and has assimilated the things that work for her into it into the ability to help herself.

Faye is able to describe how she needs to listen to her own emotions and give them some space to be processed and managed.

If I'm feeling depressed I try and check in with that emotion, and actually like give that emotion some time and think right why am I feeling depressed? What's happened? Or if anything has happened, um where's this come from and that can just like…. um (pause) I think that that's just the biggest thing for me, just giving that emotion the time of day (Faye, p.12).

This is an emotional skill that she has learnt and that she gives priority to in the self-management of her own mental and emotional health. Faye demonstrates an ability to be emotionally responsive to herself and give herself time to acknowledge her feelings and in the process recognise, accept, accommodate and adapt. It is truly self-caring and self reliant in coping style and protective of her available resources.

The mothers talk about their difficulties recognising their mental ill-health (Chloe, p.4; Grace, p.4; Kelly, p.3). However when the mothers are able to recognise the significance of how they feel, they can move on to an ownership and acceptance (Beth,

p.17; Chloe, p.13; Hazel, p.17), which enables them to begin the process of taking back control in a way that supports their coping (Dawn, p.19; Faye, p.12).

Theme thirteen- Learning through experience and adversity

The ability to learn from experience and adversity is documented within the participant interviews, as has been seen in the Phase one study theme *Passing on coping,* where the mothers showed the use of their experiences of knowing to inform their behaviour with their children, knowing what they lacked, knowing what life's challenges can bring, knowing about what coping means to them as individuals. This theme specifically explores the mothers lived experience of *Learning through experience and adversity* building on and developing the earlier findings.

Jinny remembers how when she was growing up things were so difficult for her own mother that she feels her mother was unable to form the necessary relationships with her children. As a consequence of this experience, she herself takes extra care that she attends to the quality of relationships that she has with her own children.

> *She had such a tough time being poorly when we were younger, there are five of us, that she's missed that relationship building that I really take care of now with my children* (Jinny, p.12)

Kelly is able to learn from her own experiences of difficulties caring for newborn babies.

> *It doesn't really matter if you don't achieve anything during the day your baby's is only like four weeks old kind of thing, you just need to be ok* (Kelly, p.10).

Kelly develops an acceptance of her own limitations and this is for her a way of coping. It restructures her experiences into understandable and thoughtful reflections.

Grace describes being influenced by her father in searching for the positives to look forward to.

> *I think my dad probably always did the finding something to look forward to thing* (Grace, p.11).

This really interesting recognition of her fathers influence, examples a cross-generational transfer of resiliency and coping strategy. It is not possible to know how far back in the generations this strategy goes without speaking with Grace's father, but at some point he has developed this strategy or has similarly inherited it. Grace is also able to identify her mother's influence of her in using the outside as a place that she is able "to clear my head" (Grace, p.11).

> *I think my mum probably always encouraged us to go outside, I've always found like if I'm out in nature that it will be.... easier* (Grace, p.12).

This trans-generational influence clearly being seen here again, and showing the importance of the inter-generational passage of resilience and coping. In this passage Grace explains that her mother who died of cancer when Grace was 13 years old, was able to intentionally leave some letters of advise for her children before her death.

> *She had kind of left us all a couple of letters and that was her piece of advice to me was that um if you need help you have to keep asking for it and if you're not getting it from someone, you just have to ask the next person, and not be offended if somebody can't help you it's to do with them not you and just keep asking that's all.…*(Grace, p. 12).

This ability to ask for help, and to keep asking was a precious jewel that she was giving Grace, not to be ashamed for needing help, and to keep asking even if some people are unable to help. The detail of recognising that when other people are unable to help, it is to do with them not the help seeker is insightful and enabling; not taking it personally if someone is unable to help you can ease the way to asking someone else. The memory of the letter was precise and readily recalled; it had become part of Grace's coping repertoire.

Recognising the effectiveness of a coping strategy enables it to be used purposefully to facilitate coping. This recognition of coping strategies also enables the development of a coping repertoire that can be consciously accessed in times of need. Hazel describes learning from her recognition of her child's needs, how to meet some of her own needs.

> *So I'm sort of recognising what she needs and applying it to myself to recognise what I need, so do I need some like quiet time or do I need …. am I tired, am I hungry, am I you know upset about something that's happened this morning is kind of like, trying to apply how I look after her to how I look after myself* (Hazel, p.18).

Her mind-mindedness for her child has provided insight for herself in the recognition of her own legitimate needs. This recognition of the need to attend to her own needs is able to enhance her ability as a parent and is protective of her child. This coping is self-actualizing: meeting her own needs; developing an attitude of self-compassion; it is self-reliant; and protective of personal resources. Hazel is able to understand the potential loss of self that can come with meeting the needs of others to the neglect of self.

I can't put everybody else first before myself all the time because there will be nothing left of me (Hazel, p.18-19).

It is not completely clear when this realisation happened for her, except that through her observations of her child's legitimate needs, she is able to validate her own. Hazel also finds the acceptance of her own choices and responsibility in deciding to have a child helpful. This cognitive reasoning supports her resolve to be as good a parent as she can be, it is realistic and clear in its reasoning, it is understandable and meaningful and that helps it become manageable.

Knowing that I'm her mum, there are other people that will help but we chose…. I mean we chose to have to have a baby so I guess that's oh I don't know if it's really hard…. um knowing that there's just me and H to do it (laughs) it our response… you know it's our responsibility (Hazel, p.17).

This acceptance of her ultimate responsibility in her own choices and for the care of her child is supporting of her coping resolve. Hazel is also able to imagine helping her child in the way that her child has enlightened her.

I think for me things that I want to pass on to her, it's sort of a bit of a circle, because the things that I want to pass on to her are the stuff that she's teaching me to do, (laughs) like to be.... sort of the stuff about being resilient that she is teaching me about myself that I hope that I can pass back to her, so we are sort of guiding each other in a way (Hazel, p.27).

Hazel has developed a relationship with her child that enhances her coping and provides a sense of purpose for the future for them both. The use of the word 'circle' provides an image of containment and of continuance in a sustained way as Hazel and her child cope together as a dyad.

In this passage Hazel remembers aspects of adversity from her childhood and reflects on her inability to express or talk about what was happening to her.

> *I don't think I did that when I was younger, I don't think I ever talked about being bullied, I certainly didn't talk about my parents separation, and so over the years I think I've probably internalised an awful lot of that and it kind of causes.… not causes me but it's fed into who I am and I think yes if people are going through something or feeling things it's important that they talk about it, even if it's to a parent or a friend, do you know what I mean, I'm not saying they have got to go and seek professional help, I just mean to vocalize what they are feeling so they can understand it better.…* (Hazel, p.28).

Her conclusions from her reflections are around the fact that in the past she has been unable to talk about things, which led to her feeling that she would have been able to understand things better if she had been able to talk them through. This processing of early traumatic experiences would have been beneficial for her and she is able to see the benefits of it now enough to recommend it to others. The ability to learn through experience and adversity develops coping resources for the future.

The phase one study data is able to provide additional perspectives in this phase three study theme. Beth has a large repertoire of coping strategies by the time of the interview when her child is eighteen months old. However initially she does not perceive these as coming from her experiences of adversity when asked "what ways of coping came out of your past experience of coping with difficulties" she replies "Absolutely none, none no"(p.12). However at another point she can see a connection.

It was the dread from my own experience of being a child that drives me as well to be better (Beth, p.11).

However with Ava you get a sense that her developing confidence in her general ability to cope is more important than her learning through specific experiences.

I think being confident in your coping mechanisms of knowing what's best for you (Ava, p.15).

In "knowing" Ava (p.15) communicates an awareness of her self-knowledge and that this is important and helpful for her.

Both mothers have undergone adversity in their early experiences of motherhood, Beth's experiences in some ways are more extreme and the help she receives from professional support services are more complex. It is interesting that Beth subsequently develops a large repertoire of coping skills of which she appears to be cognisant; having knowledge and awareness of these to the point that they appear to be fairly easily brought to mind and expressed where as Ava appears in some ways less able to identify her coping strategies as readily.

The ability to reflect on the self is clear in Chloe's interview and it is this ability that presents learning opportunities for her. She is worried about the risk to her children of mental ill-health and adjusts her parenting style as a consequence.

I am really aware that children with parents with mental health conditions are more likely to have mental health conditions themselves so I'm really keen to do what I can to make that less likely. So in terms of my parenting style we don't um…. we don't allow them to cry and I try to be really attentive towards them

because leaving babies to cry is known to change their brain development (Chloe, p.13).

Chloe is mind-minded for her children and reflects further back to her own experience of being parented and has made conscious decisions about how she wants to parent her own children.

I'm very aware of what sorts of things were.… how things were dealt with when I was a child, and how they're not the way I want to do things with her (Chloe, p.13).

There is an absolute decision by Chloe that she wants to do things differently. The decision is made by reflection upon her own experiences of being a child. Chloe demonstrates an on-going ability to be reflective; she observes her child's self-talk one day and is concerned for her.

She has a rainbow toy which is sort of a stacker, it's um semi circles of wood and she placed it against her stomach and said 'I've got a big fat tummy just like mummy'. And I thought there's no way that she's.… she's got that from watching me getting dressed in the morning, that's the only place she could have got it from. And it made me realise that actually I need to be really careful about how I talk to myself, in front of her because I don't want her to do that (Chloe, p.14).

Chloe is able to recognise the need to moderate her own behaviour so that her daughter does not copy her negative self-talk. Chloe's protective stance for her children and her ability to demonstrate reflective function are instrumental part of her ability to learn from her experiences and from adversity.

Dawn's reflections are painfully honest as she realises what she viewed as a strength might not be.

> *I felt over the years that I was letting myself, where I thought I was being laid back in a relationships, I started to think maybe I was more of a walk over* (Dawn, p.10).

This recognition is empowering for Dawn: she is now equipped with knowledge that she can use to improve her life as an individual, as a partner and as a mother.

The learning that Ellie demonstrates from reflection is around her value as a mother.

> *I might not think that I'm good enough for them, but nobody else is going to be better* (Ellie, p.23).

Ellie has concerns about her abilities as a parent, but she knows on reflection that no one else would be able to take over and do a better job. This information is motivating for her and helps her to carry on when things are difficult for her.

Faye reflects on her experiences as a child of her mother's anxiety-

> *When I was a child she'd be like…. 'Oooh don't do that you are going to fall and hurt yourself' .... and things like that…. or 'don't do that because of this….' And you do pick up on things like that and then I was very anxious to do anything because I thought I was going to hurt myself and I didn't want to have new experiences because I was frightened so I definitely picked up on my mum's anxiety* (Faye, p.23).

Faye is able to discern that she was influenced by the expressed anxiety of her mother, she understands the influence that it had for her in making her fearful of new experiences and she seeks to protect her child from this.

> *It's something that I'm trying not to project now on to my child* (Faye, p.23).

Her ability to reflect on this experience and be mind-minded towards her own child, gives her the resolve to try and do things differently for her own child. In this way adverse experiences can be protective for future generations if there is the ability to learn from them. Faye describes her own character as a child-

> *I was quite shy, quite timid, and I always wanted to make everyone happy so if I drew a picture for my mum I'd have to go and then draw a picture for my Dad, I couldn't bare the thought that anyone would feel unequal um I probably wouldn't have given… if somebody had said…. what do you want to do today…. I would have been like whatever you want* (Faye, p.20).

She recognises the inability of herself as a child to make decisions based on her own needs and when she watches her daughter develop confidence and independence she is aware of her feelings about this.

> *It's nice when I see her go off and do something independently and not look back that gives me a sense of achievement as well that she's so secure and independent and happy that she feels that she can go and do that, so it's a weird feeling because you want them to want you, but also you want them to be, to be independent*…. (Faye, p.20).

Faye is able to understand her ambivalence towards her daughter's independence whist really enjoying a sense that she has achieved something as a parent, and that her daughter is developing in a healthy way. This demonstrates coping in the form of emotional intelligence; using self-awareness, self-regulation and relationship management.

The mother's demonstrate an ongoing ability to learn from both past and present-day experiences in their own and their children's lives. Experiences which are both adverse in nature and positive in nature are used to inform and support the mother's choices, improving outcomes for them and their children. The experiences are from childhood through to adulthood and also inter-generational in nature. Having the ability to be reflective and examine lessons learnt in term of coping is protective for individual mothers and for their children.

Theme fourteen- Co-parenting and mental health

The relationship between co-parenting and mental health is complex. This theme examines an aspect of intimate partner support in Bronfenbrenner's (1979) micro-system, the ability of the relationship between parents to provide support for maternal mental health and parenting within the family structure.

Jinny relates her experience of receiving support from a peri-natal mental health nurse who helped her and her second husband (P) to work together to support her mental health and take care of their children.

> *I had a peri-natal mental health nurse that came out to see me at home and she was amazing and yes helped me through going on the anti-depressants, coping strategies, what we could do, because I can always tell when I'm coming up to being quite.… I'm not feeling myself, so together with P and myself we came up with ideas of what I could do to manage these before I had that blip and went into hiding* (Jinny, p.4-5).

The phrase “I’m not feeling myself” (Jinny, p.4) becomes a key word for them as a couple; that her husband is able then to respond to with coping actions.

> *So I noticed straight away quite soon that I’m not feeling myself, so I tell P that I’m not feeling ‘myself’ that’s the key word, and we change something within our day, so we don’t stick to the routine we do something that’s completely non routine for us* (Jinny, p.5).

The ability of Jinny to be self-aware to this level and of her partner to listen is significant here: both elements being required for successful coping to be implemented. The acceptance by Jinny’s husband of his ability to have a role in the implementation of coping in this respect is key.

> *If I say I’m not feeling myself I just need a little bit of time to myself, because we’ve got very busy lifestyles he will quickly grab the kids and whisk them off to go and see their grandparents or go down the beach or something just so I can go and have a bath, and just half an hour to myself* (Jinny, p.6).

The two main coping strategies that they then put into play are ‘doing something different’ and or facilitating ‘time for self’ for Jinny. Both are restorative for Jinny and prevent further spiraling into mental suffering for her. The value of this support for her as a person is momentous; but also the making space for Jinny to have ‘time for self’ allows her to cope by emotionally down regulating and therefore be able to be more present emotionally for her children. This presents as a protective action by both parents for their children and minimises suffering in the family; by using extended family for support, or the outside natural environment in these moments of need.

Isla talks about her husband’s checking in behaviour with her.

I think he was quite conscious of talking to me, making sure that you know he was asking me how I was feeling, asking if there was anything that I needed (Isla, p.12). Isla seems to find this supportive in that her needs are being thought about; she is aware that her feelings are being consciously considered and in this way valued; it is recognition of her personhood.

Lynne expresses the difficulty faced by her and her husband when their children were very young and had additional health needs, which needed very high levels of care.

> *My husband um we kind of hit rock bottom really when (child) was about a year old because he (husband) was sleeping on my daughters floor for a year because of how (second child) was sleeping and he needed to go to work the next day so even that relationship, you know we just didn't know who each other were anymore because we were just like ships that passed in the night* (Lynne, p.8).

The toll that the demands of work and child care takes upon their relationship is evident, but also evident is the commitment that they are both displaying to the care of their children. Lynne describes the recognition of the support that they both need at different times.

> *We've really had to work on that, that communication between the two of us, that understanding that we are both feeling certain ways at certain times, and supporting each other with that, but you know I've become a lot more assertive in saying… well actually no I need to do this for me…. or…. no you need to have her so I can go and just go and have a bath or something…. Because it…. not because he wouldn't do that it just doesn't come naturally to think.…oh well I'll offer to do that…. if that makes sense….* (Lynne, p.9-10).

Part of Lynne's coping has been directed towards improving her own communication skills with her husband; the ability to be specific in the communication of her needs and not interpret the lack of a particular supportive action in a negative way. This is problem solving in approach with adjusting of her actions to be effective. Lynne is able to recognise that her husband is not able to carry out specific tasks that would be helpful to her, without her specifically requesting them. This is potentially important to the success of their partnership and to the joint care of their children. It is effective in removing areas of potential friction and improving clarity within their relationship.

Kelly reflects how her husband struggled in his transition to fatherhood with their first child; but by their second child he found his role much more naturally.

> *My husband really struggled first time around, I think it was a big shock to the system him becoming a Dad but then this time around its all seemed kind of natural to him and he's been really good with my older son* (Kelly, p.8).

This acceptance by Kelly of her partner's lack of experience appears non-judgmental and positive in its focus on the development of him into being a father to their children. The transitions for mothers and fathers are uniquely individual and Kelly's ability to understand this process for her husband demonstrates adaptive accommodation in its coping style. The ability to be sensitive to each other's mental state and well-being is bi-directional and Lynne here also acknowledges that her husband has had time when he has felt low when one of their children was unwell.

> *You know he had similar like err down, low times when we were going through what we went through* (Lynne, p.9).

This acknowledgement is helpful in several ways: Lynne is not alone in feeling low; understanding each others mental state facilitates tolerance; and recognition enables coping actions to be taken at specific times when the person is feeling vulnerable.

Grace describes how her husband is able to pick up on the warning signs that she is in need of a break.

> *Sometimes I think he's better than me at seeing when I need a break even because…. it happened on Saturday…. I think maybe I shouted at F (second child) or something and I think it was about something…. do you know something not worth shouting about and he was like 'Right so after we have breakfast, I am just going to go take them to the park and you can….'* (Grace, p.9).

The knowing of a person's normal enables the picking up of stress cues that can be helpful; as Grace says her husband was aware before she was that she needed a break. Grace's husband takes supportive action, which appears to be coping based and is protective for Grace's ability to manage her equilibrium. This ability to parent in partnership is effective in promoting coping abilities within the family unit and for the benefit of the family unit.

The integration of the phase one interview data was also able to example the theme in relation to co-parenting and mental health. Ava talks of a time when her husband was 'taking' the baby to give her a break, but she was struggling with ambivalent feelings about this.

> *I just felt like he was taking him away from me, but he wasn't he was doing a really good thing, that I could get to bed, have some rest, feel a bit fresher for when they got back, tidy the house up, have a bath, whatever I needed to do, he was allowing me to do that. I just didn't see it like that* (Ava, p.11).

Ava's partner was doing the right thing to support her mentally and physically, but her anxiety and sense of loss at having to spend time away from her baby was making it counter productive in terms of support. The balance and sensitivity required in co-parenting is challenging, even when both partners have the best of intentions. The early emotional bonds between Ava and her baby made it hard for her to be separated from her baby; Ava and her partner had to reach some sort of compromise that enabled her to rest, whilst not causing her emotional distress.

Beth is reflective about the needs of her husband and her responsibility to help him within their relationship.

> *There's the extra pressure on the man as well in the relationship, if the man's around, you know because you have a commitment to your marriage and um they are changing as well, but you have to help them through it as well, as a wife now, you know…. but, I don't know…. it's really difficult when you have got a baby that won't stop crying (laughs)* (Beth, p.7).

Beth is aware of the extra pressure on her husband as he is adapting to being a father and part of a family, coping with things unknown. Beth's dialogue becomes disjointed as she struggles to be clear in her thinking, she ends up laughing as in apparent resignation and acknowledgement of how hard it is for her to meet his needs whilst caring for a crying baby. However there is a sense of their joint

struggle, something that they are going through together, difficult and transforming at the same time.

Chloe describes feeling disconnected with her husband in their day-to-day experiences of being a parent as he is out at work and she is at home with the children.

> *My husband although he was a very supportive person he doesn't know…. we live in very different worlds, he goes to work and hasn't ever spent a long time at home with the children* (Chloe, p.11).

> *He's got to try to understand what it's like to be a mum, 24/7 and also understand the mental health side of things, where as I've got friends who understand at least the 'being mum' anyway so it makes it easier for them to kind of wrap their head around my entire situation* (Chloe, p.11).

The two things for Chloe, the 24/7 parenting and her mental ill-health are unrelated experiences that make it more difficult for her to feel that her husband is able to understand her situation. However she realises that when she is able to express how she if feeling it can result in her getting the support that she needs.

> *Some days, telling somebody else how I am feeling, is a really really vital tool, even if it doesn't change how I am feeling, it means that that person is able to understand me a little bit better if I'm going to come into contact with them, um and kind of often leads to more of the care that I might need, so if my husband knows if I am feeling like that he might come home* (Chloe, p.21).

When Chloe tells her husband how she is feeling, she is enabling him to support her mental health and her parenting.

For Dawn looking back, she feels that she should have been stronger in asking her husband for help.

> *I should have have insisted that my husband helped and if he wasn't going to then I needed to know, am I doing this on my own or if you're not helping, we are not doing this as a team we need to…. just stand your ground, look after yourself* (Dawn, p.21).

Dawn would like to feel that they are able to parent as a team; she identifies her difficulties in ensuring she has the appropriate support from her husband, as a lack of care for herself. There is an absolute sense of her struggle here and to know that she needed to do it alone would have been better than parenting in isolation as part of a couple. If she was sure that she needed to parent alone, she implies that she could have started to make provision for it. In terms of coping, she is reaching a point of identifying her limits; this low point of recognition that things have to be different is her potential turning point, where she can start to prioritise her own needs.

Ellie talks about how her husband helped her adapt to being a mum and in this way supported her mental health.

> *My husband, I remember with F it was always 'I cant do it, I cant do it' but he kept going 'you've just done it' and that really helped* (Ellie, p.7).

His matter of fact positivity about her abilities gives a sense of calm engendering confidence in her own abilities.

The relationship between parents can provide a source of intimate support that is pivotal to coping with maternal mental ill-health and motherhood within the family

structure. The mother's accounts are able to give examples of bi-directional effective and ineffective support between parents. The subtlety that differentiates the two, evidences the challenges of co-parenting and mental ill-health, with effective communication being recognisably important for success. It is a learning experience for both parents as the double challenges of mental ill-health and parenthood together can be substantial.

Discussion of the phase three study results

This third phase study is able to develop aspects of the themes from the earlier study phases, in some ways being able to build on from the previous phases and view things from differing perspectives. Theme ten examines *Things not spoken about,* where the things are not spoken about for a variety of reasons: it is too intimate and too personal for Isla (p.4): or not spoken of in the participant's family (Jinny, p.1-2): there appears to be a strong component of the subject matter being perceived as unacceptable to others (Beth, p.12; Chloe, p.3; Dawn, p.3). This theme extends an aspect of the theme *Being open and honest and asking for help*. It is complex for the mothers, they are vulnerable and show the use of avoidant coping strategies in an attempt to protect the self from a more public sense of embarrassment, shame or blame and potentially further distress and discomfort.

Avoidant coping strategies can be seen to have several aspects including the focusing on emotional, behavioural and mental disengagement; however although usually seen as unhelpful, it can minimise distress and facilitate coping (Carver, Scheier, & Weintraub, 1989). Nevertheless from the perspective of support seeking it can be disabling, as others are unable to offer care if the unspeakable remains unspoken. Carver et al. (1989) suggest that social support can act as a bridge

between active planning styles of coping, emotion based venting of emotions and avoidant styles. The link between avoidant coping and low well-being was also found to be mitigated by social support in a study by Chao (2011).

The benefits of emotional disclosure in a safe environment for the individual can include increased physical, mental and emotional well-being through the integration of trauma, which can lead to more effectively implemented coping strategies (Snyder, 1999). The confronting and making sense of difficulties within conversation with other supportive persons can enable the processing of difficulties and the planning of coping strategies (Snyder, 1999). Social support in this way can be pivotal to well-being and if avoidant coping strategies cause lack of support seeking behaviours, this can be detrimental to individuals; however avoidant strategies can be understood in the context of attempts to protect the self from emotional pain. This theme replicates some aspects of the Stone et al. (2018) theme of 'What is not allowed to be said', which found that women might not want to disclose the level of their depression to health professionals.

Theme eleven *The importance of nested support structures* was able to illuminate the mothers awareness of many of the external structures such as partner and close family support, community and professionals and extends the phase one study theme *Identifying effective support*. Leahy-Warren et al. (2011) in a study with 477 first-time mothers found that most frequently identified sources of support were mothers, husbands/partners and sisters, which was supported in this theme. There was a recognition of the value of this intimate support from partners or close family members across several themes (Chloe, p. 19-20; Ellie, p.15; Hazel, p 6;Isla, p.10-11; Jinny, p.5): these close relationships consist of the people that have that intimate

knowledge about what is going on for the person and the ability to recognise when things are not working in a way that is safe or productive.

Levine and Kline (2007) use a variation of the Bronfenbrenner (1979) nested support structures: they example both internal and external support structures. The internal support structures include, personality strengths such as initiative, ingenuity, intelligence and wisdom: and the external support structures example supportive relationships, environments and community (Levine & Kline, 2007). The mothers are aware of developing as people as Beth describes in the theme *Learning the importance of self-care* "I'm developing as a human, and my highest level I have ever done" (Beth, p.16): these internal resources are an aspect of nested support structures which are not always recognised.

Additionally Leahy-Warren et al. (2011) found that lower levels of support were significantly linked with higher levels of depressions. Mothers with two children have been found to have higher social capitol, possibly through increased social opportunities from two children and increased need for reciprocity activities, for example child minding (Strange et al., 2015). There appears to be a germaneness of the Sharma et al. (2017) descriptions of the relevance of socio-ecological models of coping that encompasses factors that promote resilience across the nested social ecological levels of the: individual; family; community; institutions; and culture.

The final source that Bronfenbrenner (1979) mentions in his ecological systems theory is chrono-systems, which are time based. There are numerous examples from the mothers of time based supportive influences from the cognitive aspect of being able to wait and endure until things get better to the learning from experience over time. These are specifically included under other themes of *Mother's lived experience of coping* and *Learning through experience and adversity*. The ability to seek support

from intimate and wider sources rather than relying on only one or two sources, creates the structure of nested support which provides a safety net that is better able to support coping. The additional temporal aspects of support structures and the Levine and Kline (2007) internal systems add new dimensions to considering what can support coping in mother's who have mental ill-health.

In theme twelve *Owning mental health* the mothers talk about their difficulties recognising their mental ill-health (Chloe, p.4; Grace, p.4; Kelly, p.3). This theme relates with several previous themes including *Learning the importance of self-care* and *Loosing selfhood: Reclaiming selfhood* which examined the mothers journey through mental ill-health and motherhood. Transition to parenthood can be a period of acute stress in which there are enormous levels of adaptation (Berthelot, Lemieux, Garron-Bissonnette, Lacharite, & Muzik, 2019). Compromised capacity to understand oneself has been shown to play a role in mental ill heath: mentalizing and reflective function abilities are considered to develop within the context of attachment relationships and can foster affect regulation, self control and secure attachment in offspring (Luyten, Mayes, Nijssen, & Fonagy, 2017).

Adults who are able to develop good mentalization skills, despite experiencing adverse life events may be more resilient (Berthelot et al., 2019). When the mothers are able to recognise the significance of how they feel, they can move on to an acceptance (Beth, p.17; Chloe, p.13; Hazel, p.17), this enables them to begin the process of taking back control (Dawn, p.19; Faye, p.12). The ability to perceive the self and others in terms of mental states contributes to sense of coherence in terms of my life is understandable, my life is meaningful, my life is manageable (Luyten et al., 2017; Antonovsky, 1996).

One of the pivotal factors for some of the mothers is the need to protect their child (Grace, p.4; Kelly, p.3; Lynne, p.11); this promotes an imperative to move into acceptance and planning of support seeking behaviours and self-care strategies (Dawn, p.19; Faye, p.12). This protective role of mentalizing and reflective function is felt to act as a mediator between child maltreatment and psychopathology (Berthelot et al., 2019). Berthelot et al. (2019) consider that interventions that help parental understanding of psychological functioning can be beneficial when given prior to the birth to help parents navigate the transition to parenthood.

Theme thirteen explores *Learning through experience and adversity* and relates to the core research question about surviving adversity and developing coping mechanisms. The mothers in this study demonstrate an ongoing ability to learn from their own and their children's experiences. Experience and adversity is used to inform and support the mother's choices, improving outcomes for them and their children. The experiences are from childhood through to adulthood and also inter-generational in nature. Having the ability to be reflective and examine lessons learnt in term of coping is protective for individual mothers and for their children.

Understanding the way that we are able to learn from adversity implies that it can be a mistake to always attempt to protect people from negative emotions. Maslow (1954, 2011) explains that "if grief and pain are sometimes necessary for growth of the person, then we must learn not to protect people from them automatically as if they were always bad" (p.17). Maslow (1954, 2011) continues to argue that the over protecting from pain may imply a lack of respect for the intrinsic integration of the person and their future development. The ability to learn and grow from adverse experiences may be able to be utilised in a significant way by mothers when caring for

their children. Certainly the mothers in this study demonstrated protective instincts that were partly based on their own experiences of adversity.

This theme also relates to the previous theme's discussion of reflective functioning. The mothers describe experiences of learning and adaptation through their own experiences (Dawn, p.10; Ellie, p.23; Faye, p.23; Hazel, p.18-19; Kelly, p.10) and the experiences of others (Beth, p.11; Chloe, p.13; Grace, p.11; Jinny, p.12), including their own children (Chloe, p.14; Hazel, p.27). This is only possible through the ability to reflect thoughtfully on these experiences. The integration of concrete and abstract information in reflective functioning permits the integration of learnt knowledge in order that it can be applied to future experiences (Crittenden, 2008). Hazel (p.27) is able to think positively and thoughtfully about the circle of learning that is developing between her daughter and her, as they are able to guide each other.

Crittenden (2008) discusses the most sophisticated form of this, metacognition which encompasses the ability to think about how the self thinks, exampled by Dawn (p.10) when she realises the suffering she is causing herself because of her attitude to herself. Maslow (1954, 2011) states that "personal growth demands courage, self-confidence, even daring" (p.82). The mothers show their courage and daring in the face of adversity and their ability to grow through their experiences even when these are adverse.

The final theme is theme fourteen *Co-parenting and mental health* which examines the role of intimate partners in supporting mental health and motherhood and relates with the previous themes *Identifying effective support* and *The importance of nested support structures*. The roles of partners can be complex and influential: partner support has been shown to take precedence over support from other existing relationships in terms of psychological well-being and life satisfaction and can be

preventative in terms of avoidance of maternal anxiety and depression after childbirth (Beard, 2019). Having a partner who can understand and appreciate what is happening for you on a day-to-day basis is supportive for the mothers (Chloe, p.21; Grace, p.9; Jinny, p.4-5).

Co-operative parenting has also been shown to have positive outcomes for children and can impact the relationship between mother and child (Beard, 2019). The protective aspect of co-parenting and mental health is significant, the partner who can check in (Isla, p.12), the partner who can see that she needs support even before she sees it herself (Grace, p.9), the partner that can support the day's coping by helping change something (Jinny, p.4-5). The mothers perceive the importance of bi-directional communication (Lynne, p.9) and show understanding that the fathers also need support in their new role as a parent (Beth, p.7; Kelly, p.8). Crittenden (2008) points out that yesterday's children become today's mothers and fathers, what she means is that we all carry a prototype of child and parent into the role, it is complex and difficult and in the presence of trauma, we all will need support.

This chapter has presented the data analysis of the phase three study interviews, which were triangulated with the phase one interview data to provide additional perspective and context to each theme. The themes presented were an extension of the previous study themes and brought out different experiential aspects of coping as a phenomenon. The themes were then discussed by placing them within the context of the existent literature. The next chapter brings the three phases of the study together and presents three super-ordinate themes, which are more abstract in quality and relate to the study as a whole.

Chapter ten: Super-ordinate themes

"In no domain is there a complete knowledge, except together with the grasping of the living history of knowledge" (Schleiermacher, 1838, 1998, p.279).

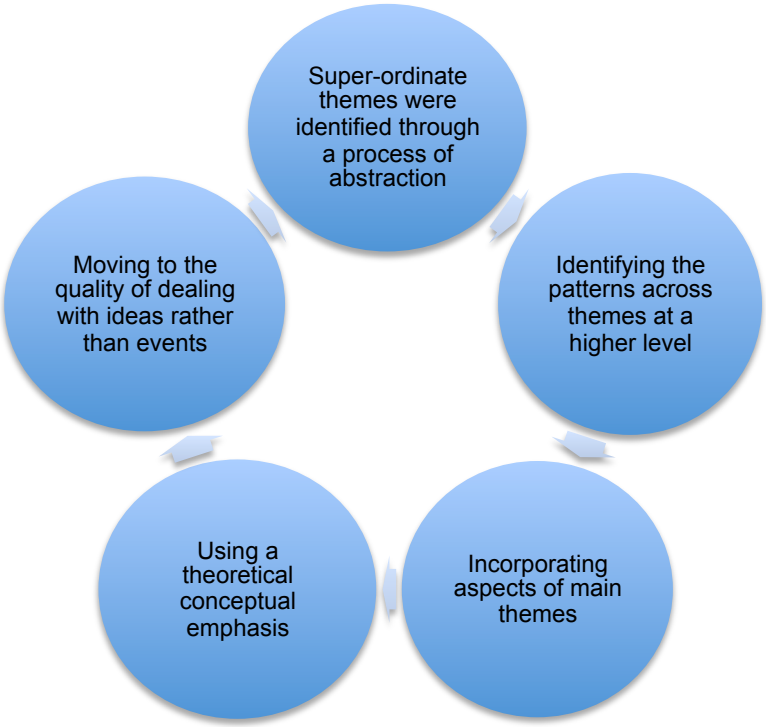


Figure 18. Identification of super-ordinate themes.

Following the writing of the group experiential themes in the three phases of the study, the three studies were amalgamated and viewed as a whole. This chapter presents three super-ordinate themes of: *Coping-do we know; Trauma and physical pathways to healing;* and *Dydadic coping-Mother and infant,* which were identified across the amalgamated studies. These super-ordinate themes were identified through a process of abstraction,

identifying the patterns across themes at a higher level, incorporating aspects of main themes with a more theoretical conceptual emphasis (see Figure 18).

Willig (2013) explains that abstraction of higher-level super-ordinate themes involves moving to the quality of dealing with ideas rather than events, where some themes may be subsumed by others. The concept of 'gestalt' is relevant here as the theme is developed in a way that is more than a sum of its parts (Smith et al., 2022). The formation of super-ordinate themes is less about introducing new data and more about ensuring that there is space for reflective analysis of meaning. Smith et al., (2022) suggest that the organisation of themes in more than one way is a creative process, which can push the analysis to a higher level as the analysis continues into the writing phase of the study.

First super-ordinate theme- Coping- do we know?

There is a question that emerges from this study around how much awareness we have around our coping efforts; there is inevitable individual variation, but there is at times an apparent inability to recognise coping when it occurs. There appears to be a significance of the concepts of Merleau-Ponty (1945,2014), where he points to a differentiation of the things of which we are aware and the contents of our consciousness about them; described by Smith et al. (2012) as the difference between situated knowledge and interpretative knowledge. This super-ordinate theme explores the awareness of proficiency of adaptive and mal-adaptive coping strategies.

Dreyfus & Dreyfus (1985) describe aspects of proficiency in coping, moving through awareness during the learning phase, to intermittent awareness during the increasing competence phase, and lack of awareness of specific process in the expertise phase.

- Novice- The novice is guided by rules and judges success by adherence to the rules
- Advanced beginner- The advanced beginner after seeing sufficient examples, is able to seek out features and determine actions by applying the rules
- Competence- In this stage the experiential information and the rules are developed into a hierarchical view of decision making, achieving planning of goals and perspective
- Proficiency- At this level the level of experience enables the person to spontaneously see an appropriate plan to the given situation and has a large repertoire of strategies
- Expertise- The expert is able to understand, act, and evaluate results without conscious awareness of the process

(Dreyfus & Dreyfus, 1985, pp. 30-34).

Learning the rules of a specific coping action is exampled by the mothers as they teach their children how to cope in specific circumstances and this model of proficiency appears to fit here. There is an inner and outer horizon; both horizons filter out unnecessary information so that the focus is on the strategically important factors that are specifically relevant to the coping task at hand. Coping skills can be flexible and are transferable to new situations, with 'what works' becoming embedded in our coping repertoires.

However many coping efforts appear to be going unrecognised and unacknowledged and unappreciated by individuals themselves and by observers. Significant attempts by the individual person to deal with stressors can be missed if a narrow view of coping is taken. Broadening our understanding of coping as a phenomenon could help individuals appreciate their own coping efforts as well as enable people supporting them

through personal or professional relationships to recognise when an individual is making efforts to cope. This recognition could enable coping support to be built on existing coping strengths rather than starting from a point of non-recognition.

Individuals differ as to what extent they use adaptive or mal-adaptive coping strategies. With regard to maladaptive coping, these coping efforts appear similarly unrecognised as coping. Recognition of maladaptive coping efforts could open up the potential to evaluate the effectiveness of these efforts and appraise change opportunities. Bittner, Khan, Babu and Hamed (2011) looked at maladaptive coping in surgeons suffering from burn out, they identified: keeping stress to oneself; concentrating on what to do next; and going on as if nothing has happened, all as maladaptive and correlated to feelings of emotional exhaustion and denial of stress.

The similarities that are recognisable here with the mothers coping attempts are tangible. Beth talking about how desperate she is feeling explains, "I remember feeling at the time, that I hadn't told anyone" (p.6). This keeping it to oneself may be for multiple reasons; to prevent the recognition of the problem or to protect the self from feelings of shame; to protect the self from blame? Or as in Faye's description of her misunderstanding of self-

> *I didn't understand that I had.... I was suffering from an illness I just.… you know kind of just thought this is who I am* (Faye, p.4).

The reasons are multiple and possibly self-protective in essence but nevertheless prevent access to support and are negative to the person in the longer term.

Lopez (2014) identified that maladaptive types of coping in social work students including: venting; behavioural disengagement; self-distraction; self-blame; substance use; and denial: all had a direct relationship with greater perceived stress and that they

were ineffective in terms of reduction of stress levels. Conversely in the same study, the use of more problem focused coping increased the use of emotion coping and led to more adaptive coping strategies (Lopez, 2014).

Brown and Bond (2019) correspondingly identified maladaptive coping strategies in a cohort study to include: escape-avoidance, for example wishful thinking; denial; self-criticism; and passivity in accepting responsibility (similar to self-blame). They identified that maladaptive styles tend to decrease with age and maturity; where as adaptive styles including: analysing the problem in order to understand it more; personal growth; optimism; creativity; flexibility; and solution focused actions, were less age related (Brown and Bond, 2019).

Adaptive coping identified by Bittner et al. (2011) included: recognition of stress and burn out; cultivating and maintaining healthy personal relationships; seeking health focused support, including mental health support; and maintaining appropriate nutrition and physical fitness.

The mothers in this study do example all of these identified healthy coping strategies, Dawn in particular identifies the value of exercise for her-

> *The gym had been such a pivotal point in getting out of my depression or at least um you know helping with the suicidal thoughts* (Dawn, p.25).

Chloe is analytic in her approach to her own thinking, she is honest with herself, and this helps her to have a realistic focus. It is a very personal and private kind of cognitive coping-

> *To pick apart um when I am worried because I am worried (laughs) and when I am worried because I have a legitimately have a reason to be worried* (Chloe, p.2).

In contrast Kelly describes being able to access support from her mother-

> *I've had panic attacks before and I just rang my mum and I told her, she just kind of reassured me* (Kelly, p.12).

It may be that keeping things to yourself can be maladaptive but may be less easily recognised as a coping strategy, where as more severe maladaptive coping such as substance misuse or self-harm would be more easily recognised. The ability to identify the use of mal-adaptive coping strategies is important, not having to keep secrets from yourself about the ways you have managed to survive can lead to recognition that a person has done what it takes to survive and this is a compassionate stance (Van der Kolk, 2014).

There are also a range of adaptive coping exampled by the mothers that may not be usually ascribed as coping, for example, Beth's description of self-care of "paying a bill" (p.13). This self-care coping appears to be pragmatic but also cognisant of the emotional effects of having unpaid bills.

In a similar way Dawn demonstrates the ability to reflect on her needs, deciding to make changes that are indicative of her decision to cope. The decisions that she makes are not necessarily perceived as coping by an outsider, but are realistic and effective decisions for her.

> *So that's when I thought I need to change my life so the yoga, I changed my diet, and my lifestyle and everything so I was quite not rigid, but I changed my life style, I changed my way of living* (Dawn, p.2).

Coping comes in so many different guises; one form discussed by some of the mothers across several themes is the use of humour (Dawn, p.20; Grace, p.2; Isla,

p.6). It is often exampled in the mothers' speech (Ava, p.17; Chloe, p.35; Faye, p.22; Grace, p.2; Hazel, p.27; Isla, p.13). Sometimes we laugh because it is no laughing matter, but we acknowledge the irony of a situation. It can mean embarrassment, a nervous defense mechanism against emotions that make us feel weak or vulnerable, or a way of connecting: it is part of our universal language.

The mothers use humour in different ways: as a reflective support, which changes the context from distressing to funny, for example "poo explosion" (Isla, p.6); or specifically seeking out humour to find laughter (Dawn, p.20).

> *I am working really hard at doing as much as I can to enjoy life again really and having the stand up comedy the funny audio books ready to go so I can put them in so I force myself to listen to them to get.... to find…. to pull out a laugh or something* (Dawn, p.20).

Humour has been shown to have a positive effect on: reducing pain; increasing immune function; increasing positive emotions; and improving interpersonal process (Gelkopf, 2011). Laughter has been shown to decrease the serum levels of cortisol, epinephrine, and a dopamine catabolite called 3,4-dihydrophenylacetic acid, indicating a reversal of the stress response (Yim, 2016).

Laughter is thought to facilitate mental health through helping cope with negative life experiences; things cannot be too bad if you can still laugh at them (Galloway & Cropley, 2001). Victore Frankl wrote in *Man's search for meaning,* (1959, 2004, p.55) "to develop a sense of humour and to see things in a humorous light is some kind of trick learned while mastering the art of living". Perhaps the lesson is that we should not limit our understanding of the human capacity to cope.

Increased understanding of coping as a phenomenon could assist individuals and

practitioners to structure positive coping frameworks that can support the development of coping and resilience. The relationship between coping and resilience is complex, Rutter (1999) suggests that it is important to emphasise that resilience is different from the acquisition of social competence, self-efficacy or positive mental health. It appears for Rutter (1999) more to do with the strength of personal relationships. It could be argued that the development of positive adaptive coping skills that can be said to lead to resilience would be more difficult in the absence of healthy personal relationships. The maternal infant dyad is an example of a bi-directional coping relationship and is significant in this way.

The development of coping self-efficacy involving the perceived capability to manage internal and external recovery demands, is involved in resiliency: Amnie (2018) suggests that supportive interventions need to include skills training to reduce the use of maladaptive coping and increase coping self-efficacy. Ewert, Vater and Schroder-Abe (2021) in their study emphasise the role of self-compassion in successful coping, finding a correlation between high self-compassion and adaptive coping strategies, and a lower use of mal-adaptive strategies.

Self compassion involving being aware of and caring towards the suffering of the self, correlated with the use of emotion focused and problem focused coping (Ewert et al., 2021). Turning compassionate attention to the self and own attempts at coping has the potential to increase coping self-efficacy, through the use of examination and discernment. Increased awareness of coping styles provides the potential to support positive coping and reduce the use of mal-adaptive coping. Interventions need to take into account the vulnerabilities and therapeutic choices of individuals that resort to maladaptive coping (Amnie, 2018).

Second super-ordinate theme- Trauma and physical pathways to healing

This second super-ordinate theme intends to examine the literature on psychological trauma, how it is defined and the ways in which it can impact the body. The theoretical understanding for the inclusion of eastern philosophies within mental health care provision and consciousness and physical pathways to healing such as yoga are then explored.

Trauma can be defined as the encountering of experiences that violate a person's sense of safety, order, predictability and justness, to the extent that person is unable to integrate the experience and bear the reality, becoming instead overwhelmed (Cope, 2011). Many of the mothers in this study have reported that they have turned to yoga or have mentioned an aspect of eastern philosophical influence such as mindfulness or being present in the moment, as a part of their efforts to stay mentally healthy or recover from trauma and improve their mental health (see Table 19).

Table 19. Potential Eastern philosophical influences mentioned by participants.

Name	Potential Eastern philosophical influence mentioned by participants
Ava	"I did pregnancy yoga, and I learnt a lot with breathing" (p.12).
Beth	"Some people have mindfulness techniques, like you know, five things that you can see, four things that you can hear, touch, smell, whatever, em and I think that kind of helped but its not there when you are desperate generally" (p.11).
Chloe	"One of the coping strategies that I use that works really well is to voice what is going on in my head so like if my brain is telling me I'm worried about M's um , saying aloud "I'm worried about him breathing", can stop that kind of cycle of things" (p.20).
Dawn	"I'm still getting the…um I'm still recognising what I enjoy doing just it doesn't need to be where I am just as long as I'm doing it, with that I mean exercising and yoga really" (p.25).
Ellie	"Take one day at a time" (p.28).
Faye	"I think telling myself its not going to be forever" (p.11).
Grace	P- "We actually do a lot more of that… we did a lot of the Cosmic Kids Yoga, um during the lock down and she does a thing called Zen Den, um which is like mindfulness for children, so she does one about a pond with lots of fish in it and the different fish are the different emotions, um and how you need to be… you can recognise the different emotions, the angry fish, the sad fish and the happy fish, but you should try and be the pond so quite often we use those kind of things to talk to them…" R- "Oh I love that, have you done yoga yourself?" P- "yes yes" R- "Has that been helpful?" P- "Yes I think it is helpful actually just the reminder to breath and stretch as well I think you hold lot of tension in the neck and stuff like that don't you" (p.15).
Isla	Reports that she is attending a baby yoga class (p.12).
Jinny	"Just mixing your day about a bit so your brain… your brain is expecting the next step of not being happy, but its … no we are going to go this way…." (p.20).
Kelly	"I did yoga both times it really helped me" (p.20).
Lynne **Lynne** **Lynne**	"I did Yoga before I got pregnant" (p.19). "If I'm struggling to sleep at night do a bit of a breathing exercise, just doing deep breathing and imagining um that I err kind of like breath in a purple colour, and breathe out black" (p.20). "We got her almost like a mindfulness diary, of like little things to work through that talk about perseverance, resilience, compassion" (p.24).

The trauma experiences that the mothers talk about in their interviews include factors that are within the Adverse Childhood Experiences (ACEs) categories (Public Health Wales, 2015); for example Beth here describes parental abandonment-

> *My mother abandoned me when I was a child, so when I was three years old my mum moved to another country* (Beth, p.7).

Other trauma described by the mothers is birth trauma related; Lynne describes her birth experience as being traumatic when she suffered a haemorrhage following the birth of her child, but she questions her reaction and concepts of what trauma is-

> *I had the haemorrhage and stuff I kind of question myself as to am I…. I don't know how to put it into words um kind of like…. am I over reacting to it…. that sort of…. am I blowing this out of proportion in my own mind, and is that what I do because it felt really traumatic to me….* (Lynne, p.21).

Burczynski in conversation with Porges (Porges, 2017, p. 181) finds it is important not to define trauma in a limited way that minimises people's experiences, it is an individual's experience of an event that needs to be considered. All the mothers in this study described experiences that they perceived as trauma: six were pregnancy or birth related: (Ava, p.9; Ellie, p.1; Faye, p.3; Hazel, p.2; Isla, p.2; and Lynne, p.4); five were inclusive within the ACEs concepts (Beth, p.7; Dawn, p.2; Grace, p.1; Jinny, p.12; Kelly, p.12); and one experience was perceived as traumatic which was work related (Chloe, p.2).

Trauma involves some sort of threat to a person in terms of physical, emotional or psychological safety (Emmerson & Hopper, 2011). In terms of women and childbirth, the stories of these women involve experiences of critical blood loss, hearing concern expressed about their babies heart rate, having their baby taken away to intensive

care, separation and loss. It is somewhat unsurprising that some of these experiences are processed as trauma.

The ACEs research indicated that there are a high percentage of traumatised individuals in society, with 14% of individuals in Wales reporting experiences of four or more ACEs which include childhood experience of domestic violence, parental mental illness, alcohol abuse, drug use, parental separation and parental incarceration and the connections to poor mental health outcomes and inter-generational effects are apparent (Felitti et al., 1998; Public Health Wales, 2015). Trauma reactions include states of dissociation and thoughts of unreality, disbelief and dream like estrangement (Laing, 1960,1990).

Trauma is becoming more understood in terms of the way it can overwhelm the body's physical reality causing an imprint, which affects the person's ability to survive in the present (Van der Kolk, 2014). Van der Kolk (2014) explains that trauma results in a fundamental re-organisation of the way the mind and brain manage perceptions, "it changes not only how we think and what we think about, but also our very capacity to think" (p.21). Levine (2011) identifies that the commonality of trauma is a feeling of alienation and disconnection from the body and a difficulty being present in the here and now. Somatic memory within the body of physical and emotional experiences, may be present and stored within the body (Van der Kolk, 2014). There is an intricate and robust relationship between internal organs of the body and the brain, the dorsal vagus nerve which is the tenth cranial nerve, connects the brain with most of the visceral organs, including the pharynx, the heart, the lungs and the digestive tract (Levine, 2010).

Talking about trauma in a therapeutic safe environment has the potential to facilitate the integration of the right brain which processes emotion and autobiographical

memory and the left brain that logically makes sense of the feelings, experiences and memories (Levy & Orlans, 2014). Jung (1933,2017) describes speech as a "storehouse of images founded on experience" (p.102). However what has been discovered by some therapists is that the ability to relate what has happened in a meaningful way, may not be enough as the body can hold hyper-vigilant autonomic hormonal reactions that remain prepared to be attacked at any moment in time; in other words, trauma is held in the body (Van der Kolk, 2014).

Allen (2005) describes the body's "somatic re-enactments" or body memories, which create body sensations of pain associated with the trauma (p.177). Anger, fear, sadness and shame occur in the body at a somatic level and are felt physically (Levy & Orlans, 2014). The rational brain is unable to communicate with the emotional brain leaving stress hormone levels, including adrenaline and cortisol at levels that disable memory and attention capacity (Van der Kolk, 2014). Neuroimaging studies have shown the increased activation of the subcortical brain regions and decreased activation in the frontal lobes in people who are in a highly emotional state (Van der Kolk, 2014).

Cozolino (2017) discusses the development of the mind, which has come from the evolutionary development of the group of brains, including the brain stem, the limbic brain and the cerebral cortex, which have come together. The brainstem and the limbic areas serve as the source of emotional life, influencing cortical functioning and demonstrating that emotion and cognition are integrated processes within the nervous system (Siegel, 2015). Siegel (2015) explains that there is a mind/brain relationship that arises from both neural and relational processes, which interface with each other. The brain which has evolved to keep us safe from danger, causing the fearful voices in our heads, the thoughts that can become "the emotional

soundtrack of our lives": however these can be interrupted by the mind to create new narratives for more adaptive thoughts, feelings and behaviours (Cozolino, 2017, p.425).

Under extreme stress the hippocampus area in the brain, which stores episodic memory has been found to shut down due to the glucocorticoids that are released during trauma (McWilliams, 2020). Accurate appraisal of what is happening around us is crucial for adaptive functioning and is reliant on the ability to self-regulate and be flexible in our responses to demands (Hill, 2015). Emotions serve as a vital protective signaling function, however emotional reactivity is usually the pre-conscious awareness phase and negative emotions contain conflicting impulses of fight and flight or freeze (Levine, 2010). When affect is dysregulated, we can become disorganised in our thinking and responses and disassociated from the here and now (Hill, 2015).

The contribution of Eastern philosophies to current thinking within mental health therapies for example in Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) is being recognised (Cozolino, 2017; Linehan, 2015). Linehan (2015, p.151) specifically attributes "Zen" practices but also mentions other Eastern practices as an umbrella term. Classical Buddhism holds philosophical understandings around concepts of: impermanence, seeing everything as passing; non-self, understanding the self as separate from things that happen; non-attachment, which understands all suffering in terms of attachment; and acceptance, learning how to tolerate distress (Piyadhammo, 2019). These philosophies are used within Buddhism to investigate and manage painful emotions; there is recognition that the evolution of the brain has resulted in the capacity to be absorbed by thinking about past negative events and concerns about the future (Piyadhammo, 2019).

Within Buddhism suffering is divided into three categories: the pain of impermanence; the pain of attachment; and existential pain including emptiness, despair and meaninglessness (Cozolino, 2017). The understanding of human suffering within Buddhism has led to the development of many strategies for alleviating mental suffering (Cozolino, 2017). The focus on behaving in a certain way, cultivating discipline, practicing mindfulness and meditation has proved compatible with some Western therapies like DBT (Cozolino, 2017; Linehan, 2015). DBT specifically includes: mindfulness; walking the middle path; emotional regulation, mindfulness of emotions; and distress tolerance, practicing radical acceptance (Linehan, 2015). Compassion is seen as a result of these actions, which lessens suffering by the understanding that everyone is suffering and this takes away the aspects that relate to shame (Cozolino, 2017).

Emotion serves as a central organising process within the brain, individual's abilities to organise emotion shape the ability of the mind to integrate experience and adapt to stressors, being aware in our mental lives permits conscious choices (Siegel, 2015). Hawkins (2012) proposes that our thoughts are filed within our brains under the associated feeling not the facts that they carry. Additionally as Frankl (1959, 2004, p.82) points out "emotion which is suffering, ceases to be suffering as soon as we form a clear and precise picture of it". This relates to the mindfulness of emotions, being able to identify emotions and be aware of the sensations that they produce within the body and move towards being able to release difficult and painful emotions in a healthy way. Hawkins (2012) explains that letting go of painful emotions involves being aware of a feeling, staying with it and letting it run its course and letting out the energy behind it: however it can be challenging and difficult to do.

Van der Kolk (2014) discusses the top down therapies including talking therapies, but

finds that for some people who have suffered trauma, a bottom up approach that is able to assist the recalibration of the autonomic nervous system is what is needed. Because trauma can result in dissociation and a shutting down where “people are not in their bodies”, gentle classes that restore the mind body connection such as yoga can be beneficial in restoring body connection and boundaries (Levine, 2010, p.112). Levine (2010) proposes that when people learn to identify bodily sensations, which align with an emotional reaction, they can identify how to remedy it.

Yoga is an example of a mind-body technique, which involves relaxation, meditation and physical exercises performed in sync with the breathing (Trakroo & Bhavanani, 2016). The supporting of the parasympathetic nervous system through yoga that is trauma sensitive and encourages controlled breathing, and the noticing of bodily sensations can trigger the release of acetylcholine, which acts as a break on arousal (Van der Kolk, 2014). Porges (2017) who developed Polyvagal Theory describes the mammalian vagal system working well when the sympathetic and parasympathetic nervous systems “are functioning in a homeostatic dance reflecting the positive features of autonomic balance” (p.172).

The preliminary practices of yoga are predominantly about building a ‘calm abiding self’, or ‘equanimity’ which encompasses the capacity to feel soothed, calmed, grounded and centered: however this is achieved through connectedness with others (Cope, 2000). People who have internalised this capacity can transmit it to others, the mirror neurons in the brain process being seen in a loving and accepting way as an identity of self (Cope, 2000; Levy & Orlans, 2014). Reality in a way must be triangulated by another person (Cope, 2000). Being in a shut down or hyper-vigilant state can diminish a person’s capacity to receive empathetic support, this makes it especially important for people who have experienced trauma to engage in safe

practices which can reconnect with bodily sensations (Levine, 2010).

Van der Kolk (2014) had extensive knowledge of treating trauma victims and describes four stages of healing trauma-

- Finding a way to become calm and focused
- Learning to maintain that calm in response to images, thoughts, sounds or physical sensations that remind you of the past
- Finding a way to be fully alive in the present and engaged with the people around you
- Not having to keep secrets from your-self including secrets about the ways you have managed to survive (pp.203-4)

The last point links directly to feelings of shame and self blame that are inextricably linked in trauma (Van der Kolk, 2014).

Individuals striving to cope with mental health difficulties may be instinctively drawn to Yoga as a healing action and part of their coping strategy (Levine, 2011). The specific quality that yoga can provide is the emphasis on looking inward and listening to the body; being able to access physical and sensory experiences within a safe environment that can help the person to explore how their body is programmed to be hypervigilant and begin to tolerate their sensations (Emmerson & Hopper, 2011). Other 'bottom up' approaches include approaches that encompass art, music, dance, and working with animals: the physical aspects of these practices having impact on the autonomic nervous systems (Van der Kolk, 2014).

The history of yoga dates back more than 5000 years, with some of the earliest writings that have been found, coming from what we now know as India and Pakistan; it encompasses a range of practices including: breathing practices; static stretching postures; breath body movement co-ordination practices; relaxation; diet; self care; and mindfulness (Emmerson & Hopper, 2011; Suriya, Subramaniam,

Bhavanani, Sarkar, & Balasundaram, 2019). Yogic philosophy understands health as a dynamic continuum where one of the central themes is finding a middle path of moderation and homeostatic balance (Bhavanani, 2016). Trauma focused yoga is very much focused on being safe and gently allowing a person to try to reconnect with their independent stable center; it never forces or coerces and is never extreme (Emmerson & Hopper, 2011).

Dr. Bhavanani in his keynote address to the Global Yoga Therapy Day in 2019 explains that the word salutogenesis derives from the Latin word 'salutary' meaning 'health' and 'genesis' from the Greek meaning 'to give birth' (Bhavanani, 2019). The word salutogenesis coined by Antonovsky (1979) has a basis in a persons sense of coherence, this comprises of three components: firstly that the world is understandable to the person; secondly that the world is manageable to the person; and thirdly that the world has some semblance of meaning to the person (Bhavanani, 2019).

These elements are intrinsically linked to the human stress response, if a person is feeling that the world does not make sense, that they do not know how to manage in it, they will feel that they are unable to cope and will feel stress (Bhavanani, 2019). Antonovsky maintains that "all of us throughout life, in even the most benign and sheltered environments, are fairly continuously exposed to what we define as stressors" (p.77). Antonovsky (1979) addresses the "heath ease / disease continuum" (p.9), and argues that the search for the factors that are able to promote health and a sense of coherence is more vital to attaining health than the search for specific diseases.

In the sense that the cognitive skill of coping is being able to be motivated, to think about things, to understand and make decisions about what to do based on these processes;

when a person does not have understanding of manageable meaningful events, they will be unable to cope. When we understand concepts of health and well-being they will naturally include aspects of coping. Not all yoga classes will be trauma sensitive, but there is another aspect to this theme, which are the helpful effects of exercise recognised by some of the mothers (Ava, p.12; Dawn, p.25; Grace, p.11; Kelly, p.20; Lynne, p.20). Exercise in itself is highlighted in several research studies as beneficial to mental health (Schoenfeld & Cameron, 2015; Tada, 2017).

Yoga Therapy models have been developed that are holistic in nature and lay out principles of care which may also be compatible with western mental health care provision. These principles include -

- Developing awareness of the body, emotions and mind
- Changing dietary habits
- Conscious relaxation of the entire body
- Slowing down the breath making it quiet and deep
- Calming down the mind and focusing it inwardly
- Improving the flow of healing pranic life energy
- Non-reaction to omnipresent stressors
- Increasing self-reliance and self-confidence
- Facilitating natural elimination of wastes
- Taking responsibility for our own health

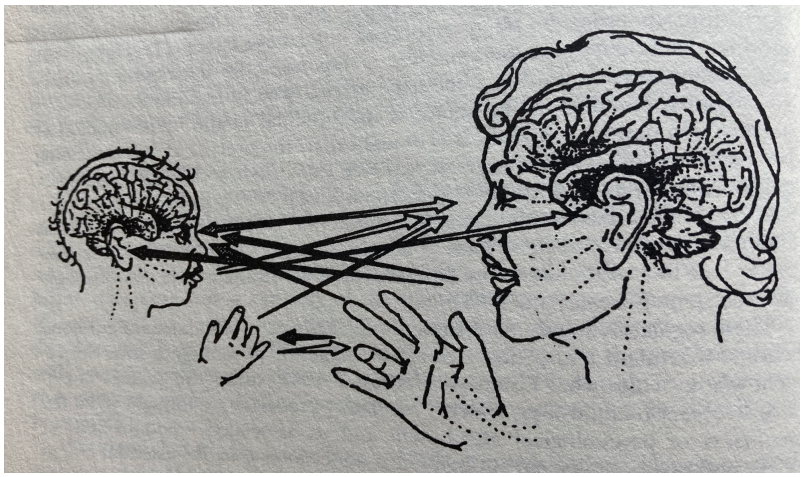
(Majewski & Bhavanani, 2020, p.38).

The emphasis on healthy activities, thoughts, diet and relationships is evident and could in essence be part of any mental health programme. The aim is to produce a stable autonomic nervous system equilibrium, which has a tendency towards parasympathetic dominance, rather than the common stress induced sympathetic nervous system dominance (Majewski & Bhavanani, 2020). Amnie (2018) in a study of 188 adults who had experienced trauma in terms of adverse childhood

experiences and adverse life events, found 42.2% used emotion focused coping including: mindfulness; meditation; and yoga. Evidence is also emerging into the effectiveness of the provision of Yoga as an adjunct therapy in depressive disorders (Suriya et al., 2019).

The links between experiences of psychological trauma and a mental illness diagnosis are a subject for independent study and are not explored in this theme. However the literature on the physical effects of psychological trauma explored in this super-ordinate theme, appear to support the relevance of physical pathways to healing. Developing understanding of the pathways to the regulation of emotional states can lead to healthy body mind integration and the promotion of mental health and enables the rationalisation for the inclusion of eastern philosophies within mental health provision and consciousness. The key to the healing of trauma experiences as Levine (2010) proposes is the deciphering of the non-verbal realm, allowing the body to heal the mind.

Third super-ordinate theme- Dyadic coping- Mother and infant



(Aitken & Trevarthen, 1997, in Schore, 2003a, p.12).

This final super-ordinate theme intends to discuss coping within the bi-directional nature of the mother-infant dyad relationship. The infant arrives the world, equipped to participate in dialogues with responsive others and is able to initiate interactions (Raphael-Leff, 2018a). Stadlen (2004, p.95) reminds us that "each relationship is an original creation". Raffaella and Silvia (2012) propose that individuals do not experience and cope with stress in isolation from others; but usually within an interpersonal context of relationships, in particular intimate others. In this way mothers and infants can be viewed as a coping dyad.

Laing (1960, 1990) finds that a persons "sense of identity requires the existence of another by whom one is known" (p. 139). Secure attachments are linked to a child's ability to learn effective strategies for emotional regulation, appropriate social skills, a strong sense of self and the development of effective behavioural or cognitive responses to stress (Maselko, Kubzansky, Lipsitt, & Buka, 2011). Resilience factors laid down in childhood are indicated to be protective into adulthood, promoting psychological and physical well-being (Maselko et al.,

2011). Early experiences which are embedded into the biological framework of the developing child, influence the stress regulatory systems in the body (Maselko et al., 2011).

The importance of the early attachment relationship cannot be underestimated, it is from this relationship that the "infant develops the beginnings of being-for-itself" (Laing, 1960,1990, p. 190). Laing (1960,1990) explains that it is through this bond that the mother mediates the world to the infant, which is one that the infant can manage to be in and become established in as the real self, which can only be done in relation to others. Schore (2019) describes the child's first relationship with the mother as a template, which molds the individual's capacity to enter into later emotional relationships: it is essentially the formation of the self.

The dyadic reciprocal non-verbal communications between mother and infant operate often beneath conscious awareness and work to regulate the infant's developing central and autonomic nervous systems and body based emotional states (Schore, 2019). The face-to-face attunement of mother and infant enables the healthy development of the orbito-frontal cortex in the infant, which is protective in relation to stress and later traumas (Levine & Kline, 2007). This interactive communication requires co-ordination between the motivation of the infant and the subjective feelings of an adult (Schore, 2003a). Wright (2018) explains that each mother and infant develop as a "mutually independent dyad" (p.12), where the infant is reliant on the mother for reflective responses in order to develop and maintain a lively sense of self.

The infant is dependent upon the mother as care-giver, for stability and grounding when they need to recover from normal periods of disequilibrium that are associated with the learning of new things (Levine & Kline, 2007). The young infant perceives the absence of the mother as life threatening and cries at her absence (Handler Spitz,

2018). The development of trust and knowledge of object constancy where confidence develops in something existing even when you cannot see it is a crucial step in the infants development, which is noticeable as the maturing infant grows in confidence that the mother will return (Handler Spitz, 2018).

For the mother, a recognition of being of something larger than self, of having care and responsibility above care of self, can be motivating and empowering and lead to a greater sense of coherence (Patterson & Garwick, 1998). Mutual love between mother and child creates a strong motivating force: the physiological responses of oxytocin and dopamine being intrinsically motivating (Schore, 2019). The construction of meaning, the creation of identity and shared values that occurs when becoming a new parent clearly influence coping attempts in new mothers.

The role of co-regulation as a bi-directional, dynamic mechanism is pivotal in this respect. Resilience in the maternal/infant dyad attachment relationship is demonstrated in the ability to establish connection after disconnection: it is a mechanism of responsiveness and mutual regulation (Berastegui & Pitallas, 2021). As this mutual regulation occurs, it becomes a source of agency for both mother and infant, which can enable the building of connections, competence, communication skills, and trust with the expectation that the self is understandable to others (Berastegui & Pitallas, 2021).

The desire of new mothers to give the best care possible is found in studies such as Dalby, Calais and Berg (2011), but feels however somewhat taken for granted. The hormonal, corticol and sub-corticol brain systems that support endocrine systems to manage stress and motivate maternal caring behaviour are complex and intricate. Swain and Kim (2011) examined the baby-cry responses of mothers and found that typically mothers find themselves highly motivated to care for their infants needs and

experience interaction with their infants as rewarding. The hormonal shifts that occur when a baby cries, triggers the release of dopamine, endogenous opioids, oxytocin and cortisol, which act to promote parental caring behaviours (Swain & Kim, 2011).

Oxytocin appears to increase the links between social memories and rewards, and decrease anxiety; when the baby-cry ceases, with the mother and infant experience a happiness reward system that can motivate future behaviours (Swain & Kim, 2011). Someone to love, to care for, relate with, talk to, be loved by, to protect: can become a reason for coping, a reason for carrying on when things are difficult, a reason for living and can lead to an increase of empathy and caring feelings, enjoyment, purpose and fulfillment. Ava specifically describes her child (M) as her motivation to carry on when things are difficult for her.

> *M definitely, that realisation of, that I've made this human, he's mine* (Ava, p.13).

The addition of routine, a need to meet with others, a feeling of social belonging, and the new status as a parent can also be supportive.

> *I had a reason to get up every morning, I had a reason to live, I had…. you know, it…. like new life brings such joy, like to everyone and everybody wants to be your friend, you know, when you have a new baby, everybody wants to see you, everybody smiles at you in the street, its just the whole world is a bit brighter I think when you have a baby* (Faye, p.2-3).

For Faye her baby gave her focus and direction, "it made me feel I had a purpose" (Faye, p.3). The maternal/infant dyad can be viewed as the inner most nested layer that places itself between the individual coping units and the wider family, community, societal support structures (Berastegui & Pitallas, 2021). Available resources of support focusing on the dyad may be able to be stress buffering. In many ways the critical

question could be ‘what helps when this doesn’t happen?’ Are there still strengths in the dyad that can be tapped into?

There is a hormonal role in co-regulation that is bi-directional, as with Faye who finds strength to feel that she can manage her situation in the moment after her child smiles at her. The serotonin love hormone stimulus is coming from her child to her and helping regulate her emotions just as her care to her child is regulating her child to feel safe, loved and cared for by her.

> *F is helping me although it is hard and you know like when she is really, really exited, to go to sleep and I’m stood there rocking her and thinking…. oh my gosh what am I going to do…. But then she’ll turn around and smile and that’s enough sometimes just to get through* (Faye, p.19).

The ability of coping to be both voluntary and involuntary is complex, with some strategies slipping back and fore between the two (Aldwin, 2011). When parents want to help their children cope in stressful situations it is going to be partly instinctual knowledge based on their own experiences of coping with adversity.

> *I mean as I’ve grown up I’ve always been quite stressed, quite anxious, and I don’t want to pass that on I want to pass on a bit of calm and tranquility almost of it.…*(Ava, p.19).

There is an instinctual protective stance that is an inspiration to cope and pass on coping and the question that is recommended to assist parents in this is around what they have learned and what they have been able to pass on in terms of coping and resilience (Berastegui & Pittilas, 2021: Crittenden, 2016).

Dreyfus (2005) points out that infants acquire skills by imitation and trial and error, but formal instruction starts with rules, as we become more skilled we move from detached rules to more specific situational coping. The rules that Ava gives are specific and situational but they are adaptable for her child to other similar situations.

> P- *I'd.... I'd probably tell him um just to stop a minute.... have a think of what you are trying to do, it might just be even building a tower that he can't get tall enough.… and it's ok that you can't get it tall enough, if you want to try again, lets start from the beginning again and.… and just go from scratch if needed.… not everything is a race, not everything has to be done there and then, if need be you step away from it, you take a breather and go back to it, rather than almost setting your self up to fail.…*(Ava, p19-20).

The rules are well-defined, unambiguous and incredibly specific-

- Stop
- Think about what you are trying to do
- Its ok if you can't do it
- You can try again if you want to
- You can go back to the beginning
- Its not a race, so take your time
- If you need to take a break and go back to it that's ok
- Don't set your self up to fail

Ava is equipping her child with transferable life skills, which are resilient in nature, thoughtful and learnt from her own experiences of her own difficulties. As in a game of chess, we can move from rule-based play, to being able to use strategies, to having expertise (Dreyfus, 2005). It is the fact that her child has a need to overcome his frustration in failing to build a tower of bricks, which inspires Ava to break down the act coping with his frustration into specific rules.

The rules are proactive and encourage functional independence through the use of self-regulation and strategizing. These are rules that were not available to her as a developing person, inspired by her protective parental instincts, in teaching her child, she is able to be incredibly specific in her promotion of her child's coping and future resilience. In doing so she also reinforces her own abilities in this regard, she has itemised and brought to mind positive coping strategies that will be nearer in her own frame of referencing when she needs them. The more experienced and expert that an individual becomes the more that they are able to move intuitively and the less deliberation about specific rules is required (Wrathall, 2014).

The protective parental instincts are instrumental in the production of joint bi-directional learning, mother to child, child to mother. Learning to cope together as a dyad, positively influencing each member of the dyad. In the old adage about learning, 'observe, do, teach', the teaching is an important part of Ava's ability to retain and readily bring to mind this knowledge.

Attachment resilience is characterised by the mechanisms of rupture and repair. Through this experience of stress and restore processes, the activation of positive coping learning experiences can occur that are supportive to both mother and infant. The figure of 30 percent that Tronick (2018) places on average levels of dyad synchronicity can empower parents to build on their existing dyad relationships. The ability to build on existing maternal strengths, facilitating a positive direction, may be more effective as an intervention strategy than more corrective approaches (Berastegui & Pitallas, 2021). Additionally emphasising the understanding of infants as complex, sophisticated and uniquely developing beings, can enhance the understanding of infant's individual strengths and vulnerabilities, personality and temperament (Hawthorne, 2018).

Coping changes from moment to moment, each hour or day bringing in differing aspects of coping as a phenomenon to bear: the transactional nature of coping can be underestimated (Litt, Tennen, & Affleck, 2011). The nature of parenting involves a continuous dynamic changing landscape of events that require constant appraisal and re-appraisal: the baby is hungry, bored, tired, in need of changing, calm, upset, playful and so on. There is a flow capacity in coping with caring for an infant requiring a flexibility of response and attunement with the needs of the infant. The mothers example pro-active, future orientated and protective coping towards their infants, for example Ava's guiding rules for her child (p.19-20). Additionally the examples of empathetic responding (Faye, p.19), can be considered a mode of relationship focused coping: empathetic responding involves efforts to understand another person and provide support in a caring manner as a means to defuse stress and maintain relationship (Revenson & DeLongis, 2011).

The interdependence of the maternal-infant dyad supports the view expressed by Hopkins (2018) that there is no such thing as individual infant psychopathology; the infant needs to be viewed as part of a relationship dyad with the mother. Infants because of their vulnerability can be disarming and bring to the fore feelings of helplessness and need in the mother (Raphael-Leff, 2018b). The achievement of maternal-infant co-regulation is a co-creation by both participants: it is a result of the efforts of both mother and child together (Tronick, 2018). In this way mothers and infants can be viewed as a bi-directional coping dyad, who support each other in their coping efforts.

This chapter has presented the three super-ordinate themes of: *Coping-do we know*; *Trauma and physical pathways to healing*; and *Dydadic coping- Mother and infant*, which were identified across the three phases of the study. These super-ordinate themes were identifying the patterns across themes at a higher level, incorporating aspects of main themes with a more theoretical conceptual emphasis, moving to the quality of dealing with ideas rather than purely focusing on events. The next chapter discusses the study as a whole, evaluating and contextualizing the study through a process of reflecting back to the research questions.

Chapter eleven: Concluding discussion and evaluation

"We called that which can be articulated in interpretation and thus more primordially in speech meaning" (Heidegger, 1953; 2010, p.155).

In this chapter elements of the study are synthesized to create a comprehensive overview of the study. The study is discussed, evaluated and contextualised through: reflecting back to the research questions; discussion of the study strengths and limitations; and by looking at future recommendations. It is not intended to generalise the study findings, as the small sample size is analysed ideographically; however a cautious development of ideas "that locates them in the particular" as advocated by Smith et al. (2022, p. 24) is discussed here.

The reflexivity of the researcher is considered further in this chapter as a vital component of methodological requirement. The inclusion of information about the researcher and the research process can contribute to the reader's ability to evaluate the research (Merrick, 1999). The use of a reflective process using the *Ways of knowing* categories from Belenky et al. (1997) indicates an example of the use of reflexivity within the study.

Discussion of findings in relation to the research questions

Gadamer (1960, 1998) describes our horizons of understanding; the horizon expresses the breath of vision that the person who seeks to understand must have (Clark, 2008). Within this qualitative interpretative phenomenological research approach, the participant and researcher seek to have a conversation that can result in a blending of their

understandings: understanding is able to occur when our present understanding is moved to a new horizon by an encounter (Clark, 2008).

The aims of the study presented in this thesis were to explore the phenomenon of coping as encapsulated in the research question *What can women's lives tell us about surviving adversity and developing coping mechanisms: with particular reference to mental illness and being a mother*. Within the study there was a progressive quality in the ability to view the phenomenon of coping from different perspectives. There are points where the emergent themes converge and intersect with each other and where a quote from one theme can illustrate an aspect of another theme. The relating of the main study themes back to the literature draws out particular detail within the study results, which build on the data to expand the understanding of different characteristics within the themes. The themes are able to add detail, to the ways in which coping in mothers who have mental health conditions can be approached and understood.

This phase of discussion intends to examine the study findings through the study sub-questions that were proposed at the beginning of the study.

Research sub-question one: *What are the lived experiences of coping for mothers with mental health conditions?*

The lived experience of the phenomenon of coping for mothers with mental health conditions was the 'unknown' factor', which provided the focus of this research study. The twelve main themes that account for the three individual phases of this study describe the lived aspects of the phenomenon of coping in the mother's lives. One consistency is the enormity of coping with change for these mothers that requires

continuous appraisal and re-balancing of their equilibrium states. Adaptation to motherhood, to co-parenting, to external influences like the Covid-19 pandemic, to changes to their mental health all require flexibility and adaptability of their coping styles. It must in some ways be a continuous learning experience for them as the practical day-to-day reality of their lives influences their coping choices. Life is filled with experiences, which develop our repertoire of thinking, feeling, behaving and coping (Snyder & Dinoff, 1999).

There is an inherent imperative to cope but there can be consequences of the depletion of coping resources, leading to a need to replenish and recover. The mothers' mental health may be dependent on the ability to recover their coping resources, as they develop an awareness of the need and the ability to care for themselves. Recovery from stress and coping depletion may require that the person finds a way to live that does not make serious demands on the self. Some authors suggest that there is an adversity intelligence, which denotes your ability to go through adversity with equanimity; Kuhon (2020) explains that few of us are aware of this aspect of ourselves and it is not a fixed entity, but may be improved.

This study highlights the range and depth of coping resources that are utilised by the mothers included in the study. The study was not intended to be judgmental of mal-adaptive coping and it was felt to be important to recognise the role of mal-adaptive coping in survival: acceptance of the role of past mal-adaptive coping strategies can support the building of self-compassion which is essential to recovery. The ability of individuals to be aware of their own coping strategies and those of other people can enable the building of resilience by building on effective strategies and minimising the use of ineffective strategies. This stance is not a sentimentalist stance, but rather more aligned with the evolutionary concepts of species survival: to build on individual's strengths and effective coping is aligned with survival.

Motherhood itself can be a source of strength; the imperative to cope is high when looking after a vulnerable infant. Moreover the development of a positive sense of identity beyond mental ill-health can be supported through motherhood as a source of identity and this can be an important component of personal recovery (Hine et al., 2018; Perera et al., 2014). Self-awareness of individual personal coping strategies may not always be present as discussed in the super-ordinate theme *Coping do we know?* It was possibly easier for the mothers to talk about and identify ways of coping they wanted their children to have than to talk about their own ways of coping. This advocacy role in motherhood is potentially strengthening for the mother and supporting their child's coping may reinforce their own coping awareness and understanding.

Research sub-question two: *How are mother's experiences of coping affected by motherhood and mental illness?*

The study was able to explore the mother's journeys through their experiences of motherhood and mental ill-health. The mothers were impacted by motherhood in different ways, some of the ways were incredibly challenging to their ability to cope, other ways were more constructive and supportive of their coping potential. The study was able to show the wide variety of responses of mothers to motherhood and mental ill-health, emphasizing the importance of understanding each person as an individual, complex and unique. Their experiences influence the development of their coping abilities and strategies and there is a need to acknowledge the importance of diversity. Each person has strengths, which are personal to them and there can be no one answer for all: we need to respect individual coping responses that have developed as a tuned reaction to individual circumstances.

The mothers in the study all describe placing their vulnerable infant's needs before their own; this altruistic stance appears to feel at times unacknowledged by the wider social structure of society. The ability to balance meeting the needs of their infants with meeting their own needs is critical to maintaining coping abilities and health. Some mothers related accounts of being at 'rock bottom', feeling that their needs are placed at the 'bottom' of the pile, at the 'bottom' of the hierarchy of need. This can be a pivotal change point but it is also a point of vulnerability (Montgomery et al., 2011). The journeys that the mothers shared within this study show how they developed self-awareness, the courage to ask for help at often their most vulnerable, and their ongoing efforts to incorporate self-care into their lives. A positive relationship between self-care ability and post-partum quality of life was found by Ozdemir, Ozturk, Karabulutlu and Tezel (2018), with mothers needing self-care ability in order to sustain the health of both themselves and their babies.

The mothers in this study demonstrate a developing awareness and ability to acknowledge the need to balance the needs of the vulnerable infant with their own needs. There was an emerging significance for the mothers in being able to have a sense of their own mental health, which was enabling to the process of taking back control. However it is not easy for them and the balancing of needs is difficult to achieve and maintain. Montgomery et al. (2011) suggest that receiving support is critical to ameliorate the complex interplay of mothering and mental ill-health. The complex experiences that mothers' with mental ill-health face emphasises the need for specific support from health and social care that is able to take this need into account (Perera, Short, & Fernbacher, 2014).

Research sub-question three: *What ways of coping come out of past experiences of coping, where does strength come from?*

The study found that the mothers included in the study had developed coping efforts that had grown out of their pre-motherhood and their post motherhood life experiences. Coping strategies were founded on their previous life experiences both positive and adverse, through times when they had experienced mental health and mental ill-health. Zautra, Hall and Murray (2010) explain that resilience unfolds through time and experience and there may be many periods of life where individuals may not look resilient, but those times when coped with may create the building blocks of resilience. Resilience and strength are an outcome of successful adaptation to adversity, focusing only on risks of adversity may miss the opportunity to create understanding of the ability to cope, to prosper and survive (Zautra et al., 2010). This study can offers insight into the formation of resilience through the study of coping.

Inter-generational transfer of coping was evident in the mother's accounts, transfer to themselves and transfer through them to their children. Mothers in the study were able to be inspired by their children and encouraged by their children's developing personalities. Some mothers also found it helpful to accept that they had made the decision to become parents and it was their responsibility to care for their children. The need to protect the children was ever present in the mothers' accounts. Even the extreme decision by one mother to leave her child, was essentially protective in its stance.

The mother's lived experience of the development of coping emerging from past experiences, can be framed as an engagement with phronesis enlightened

practices. The ancient Greek concept of phronesis is usually translated as 'practical wisdom' (Svenaeus & Messaoudi, 2003). The Greek philosopher Aristotle (384-322, BC) conceived phronesis as the practical wisdom that is acquired through our life experiences, which guides our actions and helps us to flourish (Malik, Conroy, & Turner, 2020). The acquisition of complex life knowledge, which can contribute to wisdom, involves a cognitive process of reflection of what works well or not in particular situations (Massingham, 2019). This may be conscious or may occur independently of consciousness, controlling our actions in the future (Reber, 1989).

This relates to the super-ordinate theme of *Coping do we know?* The way that we learn through life experience is complex and not always easy to decipher. It can also be the case that acting in the present on old information may not be protective; the development of wisdom requires that we develop good understanding to be able to judge the right action (Svenaeus & Messaoudi, 2003). Eikeland (2008) finds that the concept of phronesis is essentially ethical; the mothers in this study demonstrate an ethical understanding of the need to protect their infants from harm and this motivates the development of their lived wisdom.

Research sub-question four: *What supports coping for mothers with mental health conditions?*

Through this study it was possible to shed light on what the mothers experienced as effective support, what was supportive to coping and what was not. The mothers in the study were able to identify and articulate what for them as individuals was their lived experience of being supported. The mothers included in this study were able to example the effects of unwelcome, misguided or

misaligned support efforts such as unsolicited advice. However the need for mothers to be supported by their close and wider communities is evident for as humans we are social beings not evolved to cope alone. Social support is found to benefit individuals by acting as a buffer against stressful life events, enhancing mental and physical health regardless of the amount of stress present (Salovey et al., 1999).

There was a sense of the mothers trying to achieve a calm abiding self in their parenting relationships with their children. The mothers' use of strategies such as yoga and other aspects of eastern philosophical influence such as mindfulness or being present in the moment (see Table 19) discussed in the second super-ordinate theme *Trauma and physical pathways to healing* showing their efforts to achieve wellness. The bi-directional nature of the maternal/infant coping dyad, which was examined in the super-ordinate theme *Dydadic coping-Mother and infant,* is a source of coping that is supportive for many women. The nature of parenting which involves a continuous dynamic changing landscape requires constant appraisal and re-appraisal and a flow capacity in coping. The achievement of maternal-infant co-regulation is a co-creation by both participants; it is a result of the efforts of both mother and child together (Tronick, 2018).

Research that focuses on strengths instead of weaknesses can help support the development of social care interventions that can build on successful aspects of self-organisation, self-control and social connection that can support resilience (Zautra et al., 2010). Consciously looking for the positives that a person can bring to a stressor situation can highlight the considerable strengths that individuals can bring and this is an important aspect of theoretical coping research (Snyder, 1999). The gaining of insight from women themselves,

offering a feminist perspective into what supports mothers with mental ill-health is critical to feminist ontology, the nature of being for women. Leavy and Harris (2019) find that research from a woman's perspectives has advocacy at its core, trying to ensure that the unheard is heard, searching for multiple ways of knowing.

Research sub-question five: *What coping strategies do mothers with mental health conditions want to pass on to their children in terms of being strong and resilient?*

The study found that the mothers included in the study were all aware of their desire to pass on 'coping' to help their children develop resilience and be strong. The strategies were varied and dependent on the needs of their individual children and the life experiences of the mothers. The coping that the mothers in this study wanted to pass on were varied and sophisticated, ranging from aspects of emotional competence, validations of their child's emotions, aiding the child's ability to calm down in the face of stress, and understanding the importance of emotional connection.

Emotional intelligence is felt to consist of personal and social competency and is fundamental to coping (Danciu, 2010). Specifically aspects of emotional competence include: the ability to recognise emotions; the ability to control emotions of anger and tolerate frustrations; the ability to manage stress; and the ability to understand and communicate with others (Danciu, 2010). The things that the mothers wanted to pass on really sit on a level with these factors. It shows an ability in the mothers to reflect upon the needs of their children and an ability to meet these needs. Reflective function involves the ability to integrate

thinking around specific problems and generalise the application to new situations, which within parenting acts as a protective function towards the child (Crittenden, 2008).

Several mothers mentioned wanting their children to be better off than themselves in terms of achieving a happy childhood: through the utilization of reflective functioning, they were able to demonstrate the ability to learn from their own experiences to make life better for their children. Zautra et al. (2010) find that resilient actions can start with a moment of reflection that welcomes a broader perspective. It is absolutely vital that there are laws and structures that can protect children from harm: but it can be argued that sustainable resilience that is built over time, requires a focus on strengths not weaknesses (Zautra et al., 2010).

Raising children can be considered the most important and complex task in our lives (Crittenden, 2008). Extreme cases of where things go wrong for parents and children are widely discussed in the mass media, but the vast majority of examples successful parenting are not so news worthy and it may be hard at times for parents to feel encouraged. The mothers in this study demonstrate the mental, physical and emotional effort that is placed upon caring for their children and the complexity of the dydadic coping relationship between mother and child.

Evaluation and reflection

It is important to reflect on the elements within the study that impact its validity and review how well the study was able to answer the research question and fulfill its aims. Smith at al. (2022) consider that elements that need to be evaluated to consider the

validity of an Interpretative Phenomenological Analysis (IPA) study include: that the study reflects an orientation to phenomenology with a clear focus on the experiential; the study is interpretative and offers new insights to the phenomenon, demonstrating clear attention to the ideographic in the individual case; the study is able to show transparency within the data collection and analysis; and that the study is coherent, plausible and interesting whilst drawing on a range of data sets and incorporating further insights. This study has aimed to meet these criteria through attention to the philosophical and theoretical underpinnings of IPA, which have supported the study methodology and methods. This discussion will use these criteria as points for reflection and evaluation.

That the study reflects an orientation to phenomenology with a clear focus on the experiential

IPA is a method that is able to capture the complexities of human experience, the process of capturing the lived experience of coping as a phenomenon for mothers who are experiencing mental health difficulties through in-depth interviews has been challenging and demanding. It has involved the acceptance of perspective and the need for and expression of curiosity about how the phenomenon is felt within the participants lived experience. Phenomenology is primarily concerned with human experience, a phenomenon is something that we are aware of but stands in need of explanation (Denscombe, 2017). The aim of this study was to explore the phenomenon of coping as an occurrence that could be described by women who have experienced adversity with particular reference to motherhood and mental health difficulties. The data collected was experiential, from the first person perspective, and was written up using verbatim quotations, which placed the interpretation of the data firmly within the experiential descriptions of the participants.

The study is interpretative and offers new insights to the phenomenon, demonstrating clear attention to the ideographic in the individual case

The study was an in-depth examination of twelve women's accounts of their specific lived experiences of coping with motherhood and mental health difficulties. The interpretative phenomenological analysis of their accounts was able to explore the wide variety of their lived experiences of coping, both adaptive and mal-adaptive. A small sample size was utilised to enable the examination of ideographic detail and to do "justice to the complexity of human psychology itself" (Smith et al., 2012, p.38). The use of relatively small samples of participants within IPA does not specifically aim to be able to generalise its findings, as claims are bounded by the convergence and divergence within the specific group of participants: however it was considered possible to develop theoretical generalizability by assessing the evidence provided by the data in relation to the literature (Smith et al., 2012).

The study incorporated hermeneutic understanding, which embraces the researchers interpretation, awareness and analysis as an integral part of phenomenological analysis. The researcher attempts to make sense of the participant's understanding whilst the participant is trying to make sense of the phenomenon being studied. The reader then tries to make sense of the researchers sense making, adding another layer to the understanding of hermeneutic interpretation. It is imperative however that the researcher's interpretation is "grounded in the meeting of the researcher and the text" (Smith at al., 2022, p.30). The insights that are generated are a product of the relationship and interaction between the researcher and the data; this does not imply bias but accepts that knowledge is only possible through the interaction (Willig, 2013).

The study is able to show transparency within the data collection and analysis; that it is coherent, plausible and interesting whilst drawing on a range of data sets and incorporating further insights

This study has been able to offer new insights to the phenomenon of coping through clear attention to the ideographic in the individual data contributions. A range of data sets were drawn upon through the three phases of the study. Triangulation was incorporated in all the three phases, the phase two study follow-up interviews included temporal aspects of the phenomenon of coping and the incorporation of data from the different study phases was able to show that the themes could be supported and add to data depth. The study aimed to communicate the world of the participants and the researchers interpretation of their sense making in relation to coping as a phenomenon in mothers who have experience of mental ill-health. This thesis has endeavored to demonstrate transparency with detailed descriptions of the data collection processes and data analysis approach and it is hoped that it will be received as coherent, plausible and interesting.

Considering the contextualisation and implications of the study

When considering the implications of the finings of the study, it is important to position the research in terms of existing theories and empirical studies. The hermeneutic circle of the parts and the whole, being essential to the process of developing coherence (Grondin, 2016). The literature review undertaken prior to this study identified a prevalence of studies that were situationally specific and culturally based which indicated a gap in the literature. It was identified that there was a lack of literature on mothers and mental health and how they cope on an

everyday basis, the coping strategies they use and what makes them feel supported and this supported the need for further research in this area.

The pre-study literature review identified a need to explore the sources of resiliency in infant parent relationships (Davidsen et al., 2015). The prevalence of literature on the impact of parental mental health problems upon children and situationally specific and culturally based studies opened a widow of opportunity to look at coping in the context of motherhood and mental ill-health. Snyder (1999, p.331) specifically calls for researchers to "counteract this fundamental negative bias", by focusing on the strengths that individuals can bring to bear on stressors.

Sexton et al. (2015) found there was a need for additional research to enhance understanding of positive adaptation in the context of stress, suggesting that resilience is a key predictor for wellness in mothers and that pregnancy and childbearing may represent a motivational window for some women. They pointed to a need to identify protective factors that expand beyond illness, not constraining the understanding of resilience to lack of pathology has the potential to lead to the development of interventions that aim to booster wellbeing in at risk post-partum women (Sexton et al., 2015). Frankl (1959,2004) suggests that finding meaning in life is more important than anything else: gaining pleasure or avoiding pain and suffering are insignificant in comparison, "To find a meaning in one's life is the primary motivational force in man" (p.104). A key motivational window for women who have mental health difficulties, may be the need to care for and protect their children.

An increased focus on strength-based interventions has developed within social and mental health care practice. The guiding principles include: the recognition of individuals as unique and having potential for strength and competence; the understanding of that which holds focus and attention has the potential to become

reality; the importance of building of collaborative relationships; and the acceptance of flexibility and a survivor mindset (Hammond, 2010; Stoerkel, 2021). Strength-based interventions are client driven, offering a theoretical map to resilience that can build on past experiences, even of adversity to develop patterns of coping and resilience (Zimmerman, 2013). The challenge for practitioners can be that they are based on what is important to the consumer not the provider of health or social care support, which can involve a shift in practitioners thinking (Xie, 2013).

This study aims to benefit health and social care practitioners by adding to the understanding of women's perspectives, their coping mechanisms and their potential strengths. Benefits to service users will come through the development of understanding of mother's unique and complex coping strategies, by health care providers and the inclusion of these understandings as part of staff training and development. This research expresses a fit with, the *Well-being of Future Generations Act (Wales)* (2015), which has a focus on the way the "choices and behaviours that benefit future health are understood" (Welsh Government, 2015, p.6). The *Welsh Government* (2019-2022) *Review of the Together for Mental Health Delivery Plan* includes priorities to improve and promote mental health and resilience, creating ACEs aware public services, which hold a preventative focus.

More detail is added in the *Together for Mental Health Delivery Plan: Impact Assessment* (Welsh Government, 2019-2022), which states that the promotion of positive mental well-being needs to be a major feature in health care provision, achieved through focusing on looking at strengths rather than problems, keeping a recognition of the importance of informal support networks and factors that keep people well. The recognition of nested support structures that were present for the mothers in this study including partners, family, neighbours, community, work colleagues and the wider governance of society, is a reminder that coping is not something that the

individual does alone without influence from all that is around them: individuals are born into a social world of family and peers (Lazarus & Folkman, 1984).

This study aims to contribute to a body of work on maintaining and improving mental health, specifically looking at the needs of women. Women's lives are often centered around their caring roles for others in the form of children, families and the caring professions in health and social care roles. The challenge for women is to meet their own needs whilst prioritising others. The integration of a health enhancing focus in women's lives can support women and the people that they care for, their children and families; building resilient communities from the foundation of strong and healthy women. Women parent in partnership and although this study does not address the coping skills of partners and fathers, it accepts that this would be a worthwhile and valuable research application. The increasing of understanding of coping within the context of family life would be of interest to health and social care practitioners and could contribute to the body of knowledge available in the future.

The findings of this study could contribute to the literature base that supports policy in this area; the study has had a salutogenic emphasis that has focused on factors that support health and well-being rather than factors that cause disease and has a specific contribution to make to perinatal and infant mental health provision. The dissemination of the study to its target audience within health and social care will be an important area to be addressed, so that the participants' sharing of their understanding of the phenomenon of coping can be used to influence service delivery. A research paper with information about this study will be submitted for publication in an appropriate health and social care journal.

Messages for practice

More specifically from a personal perspective as the researcher who has spent time immersed in this project, the message I would want health care providers to know would be around supporting practitioners' ability to listen to what is being said to them. The example was given by Kelly when she clearly states that she feels that she is unable to look after her child any more "I just don't think I can look after him any more" (Kelly, p.3), but when the health visitor completes the standard tick box questionnaire used in the National Health Service (NHS) protocols it did not identify that she was significantly depressed and she had to struggle on, potentially putting both her and the baby at risk.

There is a significant place of vulnerability at the point of asking for help, it may have been a hard place to reach, a fearful place of concerns around judgment and feelings of shame as described by Chloe-

> *I think that that has always been a concern of mine that people will kind of listen to what I was feeling or thinking and go Huh! (Big intake of breath) This person shouldn't have children* (Chloe, p.38).

This makes it incredibly important that opportunities for disclosure are not missed: compassionate inquiry in a process of offering support is necessary if women's voices are to be heard.

Recognising that individuals are unique and will require different support is relevant here as well, really listening to what an individual would find supportive is going to mean very different things for different people as exampled by the mothers who could be supported by groups and those like Beth who could not "Like for me I used to go to a groups and then spend half my time crying" (Beth, p.4).

Received support needs to be in different forms and from more than one source, nested layered support is required if mother's mental health needs are to be met, involving inner and outer layers of family, friends, community and society. A practitioner's ability to recognise that mental health difficulties and resilience are not mutually exclusive is fundamental; by expressing an interest into what coping mechanisms are currently working for an individual, practitioners can support resilience. Many mothers carry strengths within them and asking what supports their coping enables building on an individual mother's strengths.

Strengths and limitations of the study

This research study has been about women who are coping with motherhood and mental ill-health, it has been hoped that by using a feminist lens the unique contributions from women about women can be appreciated. The experience and knowledge of mothers who have an understanding of mental health difficulties in the context of motherhood, are currently largely undocumented and unheard. This research study hopes to give voice to these women and uncover their knowledge and experience of coping mechanisms in the context of motherhood and mental health difficulties.

There is information in this study that has the potential to inform women's partners and family members about the difficulties that they face and some insights into how women in this situation can be supported by them. It would be interesting and valuable to contribute research from the fathers perspective on coping as a phenomenon for fathers who have mental health difficulties, it is hoped that this will be forthcoming.

The IPA methodology acknowledges the role of the researcher in the interpretation of the data. Within this study the interpretation through the hermeneutic circle was from a

lone researcher and was not a collaborative interpretative study with multiple researchers. Therefore the results are indicative of this individual researchers conceptual framework of experience and understanding of the literature and theoretical framework; an individual horizon placed together with the twelve participant's horizons of understanding. It is not only possible but also probable that a different researcher or researchers would have drawn alternative constructs and conceptual interpretations to the ones drawn together here from the participant data.

Smith et al., (2022) point out that interviews must be viewed as interactions; they are only able to provide a snapshot of a person's attempts to make sense of their experiences. The study was able to ask women to describe their coping strategies but is not be able to draw conclusions about the degree to which they have been able, or are able to implement these strategies. It is therefore a self-assessment viewpoint, however this may be a platform to be built upon by further research.

The use of interviews that involve retrospective narrative can be viewed as not necessarily including authentic experience but rather private subjectivity (Charmaz, 2014). However it was the aim of this study to elicit the views of women and gain understanding of their truth, which is held as an ideal of the "researcher as a sympathetic vehicle for the undocumented views of marginalised groups" (Cerwonka, 2013, p.71). IPA is felt to be able to provide a qualitative research approach that can examine how people make sense of their lived experience (Smith et al., 2012). The aim of idiographic data collection of participant experience is to focus on the individual and their unique personal experience of human nature, which can provide powerful insights.

Sometimes it can be felt that these insights have limited reach, however these insights can be recognised as valuable by practitioners who can hear the authentic voice of

people that they themselves work with and hold sincere truths that can aid practice (Larkin et al., 2018). This area of research could benefit health and social care practitioners by creating understanding of women's perspectives and potential strengths; it could benefit service users through the ability of practitioners to have insight into the complexities of being a mother who has experience of mental health difficulties and by the emphasis on coping strategies providing a positive focus.

In considering weaknesses of the study, it is recognised that demographic diversity was harder to achieve due to the restrictions put in place to manage the Covid-19 pandemic. It had been originally intended to recruit participants from community groups for example parent and toddler groups, which might have been able to achieve further demographic diversity, however this was not possible due to the Covid-19 restrictions.

The sample of participants did achieve geographical diversity however, which was possibly aided by having to do on line interviews: participants were drawn from, England, Wales and Scotland. It was originally hoped that the study could recruit participation from a wider range of ages and socio-economic representation than was actually achieved and the recruitment process was effectively more pragmatic in nature. However the participants were all motivated to share their lived experiences and were incredibly articulate and able to express their stories in poignant and pertinent discussions with the researcher which were able to address the research aims and objectives and the research questions. The imperative is to work out how the findings can be used to ensure that a broader range of mothers benefit from the study through inclusive dissemination.

A potential weakness in the research proposal was the ethical consideration that some vulnerable participants may be competent to consent but could find it difficult to

withhold consent if placed under implicit or explicit pressure (Moule & Hek, 2011). The mindful focus on fairness, respect and a power balance between the researcher and the participant is important to the consideration of the authenticity of the study (Lincoln & Guba, 2007). These aspects were addressed through the detail offered in obtaining the informed consent through the participant information (see appendix b.) and through the use of member checking in the interviews, including placing importance on sensitivity to the participants mental and emotional state of well-being, asking participants if they were happy to continue and reminding them that they were able to stop at any point they felt they needed to.

In terms of IPA methodology being used consistently and accurately, the semi-structured interviews schedule was able to elicit detailed and insightful data: however there could have been an argument for the use of less constructed questions, for example “can you tell me about your experiences of coping” which on reflection may have been more consistent with IPA. The questions used in the interview schedule however, were consistent with hermeneutic phenomenological tradition by being open-ended, requiring of reflective answers that allowed the interview to resemble a conversation and facilitated sense making in which the participant has space to “narrate their experience” (Dibley et al., 2020, p.96).

The gathering and naming of themes is accepted as part of the interpretative stance within IPA, it is not perceived as a perfect or purely impartial process: there is however a requirement to demonstrate that findings emerge from the data and not from the researchers presuppositions (Dibley et al., 2020). The naming of themes, which are similar to the semi-structured interview guide questions, could be viewed as potentially problematic in this way; though in defense of any similarities found, the interview questions were structured following the literature review process and if there was no

emergent data within the interview transcripts from specific questions, there would have not been a theme identified.

Bryman (2012) finds that thematic analysis can be viewed as an underdeveloped procedure, however within IPA there have been considerable developments and changes in terminology that describe the extrapolation of themes. Smith et al., (2022, p.76) recommend the use of the term “experiential statements” to describe emergent themes and when these are clustered they become “personal experiential themes” or in cross-case analysis “group experiential themes”. This development takes the interpretation close to the ideographic detail within the data and could be an emerging positive maturation within IPA.

The study could be considered to be too diverse in its approach to coping as a phenomenon, concentrating on aspects of things that support coping and how coping was expressed and not specifically how coping was experienced emotionally. Future research could incorporate investigation into less positive defenses that could lead to a process of adaptation to more health enhancing coping schema. Levine and Kline’s (2007) use a variation of the Bronfenbrenner (1979) nested support structures which examples internal as well as external support structures including personality strengths such as initiative, ingenuity, intelligence and wisdom would be interesting to study in more depth in terms of motherhood and mental health.

The part of the research question relating to surviving adversity and the development of coping mechanisms was possibly not explored in depth in this study, although it was examined in Theme thirteen- *Learning through experience and adversity*, it could warrant a more focused approach in the future. The study was able to elucidate more clearly on the ‘what” in terms of coping as a phenomenon and the ‘from’ in terms of how the coping was developed, rather than the ‘how’, although the mother’s journeys

through motherhood and mental ill-health do convey part of the process. The design of the interview schedule may have been to broad in this perspective and future studies could focus on narrower aspects of coping. Secondary analysis of the data could elicit further information on the aspects of the emotional experiences of coping.

It is hoped that this research has been successful in terms of the ability to track the analytic journey from beginning with the raw data, through to the table of themes and the results as recommended by Smith & Eatough (2006). This aspect was felt to be essential to the reliability of the study, which aimed to present the data honestly and coherently.

It was not the aim to present the data without bias, in that it was accepted that all knowledge is subjective in nature (Leavy & Harris, 2019). Nevertheless it is hoped that it was apparent that the researcher has listened to the participants and taken their words as a starting point for an interpretative account that remains clearly connected to the interview. Moses and Knutsen (2012) consider the "many layers" of reality to be studied in the complicated real world. It has been the aim of this proposal to capture the connections between mothers who have mental health difficulties and their children that enable feelings of purpose and meaning and the development of coping mechanisms.

Recommendations for further study

In this study no definition of 'coping' was given prior to the interviews and this research has been primarily concerned with coping, as it was understood by the interviewees as culturally accepted and defined. Further studies into coping as a phenomenon, could explore what participants think coping 'is' and what they understand by the term 'coping".

Coping is fundamental to human existence but it is unclear for many of us how and when we are using coping strategies. A question that might have been included in this study, could possibly have been around the personal character strengths that the mothers felt that they had, that supported their coping abilities, in line with Levine and Kline's (2007) concepts of internal strengths. This also relates to the recognition of coping abilities as a whole, the awareness of them and what can be built upon. If the awareness or recognition is not there, it cannot be built upon in the same way. Future research might incorporate investigation into less positive defenses that could lead to a process of adaptation to more health enhancing coping schema. Coping strategies have been shown to provide a protective role in moderating caregiving stress among parents (Al-Yagon & Margalit, 2012): this is a potentially important area of research, which could inform practice in health and social care.

Another perspective that could be beneficial is the use of proactive future orientated coping versus reactive coping suggested by Sohl and Moyer (2009), deepening the understanding of coping and the ways that it can be effective in alleviating distress are important. Developing awareness of personal coping abilities could facilitate appropriate use of strategies in future stressor situations and be beneficial for sense of coherence. Traumatic events can disrupt our sense of meaning and derail our life goals, meaning making can contribute to coping (Lord, Gramling, & Auerbach, 2012). This would be an interesting perspective in terms of motherhood and mental health, the mothers in this study all communicated experiences that involved aspects of trauma, however birth of children can bring a sense of meaning, value and renewed goals.

The role of the maternal/infant dyad in coping is one that could be further explored as coping occurs within the context of this relationship. Studies on parental caregiving have emphasised the association between attachment styles and the provision of

optimum care to infants (Al-Yagon & Margalit, 2012): further research on the bi-directional aspects of the maternal/infant coping dyad would be valuable. Conducting research from a father's perspective on coping as a phenomenon with mental ill-health and fatherhood would be able to add depth and dimension to the literature base. Additionally research into partner's perspectives on supporting a mother who has mental ill-health would be able to add context and understanding.

The subject of the effect of practical support on mothers mental health could also be an area for future study, the ability of close and caring relationships to be supportive in times of stress is recognised as linked to health and well-being (Feeney & Collins, 2014; Leahy-Warren, McCarthy et al., 2011; Uchino et al., 2012). This type of support is felt to function within relationships that are rooted in attachment; however mothers who have had early trauma experiences can find their support networks to be less helpful and more upsetting and unpredictable (Feeney & Collins, 2014; Light et al., 2019). This has implications for health and social care practitioners when supporting mothers who have experienced trauma or communicate poor relationships with attachment figures, so that they can facilitate other avenues of support for these mothers.

Reflexivity: Ways of knowing reflection

Reflexivity has been an important component in this study, it is a way of considering the specific ways that the research is influenced by the researcher to promote transparency which can contribute to study validity (Yardley, 2015). Qualitative research studies are complex in terms of the way that the research design can be emergent and change during the study and where the researcher is the instrument of the research (Cypress, 2017). Cypress (2017) points out that trustworthiness is

important and involves aspects of authenticity and truthfulness and relates to the confidence that the reader is able to have in the study.

Using the ways of knowing categories from Belenky et al. (1997) the development of the experiential understanding of the researcher was examined as the study developed, from the first person perspective. It is included as part of this chapter on evaluation and reflection as an example of one of the reflective elements that has been able to support the research process in this study. The formation of women's knowledge is formed from different perspectives including: silence; received knowledge; subjective knowledge; procedural knowledge; and constructed knowledge, from which conclusions are drawn about truth, knowledge and authority (Belenky et al. 1997). Using these points of reference, this reflection enables the researcher to draw on feminist perspectives and to reflect on the research process.

Silence

Silence is the before position in knowing, silence is not being heard, it is the feeling of disconnection from the world around incorporating feelings of powerlessness, lacking influence, even helplessness (Belenky et al. 1997). At this level Johns (2002) describes the practitioner having an understanding of their own opinion, but lacking the authority of deeper knowledge. As I started on this three year project I was aware of not knowing things that I needed to know. Even to the point of not knowing what I would need to know. I identified two main subject areas, firstly IPA, which was to be my chosen method of analysis, and secondly 'coping' as a subject area. These became my starting points and I began to read around these areas.

I attended a two day course on IPA and joined an IPA on-line special interest group (ipaqualitative@groups.io), which has continued to develop my thinking as a novice IPA researcher, with many other researchers sharing aspects of their work, their

difficulties and their published papers. This IPA community has been an invaluable inspiration in terms of creativity and experience, and has been able to consistently challenge my thinking on different aspects of IPA. I attempted to read the original philosophical writers whenever possible to increase my depth of my knowledge and understanding, and tried to balance these with modern thinking around IPA as a research analysis method.

Salutogenesis came up as an important influential concept and became embedded in the research design, as a protective factor for the women. I attended my first supervision and expected to be told to get on with it, but was instead guided to more general reading around the subject area, looking into motherhood and mental health within our society today. This was strange for me as I had worked as a health professional with mothers, but began to see differing points of view. In some cases what as a health visitor I had tried to help normalise, for example women's caring role, I began to question.

I began to study and read widely around coping theory, this has been ongoing and feels as if I will never be able to know enough about the different theories around coping. I was absolutely sure that I needed to know enough to be able to recognise 'coping' as a phenomenon when I started to talk with women about their individual coping mechanisms, or I would risk missing vital information from the interview stage of the research.

I also examined my own coping strategies to some extent, and have been aware that I may pick up on similar strategies to my own more easily. Each time that I go to an interview I re-visit the broad coping categories to compensate for this.

Received knowledge: Listening to the voices of others

Receiving the voices of women carries with it great responsibility to be truthful in the telling of their stories, to represent correctly women's perspectives and to be interpretative with integrity (Belenky et al., 1997). Within my supervisory meetings we began to address specific developments within the research design, the questionnaire development and the submission for ethical approval. I had to listen to the concerns of others and their points of view and accommodate these within the developing research proposals. Benner (2001) explains received knowledge is the ability to follow guidelines laid out by others, however this tends to ignore the differential importance of the different aspects of an issue, being too intent on remembering the rules.

Ethics in particular challenged my thinking, and although I was nervous about my capacity to be successful within the process, I also quite enjoyed being challenged. I had to research capacity and clarify much more exactly what the safe guards were within the proposal. Through the process I became clearer about what exactly I needed to do, and what some of the risks were understood to be. I felt more prepared and more protected as a researcher, knowing that an in depth debate had been had around the ethical implications of my proposal. In effect it did give me confidence that I could move on to the next stages of the research proposal.

Subjective knowledge: The inner voice

Subjective knowledge includes instinct and intuition, the acceptance of these sources of knowledge are questioned by some scientific traditions, whilst more respected within Eastern philosophical traditions as a primary route to basic knowledge (Belenky et al., 1997).

Moving on to the interview phase, the initial pilot interview did involve me trusting my instinct and intuition, using my experience of talking to women within their own homes. I did feel anxious in the pilot interview, but I also felt at home, it was a situation I had been in thousands of times, in that I was having a conversation with a mum, with her baby present, in her own home. I had made cue cards and did find these helpful. I did not use all of the prompts but tried to ask all of the questions, that were not covered by previous descriptions, whilst not duplicating anything already covered. I had somewhat bungled the technical aspects in the pilot interview, as I had failed to ensure that one of the recording devises was working, I did manage to retrieve the majority of the interview; however this was a steep learning curve for me.

Because it was a pilot I asked the mother for her feedback on the interview questions and her experience in general. I was relieved when she sent me an e-mail saying that she had found the experience a positive one.

> *"I found talking about it easier than I expected and even helpful. I haven't talked about it for a while and I felt that you gave me the space to speak and you were present and actively listening. I feel talking about it helped me to process the information further and to reflect on how I got through it with little support gave me a feeling of achievement that I hadn't recognised before."*
>
> (Pilot interview feedback extract from e-mail).

I felt relieved but also informed that anticipatory anxiety could be a difficulty for women being interviewed and this influenced how I approached women to interview. I was careful to record that I had given each piece of information that was necessary and did not pressure for a response.

Subjective knowledge: The quest for self

At this level Johns (2002) describes the practitioner having an understanding of their own opinion, but lacking the authority of deeper knowledge. Women's discovery of a personal authority and truth comes from a blend of her unique life circumstances and her attributes (Belenky et al., 1997). The shift for women into subjectivism is significant, the start of listening to the voice that comes from within, which is a source of strength; women are likely at this stage to start analysing things in their own past and things that are happening currently (Belenky et al., 1997).

As the interviews continued I was very aware of being in touch with my intuition as to how and when to move on to a different question within the interviews. I had to be very conscious of listening closely to what the person was saying. I was aware of the need to ensure that each participant had the opportunity to tell their story and that they felt able to speak freely and reflectively. The second interview was a virtual format, it went well and in some ways I found it easier than face to face. There seemed to be less temptation for waffling by myself or the mother. There were fewer distractions possibly as well, as it took place in the evening when there was a partner present for childcare. My anxiety about the recording devices was high but my previous experience had informed me and there were no technical difficulties this time.

Interviews are complex and create a lot of debate around ethical practice, I am not technically an insider researcher, but I am a woman, a mother, I have a personal understanding of mental health; and my personality is possibly more drawn to conversational styles, rather than question/answer interviews. I needed to be aware of all these things and cognisant of the need to be ethically strong and to manage my subjectivity.

On reflection, I realised that I was in need of the feminist lens as much as the participants, I was constantly questioned as to why I was not including fathers in the study design and I was able to explain that the study was using a feminist framework to support its aims. My intuition was that it was important to value women's contributions without the need to examine men's at the same time. I was happy to include women's perspectives on men but did not want to dilute the contribution from women for women.

As a woman I wanted to do something from a women's perspective, for other women and I think that many of the participants also felt that this was important. No participant asked me if I was going to interview Dads, but other researchers did and I wondered about this, understanding that the perspective from men is important, but I still felt that it was something necessary and valuable to look at mothers only in this study. The issues being examined by the study were already extremely complex and to add an additional element that would impact the whole study did not feel an effective way forward.

Procedural knowledge: The voice of reason

The progression to procedural knowledge is when the ability to speak with a more informed voice occurs; with the connected knower understanding knowledge through empathetic experience, and the separate knower through the ability to critically understand theory (Johns, 2002). Women encounter situations that develop understanding and knowledge on to new levels; procedural knowledge is objective in the sense that it is orientated away from the self (Belenky et al., 1997). The progression to procedural knowledge is when the ability to speak with a more informed voice occurs; with the connected knower understanding knowledge through empathetic

experience, and the separate knower through the ability to critically understand theory (Johns, 2002).

I feel very much that this procedural voice began to develop as I was beginning the data analysis process: transcribing the interviews; reading and re-reading the transcriptions; thinking and feeling into the experience of listening to the women's voices; reflecting on their voices; considering what the participant was trying to convey and the participant meaning making; initial noting of exploratory comments of the transcribed data; being aware of my own meaning making and the early recording of individual participant emergent sub-themes and moving on to the cross case comparisons and the comparison themes.

As I began to write up the analysis resultant main themes, using the voices of the women in participant quotes, I think that my voice started to develop more and I became more aware of being a separate knower, informed and connected through empathetic experience but also through the theoretical study of the phenomenon of coping.

Procedural knowledge: Separate and connected knowing

Making meaning from knowledge requires integrating the differing perspectives and ways of understanding, sometimes challenging, sometimes doubting, researching further to view impersonal stances (Belenky et al., 1997). In connected knowing empathy is utilised as a way of connecting with another's knowledge, encompassing being non-judgmental, developing trust and collaboration (Belenky et al., 1997).

Constructed knowledge: Integrating the voices

Constructed knowledge is the weaving together of the two elements of procedural knowledge, the balancing of the 'connected' and 'separate', to form an integrated voice (Belenky et al., 1997). It is within this process of sorting out these different pieces of the self, in the search for a unique and authentic voice, "that women come to the basic insights of constructivist thought" (Belenky et al., 1997, p.137). Insight may lead to searching and searching leads to listening to others, which leads to construction; with continual processes of evaluation and re-evaluating assumptions about knowledge to create truth in context (Belenky et al., 1997).

This phase for me was about the movement back to the literature phase of the study, when the study results were placed in the context of existing literature. This was during the discussion sections of the main themes and also during the writing of the over-arching super-ordinate themes. It was a weaving together of the analysis of the participant data with external studies that could illuminate aspects of the thematic interpretation. Balancing and connecting the connected and separate sources of knowledge, finding what the study had to say that was specific, relevant and able to be contextualised within the wider literature.

It almost felt like at this point the study itself was finding a voice, to present and defend its findings within the wider context of future readers of the study. An awareness that the audience of the study needed to be able to identify salient points and how these can relate to their individual areas of practice required judgment. This was challenging and less confident in some ways for me as I was able to identify areas of strength and weakness, things that could have been approached differently and with the benefit of hindsight be improved upon. Truth in context is challenging and inspiring at the same

time, a seemingly never-ending journey into ever changing sources of knowledge and understanding.

I was also aware of the need to reach back to the participants to let them know that the study had been worth their consideration and to value their contribution by feeding back to them a summary of the study. This element feels like the closing of a loop that was open and that needs completion, for without their willingness to offer their insights, the study would not exist. This was felt to be important within the feminist research approach, in which the power balance between researcher and participant needs to be respected so that the participants would be able to take an element of ownership in the study and their contributions to it.

There was a sense for me of my own development as the study progressed and also of curiosity as to what development through their reflections that the participants may have experienced. It was in some ways an easier experience completing the follow-up interviews when the joint agenda was clearer in some ways. The participants knew more clearly what to expect in the follow-up interviews and what we were going to discuss in terms of coping and we both knew who we were talking to and had shared some previous understandings together. The completion of this process by offering the summaries of the study outcomes to all of the participants would be important in the honoring of participants' contributions. The gift of 'being with' someone for a brief moment in time and sharing in their understandings which Heidegger terms as "this authentic alliance" a "Daesin-with" (1953; 2010, p.119).

One of the last challenges has been about the sharing of the knowledge gained, I have been able to present within the university to a Nursing and Midwifery Research special Interest group and also took part in a Three Minute Thesis forum on line which was a really interesting learning experience. From these two experiences I was aware that I

am better able to present using slides in a fuller sort of way, it was quite challenging to have to try and learn a script and it would not be an area of strength for me. I can talk better around my subject in a less pressurised format. I was able to present the study to the IPA special interest group (ipaquqlitative@groups.io), which was well received in term of its IPA methodology and its subject area; they have been a really supportive community who have been inspirational with regard to my IPA understanding. I was also able to present to the Post Graduate Research Conference and I have also been able to submit two articles for publication from the literature review and intend to submit a research paper of the study as a whole at the appropriate time.

Closure

This reflexive process was part of understanding the position of researcher as the instrument of research: through reflexivity researchers can become more self-aware and monitor and attempt to control their own biases, contributing to the transparency within the research process (Cypress, 2017; Yardley, 2015). I was aware of the need to be 'aware' and think reflectively throughout the research process. Being immersed in the study but maintaining some perspective in order to be able to think and cognitively evaluate different aspects within the research process has been important, integrating the voices for me has been about all of it.

This chapter has consolidated the study using processes of evaluation and reflection. The study was discussed and evaluated through reflecting back to the research questions. The polarisation and contextualisation of the study was considered through positioning the study in terms of existing theories, empirical

studies, policy and planning. Strengths and limitations of the study were examined and future recommendations were considered.

The reflexivity of the researcher was acknowledged as a vital component of methodological requirement. The inclusion of information about the researcher and the research process was considered as an essential contribution to the reader's ability to evaluate the research. The use of a reflective process using the *Ways of knowing* categories from Belenky et al. (1997) was described in detail to indicate an example of reflexivity within the study. The next chapter offers the final conclusions to the thesis, summing up and drawing together the main study findings.

Chapter twelve: Conclusions

"From survival to healing to living" (Crittenden, 2008, p.338).

This concluding chapter offers a summary of the main points of the thesis and connects the main points to the significance of the results of the study presented in this thesis. The research question for this study was *What can women's lives tell us about surviving adversity and developing coping mechanisms: With particular reference to mental illness and being a mother*. The mothers who participated in this research study were able to give a phenomenological account of their lived experiences of coping. The study has involved collecting data from naturalistic accounts in the form of semi-structured interview transcripts. The analysis is textual, based on the importance of language as a fundamental property of human communication. Bruner (1990) affirms that the examination of narrative texts specialises in forging links between the exceptional and the ordinary events in life; the mother's accounts in this study example this.

The Interpretative Phenomenological Analysis (IPA) research approach to the analysis of data, emphasises the dynamic nature of the process, with the researcher taking an active role in the interpretation and understanding of meaning within the participant's personal world (Smith & Osborn, 2015). The researcher and participant are engaged in a dialogue using an ideographic focus, about a specific phenomenon, within a specific context. Both are participating in the hermeneutic circle of understanding and interpretation: the circle of the parts and the whole, being essential to the process of developing coherence (Grondin, 2016). The hermeneutic approach can be applied to situations where we encounter meanings that are not easily understood and require some effort to interpret: the approach enables an ability to understand something from

another person's perspective (Clark, 2008). The epistemological stance of co-operative inquiry arises from the process of living and hearing the voices of ordinary people in conversation (Riley & Reason, 2015). Within IPA this is through the empathetic understanding of the participant's perspective, the inter-subjectivity of 'you' and 'I' becoming a sharing of understanding with the interpretations firmly grounded in the interview text (Smith, 2012).

The phenomenological approach with its careful attention to detail has the potential to access an individuals "Weltanschauung", their individual world view, which enables us to see the world through their eyes (Maslow, 1954, 2011, p.22). The great privilege that is felt when being allowed access to individual's inner worlds was felt strongly when carrying this research with women and hearing their voices. It was recognised that taking part in the study was something that the women themselves wanted to do; it was important to them to be able to share their knowledge and understanding of coping and adversity in the contexts of motherhood and mental health difficulties. The study was conducted from a salutogenic perspective that encapsulates the idea that "the well being of families can be best understood by studying the natural capabilities of families to endure, survive and even thrive in the face of crises" (McCubbin, 1998, p. xv). The epistemological belief that coping makes sense and that individuals wish to cope is part of the salutogenic construct (Antonovsky, 1998).

The main study findings indicated that coping was in many instances a very practical affair for the mothers, tending towards soft-organisational strategies with a sense of needing to achieve mastery and a sense of coherence in terms of 'my life is manageable'. The mother's emotional coping strategies predominantly featured self-talk with the mothers using rationalising self-encouragement to support their emotions. Other forms of emotional coping included support seeking; however the vulnerability the mothers felt in seeking support was poignant and can be considered critical for

service planners to take into account. Coping does not occur in a vacuum, it is absolutely in the context of individual's lives and relationships, both past and present. Some of these influences may be positive and supportive to current coping, others may be negative and unable to support current coping.

There was an emerging significance for the mothers in being able to have a sense of their own mental health, when the mothers were able to recognise the significance of how they were feeling, they could move on to an acceptance which was enabling to the process of taking back control. A strong theme of experiencing a journey in motherhood emerged in the study, which contained elements of self-neglect as mothers prioritise their infants needs above their own, leading to feelings of being "bottom of the pile" (Dawn, p.23), to one of self-realisation that they can not function in a balanced way without the ability to meet some of their own basic needs.

The mothers were able to identify effective support that for them was inclusive of encouragement, thoughtfulness, checking in behaviours, feeling accepted and believed in, not feeling judged and a sense of holding of their difficult emotions. Practical support was valued and included things that supported day-to-day living, such as cooking, washing, shopping, cleaning and supporting parental sleep deprivation. The ability to seek support from intimate and wider sources creates the structure of nested support, which has the potential to provide a safety net in terms of effective support.

For some mothers there was a feeling of the loss of self as they transitioned from pre-motherhood to the incorporation of children into concepts of self, with the additional complexity of mental ill-health which can also involve a loss of self in some respects, "I've lost who I was" (Dawn, p.8). However motherhood could also transform identity in a positive way by creating a sense of meaning and connection, which was supportive to coping. Motherhood can provide a healthy life focus and a sense of normality in

every day life, creating meaning outside of mental illness, “it made me feel I had a purpose” (Faye, p.3).

The maternal infant dyad was examined in terms of dydadic coping, where mothers and infants can be viewed as a bi-directional coping dyad, who can support each other in their coping efforts. The mothers in this study were able in times of difficulty to be inspired by their infants to provide adequate care for those infants. Maternal infant co-regulation was recognised as being co-created by both participants; infants are able to support their mother’s care through behaviours such as smiling, “she’ll turn and smile and that’s enough sometimes just to get through sometimes” (Faye, p.19). This is an example of the strength that mothers with mental ill-health are able to utilise. This relationship focused coping involves trying to maintain a balance between self and other, with the focus on the ability to maintain the integrity of the relationship above the needs of the individual (Revenson & DeLongis, 2011).

When considering the phenomenon of coping, it was clear that lived experience of not coping was difficult and sorrowful “and I had a really bad day, everything just made me cry” (Ava, p.8). Where as coping was experienced as a kinder more uplifting experience “I’ve achieved something and also I’m not overwhelmed, you know that’s a big achievement” (Faye, p. 19). The study results considered that having a sense of coherence seemed integral to coping, in the way that mothers were able to experience their lives as understandable, meaningful and manageable.

The study found that the mothers demonstrated protective instincts towards their children, which were partly based on their own experiences of adversity. They demonstrated a desire to pass on ‘coping’ to their children: the range of coping skills and strategies that that the mothers tried to pass on was intrinsically linked to their own

skills and abilities, with the coping skills and strategies that they themselves had found to be successful being the things that they felt confident to pass on.

Research in to how mothers with mental health difficulties cope, is important in the highlighting of significant coping strengths that can be built upon. Building on existing strengths can potentially support self-esteem and sense of agency and act as a positive motivating influence. The findings of this research shed light on the natural parenting instinct to be protective towards offspring. This can be used as a strength, even when protective care is indicated the natural protective instinct can be called upon with reasoned concerns. The bi-directional aspects of co-regulation of mother and child are important to recognise: the behavioural attempts of the infants to receive optimum care can be motivating for the mother and can be significant in terms of child development.

Increased understanding of coping as a phenomenon could assist individuals and practitioners to structure positive coping frameworks that can support the development of coping and resilience. The relationship between coping and resilience is complex: resilience is different from the acquisition of social competence, self-efficacy or positive mental health (Rutter, 1999). The ability to understand and value women's perspective and experience is important when working with families, this knowledge could enhance practitioners ability to support children and families. There may be training implications for health and social care practitioners in the identification of coping in all of its guises. The recognition of maladaptive coping also is profoundly important; the resourcefulness of the psyche in survival can be important to acknowledge. In maternal attempts for wellness, recognition of existing attempts even those that are maladaptive are essential to the compassionate understanding of a mother's ill-health.

The mothers included in this study, exampled the use of yoga and other eastern philosophical approaches such as mindfulness practices, to support their mental health and well-being. The cultural uptake of eastern philosophies within mental health provision and the literature drawn upon in this thesis supports the relevance of physical pathways to healing. Levine (2010) determines that the key to the healing of trauma experiences is in the deciphering of the non-verbal realm: the ability to support the regulation of emotional states, leading to healthy body mind integration and the promotion of mental health.

In terms of planning for health and social care practice, supporting coping skills through a salutogenic focus, by building on existing strengths was recognised as a logical and appropriate step. Recognising that individuals are unique and have potential for strength and competence is felt to be able to offer a self-compassionate stance that can take account of individual vulnerabilities and coping choices. This expresses a fit with official health policy in Wales, which states that the promotion of positive mental well-being needs to be a major feature in health care provision, focusing on looking at strengths rather than problems, keeping a recognition of the importance of informal support networks and factors that keep people well (Welsh Government, 2019-2022). The literature was found to support the premise that increasing awareness of coping schemas can support positive coping and reduce the use of mal-adaptive coping.

There is a need to consciously look for the positives in terms of coping, to enable individuals to bring their strengths to the fore (Snyder, 1999). Resilience that is sustainable for individuals is built through life's experiences, developing through 'phronesis' the practical wisdom that guides our actions. Sustainable resilience requires a focus on strengths, rather than weaknesses; it rests on accomplishing self-agency, self-mastery and social connection (Zautra et al., 2010).

There is recognition that while stress can be viewed as an inevitable aspect of the human condition, coping makes the difference in adaptational outcome (Lazarus & Folkman, 1984). The ability to capture points of resilience requires that we look at episodes of adversity differently by acknowledging the coping that happens or doesn't happen and the learning that follows these events in our lives. McWilliams (2020, p.153) explains that "everyone has regularities of experiencing and coping that constitutes a personality", our coping habits are part of what forms our personality.

Our very humanness entails us having fears and yearnings, which we deal with using the best available defense strategies to us at a particular point in time: these become our coping methods, evolving with us as we change, grow and face new challenges through our lives (McWilliams, 2020). The ability of humans to interpret experiences creates choices, through which our adaptations to experience form the essence of us as individuals. MacDonald (2010) explains Satre's (1943, 2003) thought "human existence precedes essence" as only humans "are always in the process of becoming" (p.6). Or as Plotkin (1997) spells out "we humans are bundles of adaptations" (p.182), however psychological adaptations of coping come from a past that may be different from the present and may not always be supportive of optimum functioning in the present and require examination. Maslow (1954, 2011) argues that "If grief and pain are sometimes necessary for growth of the person, then we must learn not to protect people from them automatically as if they were always bad" (p.17).

The mothers in this study were able to demonstrate reflective functioning, learning from their experiences of adversity in a way that was a positive influence in their lives, enabling them to be reflective of their parenting choices and protective of their children from harms that they themselves had suffered. It is certainly not the case that

suffering is to be sought after, but rather that it can create potential for learning opportunities that can benefit us in terms of our ability to be resilient and cope with adversity.

The women in this study were brave and articulate in their willingness to explain the phenomenon of coping within their lived experiences of motherhood and mental health difficulties. Many of them expressed a desire to share their experiences specifically so that it might help other women in similar positions to themselves. It is with great gratitude that the researcher holds towards the women who participated in this study and hope that their stories have been respectfully and honorably treated within this research. The aspiration is that the stories of women's lived experiences of coping with motherhood, mental ill heath and adversity, can have something to contribute to service planners understanding of the complex phenomenon of coping, that will be able to support future health and social care interventions which aim to support mother's with mental health difficulties.

This chapter has concluded this thesis with a summary of the results of the study. The nature of the process of interpretation has been integral to the IPA study presented in this thesis. The interpretation has been developed from the phenomenological core of the study of coping in mothers who have experienced mental health difficulties. It is with gratitude that the participants are acknowledged as the providers of the core ideographic data in this study. It is hoped that the interpretation articulated in this thesis has provided meaning to the phenomenon of coping.

Summary of study findings

The findings of this study were able to give voice to women's lived experiences of coping with motherhood and mental health difficulties.

1. Coping was in many instances a very practical affair for the mothers, tending towards soft-organisational strategies with a sense of needing to achieve mastery and a sense of coherence in terms of 'my life is manageable'.

2. Mother's emotional coping strategies predominantly featured self-talk with the mothers using rationalising self-encouragement to support their emotions, "It's not going to be forever" (Beth, p.11). The mothers described aspects of emotional self-regulation such as "riding the wave" (Chloe, p.21), and "just walking away sometimes" (Beth, p.11). Other forms of emotional coping included support seeking; however the vulnerability the mothers felt in seeking support was poignant and can be considered critical for service planners to take into account.

3. There was an emerging significance for the mothers in being able to have a sense of their own mental health, when the mothers were able to recognise the significance of how they were feeling, they could move on to an acceptance which was enabling to the process of taking back control.

4. There was a strong theme of experiencing a journey in motherhood which contained elements of self-neglect, as the mothers prioritised their infant's needs above their own leading to feelings of being "bottom of the pile" (Dawn, p.23), to one of self-realisation that they were unable to function in a balanced way without the ability to meet some of their own basic needs.

5. For some mothers there was a feeling of the loss of self as they transitioned from pre-motherhood to the incorporation of children into concepts of self, with the additional complexity of mental ill-health which can also involve a loss of self in some respects, "I've lost who I was" (Dawn, p.8). However motherhood could also transform identity in a positive way, creating a sense of meaning and connection, providing a healthy life focus and a sense of normality in every day life, creating meaning outside of mental illness, "it made me feel I had a purpose" (Faye, p.3).

6. The mothers demonstrated protective instincts towards their children, which were partly based on their own experiences of adversity. They all demonstrated a desire to pass on 'coping' to their children. The range of coping skills and strategies that that the mothers tried to pass on was intrinsically linked to their own skills and abilities. The coping skills and strategies that they themselves have found to be successful are the things that they felt confident to pass on.

7. The mothers were able to identify effective support that for them was inclusive of encouragement, thoughtfulness, checking in behaviours, feeling accepted and believed in, not feeling judged and a sense of holding of their difficult emotions. Practical support was valued and included things that supported day-to-day living, such as cooking, washing, shopping, cleaning and supporting parental sleep deprivation. The ability to seek support from intimate and wider sources creates the structure of nested support, which can provide a safety net in terms of effective support.

8. There is a bi-directional coping relationship between mother and child, which create a coping dyad. The literature suggests that mothers are typically highly motivated to care for their infants with hormonal factors at play. Maternal infant co-regulation is created by both participants of the dyad, infants also support their mothers coping with behaviours such as smiling "she'll turn around and smile and that's enough sometimes just to get through" (Faye, p.19). The mothers are also able to be inspired by their children's developing personalities, some mothers described finding the ability of their children to live in the moment, the ability to not hold on to sadness and be happy in the moment. The mothers demonstrate a joy and fascination in their children that is able to support their parenting.

9. When considering the phenomenon of coping, it is clear that lived experience of not coping is difficult and sorrowful "and I had a really bad day, everything just made me cry" (Ava, p.8). Where as coping is a kinder more uplifting experience "I've achieved something and also I'm not overwhelmed, you know that's a big achievement (Faye, p. 19). Having a sense of coherence seems integral to coping, my life is understandable, my life is meaningful, my life is manageable.

10. In terms of planning for health and social care practice, supporting coping skills by building on existing strengths makes sense. Recognising that individuals are unique and have potential for strength and competence can offer a self-compassionate stance that can take account of individual vulnerabilities and coping choices. Being aware of and caring towards the suffering of the self can support the use of more positive coping styles including emotion focused and problem focused coping, and an increase in coping self-efficacy.

Glossary

Acceptance A person's ability to assent to the reality of a situation without attempting to change it or protest it.

Accomodation A process of altering one's existing ideas about how the world operates in response to new information and experiences.

Adverse Childhood Experiences (ACEs) ACEs describe experiences occurring during childhood that directly harm a child or affect the environment in which they live.

Affect regulation A concept in psychiatry related to emotional regulation, which includes the performance a person is able to demonstrate regardless of mood or emotion.

Appraisal Within psychological theory appraisal of a situation causes emotional or affective responses that are the evaluative process that construe relational meaning.

Attachment A psychological, evolutionary and ethological theory concerning relationships between humans, particularly relating to an infant's need to develop a secure relationship with at least one primary care-giver for normal social and emotional development.

Attunement The quality of being in tune with something, particularly a person, within relationships and often applied to parents and children.

Avoidance A person's efforts to avoid dealing with something that is difficult or stressful for them.

Cognitive Behaviors Therapy (CBT) A type of talking therapy used as a treatment for mental health problems, that teaches coping skills focusing on how a persons thoughts and attitudes affect feelings and actions.

Cognitive restructuring A form of thinking which can develop an alternative view or behaviour that reduces psychological distress.

Conceptual framework The provision of evidence of a researchers understanding checking and transparency of orientation through discussion of relevant experience, literature and theory.

Coping A complex psychological phenomenon defined as managing or dealing with something successfully.

Defenses mechanisms An unconscious psychological operation that functions to protect a person from anxiety and internal conflict.

Denial The refusal to accept a reality.

Deontological principles In moral philosophy the ethical theory that the 'act' is required to be ethically beneficent.

Dialectical Behavioral Therapy (DBT) A therapy developed by Marsha Linehan as a mental health treatment that could help people when they were experiencing emotional pain. It uses concepts of mindfulness, distress tolerance and relationship skills to help manage emotional distress.

Dyad A pair of individuals in an interpersonal situation, a group of two people, the smallest possible social group.

Dynamic Maturational Model (DMM) A biopsychosocial model informed by neurodevelopmental research which views attachment as a lifelong interpersonal strategy to respond to threat.

Ecological Systems Theory A framework conceptualized by Urie Bronfenbrenner (1917-2005) through which individual's relationships within communities and the wider society can be examined. The five nested levels of external influence include: microsystem; mesosystem; exosystem; macrosystem; and chronosystem.

Emotional regulation A process by which individuals influence consciously or unconsciously their felt emotions, when they have them, how they are experienced and how they are expressed.

Epistemology The philosophical study of the nature, origin and limits of human knowledge.

Ethology The scientific study of behaviour under natural conditions.

Equilibrium A state of physical, mental or emotional balance.

Equiprimordial Existing together as equally fundamental from the beginning.

Gestalt The concept that the whole is greater than the sum of its parts.

Hermeneutics The theory and practice of interpretation of language whether written or spoken.

Hierarchy of needs model A model conceptualized by Abraham Maslow (1908-1970) which places five tiers of needs within a pyramid: with physiological needs at the base; safety and security at the next level; followed by belonging and love; esteem and recognition of accomplishments; and at the very top self-actualization.

Ideography The ideographic approach is one which focuses on the study of the individual.

Interpretative Phenomenological Analysis (IPA) A qualitative research approach which examines how people make sense of their major life experiences.

Intrusive thoughts Thoughts that can be distressing, repetitive and unwanted.
Mastery A sense of having control over the forces that affect one's life.
Mental capacity The ability to make a decision as defined by the Mental Capacity Act 2005.
Mentalization The ability to understand the mental state of the self or others.
Metacognition The ability to think about how one thinks, including the recognition of thought processes including discrepancies in thought processes which are able to increase self-control.
Mindfulness A state of being completely focused on the present moment.
Minimisation The ability to downplay the significance of an event or emotion.
Pandemic An epidemic of an infectious disease that has spread across a large region, multiple continents or worldwide.
Phenomenon Something that exists that can be observed to occur or exist.
Phenomenology The study of structures of consciousness experienced from the first person point of view.
Post partum depression A major depressive disorder with a peri-partum onset, shortly before, during or immediately after giving birth.
Priority setting The ability to evaluate what is important or less important at any given time.
Phronesis The practical wisdom that is acquired through life experiences.
Psychopathology Abnormal psychology, mental health disorder or maladaptive behaviour.
Reciprocity A social norm of responding in an equal way to a person, making mutually beneficial exchanges.
Reflective function The ability to permit integration around specific problems to be distilled and generalised so as to be applicable to other situations including some that have not yet been experienced.
Reflexivity The consideration of the specific ways that the researcher has influence in the study.
Resilience The ability to cope mentally or emotionally returning to pre-stress status in a timely manner, successfully adapting to difficult or challenging life experiences.
Salutogenesis A term coined by Aron Antonovsky (1923-1994) that focuses on the factors that support human health and well-being, rather than the factors that cause disease. The salutogenic model was concerned with the relationship between health, stress and coping.

Sense of coherence A coping capacity described by Aron Antonovsky (1923-1994) of how people to deal with everyday stressors consisting of three elements: comprehensibility; manageability and meaningfulness.

Social referencing Evaluating one's own modes of thinking or behaviour by comparing them with those of other people.

Specialist Community Public Health Nursing (SCPHN- health visiting) A branch of community health practitioners known as health visitors who generally have responsibility towards infants up to the age of five years old and their families. They take over from the midwife's care of the infant and hand over to the school nurse when the child is five years old. They work closely with primary health care teams, social care and education.

Theoretical framework The provision of a particular perspective or lens through which a topic can be examined.

Transparency The obligation on social scientists, which requires that data, theory and methodology on which conclusions rest, are able to be examined.

Trauma The encountering of experiences that violate a person's sense of safety, order, predictability and justness, to the extent that person is unable to integrate the experience and bear the reality, becoming instead overwhelmed.

Triangulation The use of more than one method or data source that can operate within or across a research strategy.

Weltanschauung A particular philosophy or view of life, the world view of an individual or group.

Withdrawal Choosing to minimise contact with others as a self-protective strategy.

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Appendices

Appendix a. Pre-study literature review

A brief preparatory pre-study proposal review of the available literature was conducted to establish viability for the research proposal. This was an important initial step in the research process. The literature search was completed using the NHS Wales e-library and data-bases including Psyc INFO, EMcare, British Nursing Database, Medline and Ovid. Broad search terms around [mothers], [mental health], [emotional trauma], [coping skills] and [resilience] were used to identify the variety and extent of the existent literature and to establish where the proposal would be of value to the body of research as a whole.

Search terms were combined to find relevant papers.

1	Mothers	40099
2	Mental Health	57278
3	1 and 2	1013
4	Emotional trauma, coping behaviour, resilience.	67226
5	3 and 4	68

The search was refined by date, published in English, and relevance. The abstracts were examined and full text sought where relevance was found. The concepts around relevance were kept broad to demonstrate the complex and various ways in which the subject of coping and resilience is approached by authors and researchers. There was a need to unpick the concepts of coping and resilience for this study, but both were included in the search of the literature; as they were both relevant to the study and could contribute to the understanding of the study area (Aveyard, 2014).

It was found that there was a prevalence of literature on the impact of parental mental health problems upon children (Agnafors, Svedin, Orland, Bladh, Comasco, & Sydsjo,

2017; McDonald, Kehler, & Tough, 2016; Savage-Mcglynn et al., 2015), but there was less available literature on resiliency factors within family relationships and the development of coping processes in mother's with mental health problems.

There were significant culturally based studies (Alex, 2016; Dolbin-Mcnab et al., 2016; Jana et al., 2016) which address the phenomenon of coping and resiliency and give insight into ways of researching the subject in question and the requirement for sensitivity to the subject group. Alex (2016) draws attention to the potential for power imbalance to exist between the interviewer and interviewee and suggests ways of facilitating conversations that are able to illuminate the subject area, including suggestions for place of interview and style of interview.

Davidsen, Harder, MacBeth, Lundy and Gumley (2015) conducted a systematic review, aiming to review the current status of the literature investigating the mother-infant interaction in schizophrenia and the factors around the transmittance of risk or resilience. They identified 160 potential papers, which following screening and exclusions, 27 studies were included in the review, the studies included women diagnosed with schizophrenia, other psychoses, depression, mania/bipolar disorder. The study recognised the infant-parent relationship as the most important factor in the development of the infants regulation system and subsequent risk or resiliency (Davidsen et al., 2015). Davidson et al., (2015) concluded that there was an absence of empirical evidence in this area, which would be able to inform therapeutic interventions and social policy. They recommended further research into the bio-psychosocial mechanisms of risk, but also noted that the evidence suggests that 50% of offspring do not develop psychopathology in adulthood and there is a pressing need to explore the sources of resiliency in this group (Davidson et al., 2015).

A complex study using validated questionnaires to assess the roles of resilience and childhood trauma history on postpartum functioning found there was a need for additional research to enhance understanding of positive adaptation in the context of

stress (Sexton et al., 2015). The study suggests that resilience is a key predictor for wellness in mothers and that pregnancy and childbearing may represent a motivational window for some women (Sexton et al., 2015). Sexton et al., (2015) point to a need to identify protective factors that expand beyond illness and not constrain understanding of resilience to lack of pathology: this could lead to the development of interventions that aim to booster wellbeing in at risk postpartum women (Sexton et al., 2015).

(Pre-study literature review publications of research on mental health, mothers, coping skills and resiliency)

	Authors	Title	Reference	Type
1	Agnafors, S., Svedin, C.G., Orland, L., Bladh, M., Comasco, E., & Sydsjo, G. (2017).	A biopsychosocial approach to risk and resilience on behaviour in children followed from birth to age 12.	Child Psychiatry Hum Dev 48(4), 584-596.	Re-search
2	Alex, L. (2016).	Resilience among Sami women.	Aging and Society, 36 (8), 1738-1756.	Re-search
3	Bethell, C. D., Newacheck, P., Hawes, E., & Halfon, N. (2014).	Adverse childhood experiences: Assessing the impact on health and school engagement and the mitigating role of resilience.	Health Affairs, 33(12), 21 2115.	Re-search
4	Blengen, N., Hummelvoll, J. K., and Severinsson, E. (2010).	Mothers with mental health problems: A systematic review.	Nursing and Health Scier 12(4), 519-528.	Sys-tematic review
5	Chen, H., & Kovacs, P. (2013).	Working with families in which a parent has depression: A resilience perspective.	Fam Soc, 94(2), 114-120.	Review
6	Davidov, M., Knafo-Noam, A., Serbin, L. A., & Mosse, E. (2015).	The influential child: How children affect their environment and influence their own risk and resilience.	Development and Psychopathology, 27 (4), 947-951.	Review
7	Davidsen, K. A., Harder, S., MacBeth, A., Lundy, J., & Gumley, A. (2015).	Mother-infant interaction in schizophrenia: transmitting risk or resilience? A systematic review of the literature.	Soc Psychiatry Psychiatric Epid-emiology, 50(12), 1785-1798.	Sys-tematic review
8	Dolbin-Mcnab, M., Jarrott, S. E., Moore, L.E., O'Hora, K., A., De Chavonnes Vrugt, M., & Erasmus, M. (2016).	Dumela Mma: An examination of resilience among South African grandmother's raising Grandchildren.	Ageing and Society,36 (10), 2182-2212.	Re-search

9	Drost, L. M., Van der Krieke, L., Systema, S., & Schippers, G. M. (2016).	Self-expressed strengths and resou of children of parents with a mental illness: A systematic review.	International Journal of Mental health Nursing, 25, 102-115.	Sys-tematic review
10	Easterbrooks, M. A., Crossman, M. K., Caruso, A.,& Miranda-Julian, C. (2017).	Maternal mind-mindedness and tod behaviour problems: The moderatir role of maternal Trauma and post traumatic Stress.	Development and Psychopathology, (29) (4), 1431-1442.	Re-search
11	Earvolino-Ramirez, M. (2007).	Resilience: A concept analysis.	Nursing Forum, 42(2), 73-82.	Review
12	Goshai, M., & Mehrotra, S. (2017).	Maternal spiritual health as a predic of psychological well-being and resilience of her young adult offspring.	Mental Health, Religion and Culture, 20(101-108.	Review
13	Gutierrez-Zotes, A., Labad, J., Martin-Santos, R., Garcia-Esteve, L., Gelabert. E., Jover, M., Guillamat, R., Mayoral, F., Gornemann, I., Canellas, F., Gratacos, M., Guitart, M., Roca, M., Costas, J.,Ivorra J. L., Navines, R., De Diego-Otero, Y., Viella, E., & Sanjuan, J. (2016).	Coping strategies for Post-partum depression: A multi-centric study of 1626 women.	Archives of Women's Mental Health, 19(3), 455-461.	Re-search
14	Irwen, J. L., Beeghly, M., Rosenblum, K.L., & Muzik, M.(2016).	Positive predictors of quality of life for postpartum mothers with a history of child maltreatment.	Archives of Women's Mental Health, 19(6), 1041-1050.	Re-search
15	Jana, S., Ghazinour, M., & Richter, J. (2016).	Mental health predicted by Coping, social support and Resilience among young unwed Pregnant Malaysian women and mothers living in shelter homes.	International journal Of Human Rights in Healthcare, 9(3), 185-197.	Re-search
16	Johnsen, A., Ortiz-Barreda, G., Rekkedal, G., & Iversen A. C. (2017).	Minority children and academic resilience in the Nordic welfare states.	International Journal of Migration, Health and Social Care, 13(4), 3 390.	Review
17	Jurecic, A., & Marchalik, D. (2017).	A Psychiatrist's search for Resilience.	The Lancet, 389 (10079), 1599.	Case Study
18	Kiel, E. J., Viana, A. G., Tull, M.T. & Gratz, K.L. (2017).	Emotion socialization strategies of mothers with Borderline Personality Disorder symptoms: The role of emotional regulation and interaction with infant temperament.	Journal of Personality Disorders, 31(3), 399-416.	Re-search

19	Kumpfer, K. L., & Bluth, B. (2004).	Parent/child transactional processes predictive of resilience or vulnerability to “substa abuse disorders”.	Substance Use and Misuse, 39(5), 671-698.	Review
20	Luthar, S. S., & Brown, P. J. (2007).	Maximizing resilience through diverse levels of inquiry: Prevailing paradigms, possibilities and, priorities for the future.	Development and Psychopathology, 19 (3), 931-55.	Review
21	Maselko, J., Kubzansky, L., Lipsitt, L., & Buka, S. L. (2011).	Mother’s affection at 8 months pred emotional distress in adulthood.	Epidemiol Community He 65(7), 621-625.	Review
22	Marks, L. (2017).	Overview of challenges to implementation of good practice in perinatal mental health promotion and management, in universal primary care and community services.	Journal of Public Mental Health, 16(3), 100-103.	Review
23	Masa’deh, R. (2017).	Perceived stress in family caregivers of individuals with mental illness.	Journal of Psycho-social Nursing & Mental Health Services, 55(6), pp.30-35.	Re-search
24	McDonald, S. W., Kehler, H. L., & Tough, S. C. (2016).	Protective factors for child developr at age 2 in the presence of poor maternal mental health: Results from the All Our Babies (AOB) pregnancy cohort.	BMJ Open, 6(11).	Re-search
25	O’Brien, L., & Carson, J. (2016).	Remarkable lives: Laura O’Brien in conversation with Jerome Carson.	Mental Health and Social Inclusion, 20(2), 74-79.	Case Report
26	O’Connell, K. (2008).	What can we learn? Adult outcomes in children of seriously mentally ill mothers.	Journal of Child and Adolescent Psychiatric Nursing, 21(2), 89-104.	Re-search
27	Piat, M., Seida, K., & Sabetti, J. (2017).	Understanding everyday life and mental health recovery through CHIME.	Mental Health and Social Inclusion, 21(5), 271-279.	Re-search
28	Roberts, J., Donkin, A., & Marmot, M. (1016).	Opportunities for reducing socioeconomic inequalities in the mental health of children and young people- reducing adversity and increasing resilience.	Journal of Public Mental Health, 15(1), 4-18.	Review
29	Rossman, B., Green, M. M., Kratovil, A. L., & Meier, P.P. (2017).	Resilience in mothers of very-low-birth weight infants in the NICU.	Journal of Obstetric, Gynecologic and Neonatal Nursing,	Re-search

			46(3), 434-445.	
30	Sagan, O. (2017).	The loneliness of personality disorder: a phenomenological study.	Mental Health and Social Inclusion, 21(4), 213-221.	Re-search
31	Savage-Mcglynn et al., (2015).	Mechanisms of resilience in children of mothers who self-report with depressive symptoms in the first postnatal year.	PLoS ONE, 10(11).	Re-search
32	Sexton, M. B., Hamilton, L., McGinnis, E. W., Rosenblum, K. L., & Muzik, M. (2015).	The roles of resilience and childhood trauma history: Main and moderating effects on postpartum maternal mental health and functioning.	Journal of Affective Disor 174, 562-568.	Re-search
33	Sousa, C., & El-Zuhairi, M. (2017).	Mothering within the context of polit violence: an explorative qualitative of mental health risks and resilience.	The Lancet, 390.	Re-search
34	Steen, M. (2015).	Pre and post survey findings from the Mind 'Building resilience programme for better me health: pregnant women and new mothers'.	Evidence Based Midwifery, 13(3), 92-99.	Re-search
35	Steen, M. (2016).	The perfect mum doesn't exist but a good enough mum does: Building resilience for better maternal mental health.	Australian Nursing And Midwifery Journal, 24(1), 39.	Re-search
36	Svanberg, P. O. G. (1998).	Attachment, resilience and preventi	Journal of Mental Health, 7(6), 543-578.	Review
37	Wagnild, G. (2009).	A review of the Resilience Scale.	Journal of Nursing Measurement, 17(2), 105-13.	Review.

Appendix b. Participant information sheet

Research question- What can women's lives tell us about surviving adversity and developing coping mechanisms, with particular reference to mental illness and being a mother.

Thank you for responding to the invitation to take part in a study, which aims to explore the views of women about mental health and coping in relation to having children. The purpose of the study is to collect your views about:

- Becoming a mother
- How you cope when things are difficult
- What ways of coping you would like to pass on to your children

Taking part in the study will involve talking to a researcher about your experiences; the researcher has direct experience of working with women who have experienced mental illness and who have children. If you would like to be included in this study please read the rest of this document, which explains what the study involves.

Who is eligible to participate? You are eligible to participate if you are a woman who has experienced mental health difficulties, you are aged between 18 and 50 years old and you have a child aged 0-2 years. It is hoped to initially recruit around 15 participants, who have experiences mental health difficulties- before becoming pregnant, during pregnancy, following the birth, or following a difficult birth experience. Approximately 6 participants would also be invited to take part in a follow-up interview to look at how things have changed for you or remained consistent.

What does participating in this study involve? The researcher will conduct a face-to-face interview with you, which will last around an hour. The interview will be conducted at a time and place convenient to you. You are able to bring someone with you if you would like to. The questions in the interview will be about- how you have adapted to having children and being a mother, what has helped you cope and what you recognise as a coping strategy, for example

- How did you feel about becoming a mother?
- What 'ways of coping' for you, do you think came out of your past experiences of coping?

You can withdraw from the study at any time during or after the study, until the time the findings have been published. You will be required to sign a consent form to say that you have been given information about the study and are happy to participate.

What will happen to the information that I give? The information will be recorded using a digital recorder to ensure that your views are correctly represented. This will be transcribed into a written format and the recording will be erased.

How will the information be kept confidential? If you participate in the study any details that might identify you will be anonymised. The information will be held in accordance with the Data Protection Act 1988. Only the research team will have access to the information. The research will be written up and could be forwarded for publication in a professional journal. The information you give is completely confidential and we will not discuss anything about you outside of this agreement without your explicit consent except in exceptional circumstances, for example, we would have a duty to inform your GP if we were concerned that there was a serious risk of harm to yourself or others.

What are the benefits of taking part? It is hoped that this study will be able to inform and provide insight to practitioners who work with mothers with experiences of mental illness.

What are the risks of taking part? There are no major risks in taking part; however talking about experiences that have been distressing may bring back unpleasant memories. If you feel the need to talk to someone about these feelings please contact any of your existing support systems or the contact numbers detailed in your information.

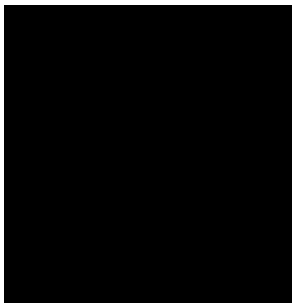
Support may be sought from- Your General Practitioner (GP),
Mental Health Helpline for Wales C.A.L.L. Freephone 0800132737 or text 'help' to 81066, MIND Cymru- 02920395123, Samaritans- 116123.

What if I have a complaint about the study? If you have any concerns about the study please contact Professor Amy Brown a.e.brown@swansea.ac.uk

Who has reviewed the study? This study had been reviewed and approved by Swansea College of Human and Health Sciences Research Ethics committee.

Who is organising and undertaking the study? I have worked as a health visitor and am currently undertaking research as a PhD student with Swansea University. I am undertaking this research as part of my studies into the strengths that mothers who have experience of mental health difficulties can identify and want to pass on to their children.

Contact information. If you have any questions about this study please contact Diana Skibniewski-Woods at [redacted] or phone- [redacted]



Many thanks from Diana S. Woods

Data Protection Privacy Notice.

The data controller for this project will be Swansea University. The University Data Protection Officer provides oversight of university activities involving the processing of personal data, and can be contacted at the Vice Chancellors Office.

The legal basis that we will rely on to process your personal data is necessary for the performance of a task carried out in the public interest. This public interest justification is approved by the College of Human and Health Sciences Research Ethics Committee, Swansea University.

What are my rights- You have a right to access your personal information, to object to the processing of your personal information, to rectify, to erase, to restrict and to port your personal information. Please visit the University Data Protection webpages for further information in relation to your rights. Any requests or objections should be made in writing to the University Data Protection Officer:

How do I make a complaint- If you are unhappy with the way in which your personal data has been processed you may in the first instance contact the University Data Protection Officer using the contact details above. If you remain dissatisfied then you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at:

Your personal data will be processed for the purposes outlined in this information sheet.
Standard ethical procedures will involve you providing your consent to participate in this study by completing the consent form that has been provided to you.
The legal basis that we will rely on to process special categories of data is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes.
University Compliance Officer (FOI/DP)
Vice-Chancellor's Office
Swansea University, Singleton Park
Swansea, SA2 8PP
Email: dataprotection@swansea.ac.uk

Information Commissioner's Office
Wycliffe House,
Water Lane, Wilmslow,
Cheshire, SK9 5AF
Website: www.ico.org.uk

Appendix c. Interview schedule

Research question- What can women's lives tell us about surviving adversity and developing coping mechanisms, with particular reference to mental illness and being a mother.

Participant Information.

Name Initials-

Age-

Partnership status-

Number of children and age of child-

Interview Questions.

Note to interviewer: Before you begin ensure that you have explained the study and the interview process, the consent form is signed, the recording device is switched on. Remind the interviewee that they do not have to answer any questions that they do not want to and that they are able to terminate the interview at any time. Remind the interviewee that there is not a right or wrong answer but it is about their experience.

Long pause prompt- "were you having some other thoughts about that".

Clarification questions can include asking 'why' and 'how' questions for example 'can you tell me more about that?', 'how did that make you feel?', 'can you remember what you were thinking? or 'where did you learn that?'

Introduction.

1. Please can you tell me about yourself and your current life?
   Prompts - What are your interests?
   - Family, marriage, relationships, children.

Introducing being a mother.

2. Can you tell me about having children and being a mother?
   Prompts - How old were you when you had your first child?
   - What was it like for you to be a mother?
   - Was it different to how you expected it to be?
   - Did it change the way you saw yourself?
   - Did you have any worries?
   - Did you worry before having your baby that becoming a mother could

affect your mental health?

3. How did you feel about becoming a mother?

Prompts - Did it change the way you saw yourself?

- Was it different to what you expected?
- Do you think that people treat you any differently?
- Did becoming a mother have any effect on your mental health?
- Did you put anything into place to help?
- What helped you adapt to being a mother?
-Are you able to take care of yourself? How?

4. Can you tell me about your baby?

Prompts - What was it like getting to know your baby?

- Can you tell me about their personality?
- What sort of things does your baby like or dislike?
- What does your baby find easy or difficult?
- What do you find easy or difficult about caring for your baby?
- What do you think the main difference between a good or bad day is for you?

5. Can you tell me about comforting your baby?

Prompts - What helps?

- What doesn't help?
- Do you find it challenging?
- Where did you learn where to comfort your baby?
- How does it make you feel when you comfort your baby?

<u>Questions about coping.</u>

6. Who supports you in caring for your baby?

Prompts - Different people eg. Partner, family, friends, professionals?

- What do they do that is helpful?
- What isn't so helpful?
- How does people helping with your baby make you feel?
- What makes you feel cared for?

7. Q. Thinking about times that have been difficult, can you tell me about how you coped?

Prompts - What helped you carry on if things were difficult?

- Where did you learn to do that?

- Can you think about what happened in the moment that helped you cope, move forward, be strong?
- What keeps you going?
- If a person helped you, what was it that they did that made it helpful?

8. What 'ways of coping' for you, do you think came out of your past experiences of coping?

Prompt- What do you think that you would have recognised as a coping skill or strategy at the time?
- What would you recognise in retrospect, looking back as a coping strategy?

9. How do you help your children cope if things are hard for them?

Prompts- What lessons in your life do you want to pass on to your children?
- What do you want to pass on to your children in terms of being strong and resilient?

<u>Drawing the interview to a close.</u>

10. Is there anything else you would like to tell me about your experiences of being a mother?

Note to interviewer- Thank the interviewee and ask if they would like to receive a copy of a summary of the research findings. Ask how the interviewee is feeling about the experience of being interviewed and check that they are happy for the interview to be included in the study. Ensure that the interviewee has the contact information sheet with details of their support professionals and the researcher if they want to talk to someone.

Appendix d. Participant Consent Form

COLLEGE OF HUMAN AND HEALTH SCIENCES

Project title- What can women's lives tell us about surviving adversity and developing coping mechanisms, with particular reference to mental illness and being a mother.

Name and Contact details of the principal researcher-

Diana Skibniewski-Woods
College of Human and Health Sciences
Swansea University
[redacted]
phone- [redacted]

Professor Amy Brown
Department of Public Health, Policy and Social Sciences
Swansea University
a.e.brown@swansea.ac.uk

	Participant Initial
I (the participant) confirm that I have read and understand the information sheet for the above study (dated 01/07/2019) which is attached to this form.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, until the data has been anonymised and is therefore no longer identifiable, four weeks after date of interview.	
I understand what my role will be in this research, and all my questions have been answered to my satisfaction.	
I understand that I am free to ask any questions at any time before and during the study.	
I have been informed that the information I provide will be safeguarded.	
I am happy for the information I provide to be used (anonymously) in academic papers and other formal research outputs.	
I am willing for my information to be audio recorded.	
I have been provided with a copy of the Participant Information Sheet.	

I agree to the researchers processing my personal data in accordance with the aims of the study described in the Participant Information Sheet.	

Thank you for your participation in this study. Your help is very much appreciated.

Print name of participant	Signature	Date

D. Skibniewski-Woods.

Print name of researcher	Signature	Date

This study is being conducted by Swansea University, College of Human and Health Sciences.

When complete: Original copy for participant, one copy to be retained by researcher

Appendix e. Participation invitation letter

Dear Participant, thank you for taking an interest in taking part in a study which aims to explore the views of women about mental health and coping in relation to having children. The purpose of the study is to collect your views about:

- Becoming a mother
- How you cope when things are difficult
    - What ways of coping you would like to pass on to your children

We are looking for Mothers who have a child aged 0-2 years who have experience of mental health difficulties and who would be willing to talk for about an hour about how they cope and what they would like to pass on to their children in terms of coping skills. Mothers who have more than one child are welcome to participate as long as one of the children is aged between 0-2 years.

It is hoped to initially recruit around 15 participants, who have experiences mental health difficulties- before becoming pregnant, during pregnancy, following the birth, or following a difficult birth experience. Approximately 6 participants would also be invited to take part in a follow-up interview to look at how things have changed for you or remained consistent.

I am a PhD student currently undertaking research with Swansea University into- What women's lives can tell us about surviving adversity and developing coping mechanisms, with particular reference to mental illness and being a mother.

If you would like to know about this project please fill in this form and we will send you information about it.

……

I am willing to be contacted to be given information about being included in research on- What can women's lives tell us about surviving adversity and developing coping mechanisms, with particular reference to mental illness and being a mother.

Name-

Address-

Contact numbers-

Please tick- I have experiences mental health difficulties-

-before becoming pregnant,

-during pregnancy,

-following the birth, or following a difficult birth experience

Signature-

Date-

Diana Skibniewski-Woods
College of Human and Health Sciences.
Swansea University
[redacted]
Phone- [redacted]

Professor Amy Brown
Department of Public Health, Policy and Social Sciences
Swansea University
Singleton Park, Swansea. SA28PP.
a.e.brown@swansea.ac.uk

Appendix f. Participant debriefing letter

Dear Participant,

I would like to thank you for taking part in this study. Your contribution is greatly appreciated and is a valued part of this research.

The information you have given me will be held anonymously, this means that it will be impossible for people to know what your answers were.

If you feel you would like support with any distress you've felt during the research support may be sought from- MIND Cymru- 02920395123, Your General Practitioner (GP), Mental Health Helpline for Wales C.A.L.L. Freephone 0800132737 or text 'help' to 81066, Samaritans- 116123.

If you have any questions, please do not hesitate to contact myself or the research supervisor Amy Brown.

Best regards,

Diana S. Woods.

Diana Skibniewski-Woods

College of Human and Health Sciences.

Swansea University

[redacted]

Phone- [redacted]

Professor Amy Brown

Department of Public Health, Policy and Social Sciences

Swansea University

Singleton Park, Swansea. SA28PP.

a.e.brown@swansea.ac.uk

Appendix g. Follow up interview guide

Research question- What can women's lives tell us about surviving adversity and developing coping mechanisms, with particular reference to mental illness and being a mother.

Participant Information.

Name Initials-

Age-

Partnership status-

Number of children and age of child-

Interview Questions.

Note to interviewer: Before you begin ensure that you have explained the study and the interview process, the consent form is signed, the recording device is switched on. Thank the participant for meeting with you again. Remind the interviewee that they do not have to answer any questions that they do not want to and that they are able to terminate the interview at any time. Remind the interviewee that there is not a right or wrong answer but it is about their experience.

Long pause prompt- "were you having some other thoughts about that".

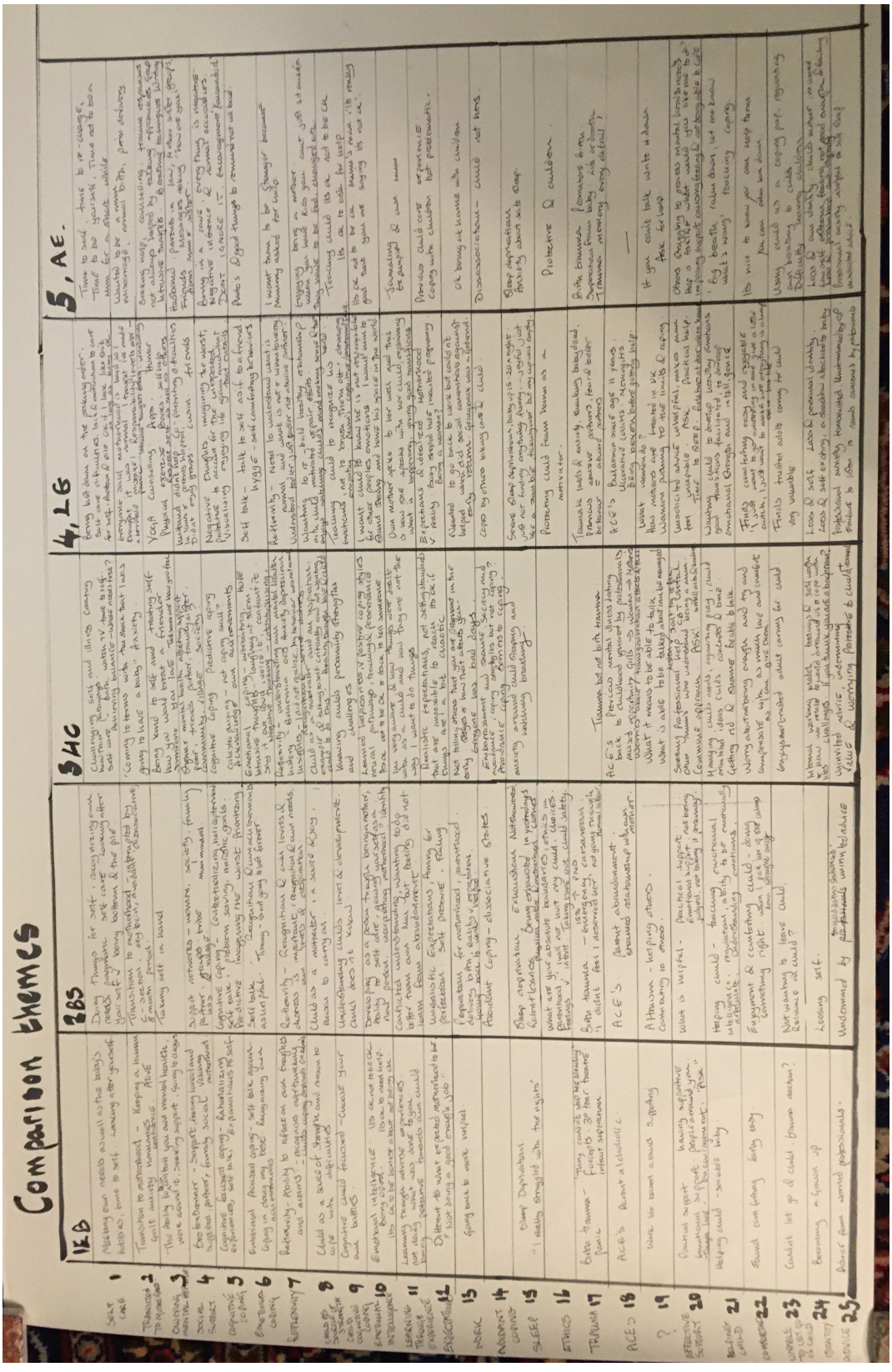
Clarification questions can include asking 'why' and 'how' questions for example 'can you tell me more about that?', 'how did that make you feel?', 'can you remember what you were thinking? or 'where did you learn that?'

1. Offer a summary of what the participant talked about in the initial interview.
2. How do you feel about what we discussed previously?
3. How do you feel that things have changed?
4. What do you feel has been more consistent or stayed the same?
5. Do you think that you have discovered anything about surviving difficult experiences and coping from focusing on it as a part of the study?

6. Would like to add anything further about their experiences of coping, being a mother, or mental health difficulties?

Note to interviewer- Thank the interviewee and ask if they would like to receive a copy of a summary of the research findings. Ask how the interviewee is feeling about the experience of being interviewed and check that they are happy for the interview to be included in the study. Ensure that the interviewee has the contact information sheet with details of support information and the researcher if they want to talk to someone.

Appendix h. Comparison themes from first five interviews



Appendix i. Comparison themes example from excel spreadsheet

	A	E	F	G	H
1	**Comparison Themes**				
2	Initial interviews	4 Dawn	5 Ellie	6 Faye	7 Grace
3	Self care	Self care- Being last down on the pecking order; self care difficulties; lack of motivation to care for self; bottom of pile; its ok if I look like shit as long as the baby is ok.	Self care- Time to self; time to recharge; time to be yourself; time not to be a mum for a short while.	P. 21 Gives time to self rather than doing the next thing on the to do list of chores	Not eating well- I think a lot of that was not looking after that side of things properly, do you know just cook for eating or yes not bothering to think about it or ... do you know that got put on the shelf p.4
4	Transition to motherhood	Transition to motherhood; Everyone said motherhood is hard so I thought it was normal; I thought I've made a terrible mistake; responsibility levels over-whelming; panic; intrusive thoughts; anxiety.	Transition to motherhood- wanted to be a mum; miscarriage; normal birth; prem delivery.	"just the best thing ever" P.2	I don't think I realized how erm intense it maybe was
5	Owning mental health	Owning mental health- Yoga; councelling; Apps; humour; physical exercise; books- reading for enjoyment; self help books; respect self as well as others.	Owning mental health- Seeking help; going to councelling; trauma responses not always helped by talking therapies; attending groups; intrusive thoughts; breathing techniques; writing.	p.6 talks about suicidal ideation as self protective drive that is misdirected	Recognition of need- And then I think I said to him in th middle of the night "oh she'd be much happier if I just wasn't here" and then obviously the alarm bells were going for him then... p.4
				Support- Wife Mum Family	I found all the baby classes really helpful, and I think with F (oldest daughter) in particular I think I went to one nearly everyday of the week (laughs) and then I

Appendix j. Bracketing interview 20/06/20

BI- Bracketing interviewer

R- Researcher.

Research question- What can women's lives tell us about surviving adversity and developing coping mechanisms: With particular reference to mental illness and being a mother.

Questions.

1. Why did you want to do this?

R- Well it dated back to my health visiting days and I had a lot of women who had severe trauma in their backgrounds and ended up with quite significant diagnoses so Borderline Personality Disorder, Schizoaffective disorder and all of those sort of quite…. what I consider to be quite major diagnoses, um and they did have difficulties but on a day to day basis they were caring for their children, they were getting them to school, they were getting them up in the morning, putting food on the table, and although we know how bad some outcomes for children can be, I felt that there was something that was missing…. We didn't really know enough about how they did cope when they were coping.

BI- So that was something that you had been thinking about for a while then?

R- um yes definitely because I felt that they did have strengths and they were using coping strategies, in a way....

BI- you felt that they were overlooked?

R- Yes definitely, they are overlooked and I think we are not valuing…. sometimes a lot of interventions are quite paternalistic in their drop down approach and you know, this is what you need to do, without actually finding out where people are and what their strengths are.

BI- So that.... its quite humanist in your approach in that the capability and the resilience of the individual….

R- yes because everyone is an individual and what helps me, may not help you and why do we assume what will help someone before we've asked them how they help themselves? In a way....

BI- that's so interesting, I'm just reading your question again…. so what is it about it that made you want to do it?

R- That…. sometimes when I was listening to women talking about their experiences, I was like I don't think I would have survived that, if I'd have had to be there, because these women had been raped as children and um lived with violence and you know… and then resorted to substances to alleviate their pain and I'm like I don't think I'd be there…. if that was me…. so I just felt that there was something there that made them strong enough to survive, but I wasn't sure what it was.

BI- So you had an admiration of them?

R- yes definitely..

2. What influences do you think your past work will have on your research?

BI- So that leads onto your second question, so how do you think your past work will influence your current research?

R- Not as much as I'd like it to because I can't get hold of that client group, in that way….
BI- So they're not coming forward?
R- No and of course they are very hard to target unless you have NHS ethics, and people are ethically quite challenged and I had professors saying Oh you know you just can't ask about things like that because you are causing such a lot of distress, and I was like but they are coping with it every day…. this is what they are dealing…. they are dealing with this on a minute to minute basis, um they think that by asking questions about how they cope that um …. so there is a lot of judgment…. assumption on their behalf really….
BI- Yes that is quite an assumption
R- So I had to…. in some ways I had to water down what I was hoping to look at buts its ok its still ok because there is nothing out there on how these women cope, its all about how you cope in an earthquake, or warzone or… but there is nothing about ordinary women coping with mental health and if you look at the prevalence of mental health for mothers' it is very high....
BI- So there's the gap that's a great gap for the research to fill, isn't it funny it doesn't have to be an earthquake or a catastrophe….
R- It can be Covid 19 can't it, so the other thing I got hit with in my lit review because all I could find was Tsunami's and war zones and all this and they were like well that's not really what you are doing surely you can find something better… and then Covid 19 happened and I was like but extraordinary things happen to ordinary people, you know its no different.
BI- that's so interesting especially in terms of Covid , I had a couple of friends give birth and they are both resilient people, and they can't be with their mum's and they have no support round them, and their partners are still working so they are home alone, surely that's a perfect ground for mental health difficulties that isolation and being a new mum…
R- yes and if you've got no support its tiredness, is massive because nobody would cope with the lack of sleep that young mum's cope with and its unreal the expectations on them.… because they are healthy young women they are supposed to cope with no sleep.... but nobody can….
BI- yes there is a reason it's a form of torture…. So in terms of how your work in the past and its influence on your research, do you think you come with an expectation of wanting to prove in a way that this is a thing…. that it doesn't have to be an earthquake, this extraordinary thing happens to ordinary people?
R- (pause) I don't know I'll have to think about that.… that ordinary people have extraordinary things happen to them..
BI- Well you had professors say you know you can't ask this question.…
R- I do worry because I've had a few fights along the way, and I was watching something on Vera Lynn the other day and apparently she had loads of criticism because people said she was making the troops home sick and I thought oh even Vera Lynn had to fight her corner and I found that quite encouraging because sometimes I worry you know that I'm too rebellious or too controversial or too .. I don't know pushy or….

BI- I bet your male counterparts in their PhD's are not worried that they are being too pushy, I think that's a very feminine thing to think of I'm doing it wrong, no it's your research. It's so paternalistic to say no you can't ask these women when they have dealt with adversity beyond belief....

3. What could be a negative impact of your experience?

R- I can't remember if this was what I was thinking of but I do worry that I have a need to be a fixer, so I worry that I'm too present because if they say something derogatory about themselves or agree with something derogatory, I cant let that go and I have to say but actually you did a really good job because or something…. And I have a fear that I'm not a proper interviewer because of that.... but then I think that that it perspective isn't it as well because there are perspectives as well you know that the value of creating a narrative in a way is therapeutic for people and you are part of that…

BI- yes totally.... so you feel you have to fix…. so why is it so difficult to allow them to have a negative feeling, why does that feel hard?

R- Because its making them not ok and they are not giving themselves…. They are not finding it ok to be kind to themselves….

BI- and do you feel responsible for them being kind to themselves?

R- I don't feel responsible I don't think but I want them to be ok interestingly that was one of my big mistakes as a parent that I think a lot of parents do wanting the kids to be ok but actually you have to let people not be ok sometimes, because that's part of their journey?

BI- Yes because that's what you are saying about these women that have survived so much and been not ok before and you are asking them to speak about them not being ok and you are saying they survived, it should be ok to talk to them about it but on the other hand its hard for you to sit with them not being ok and kind of showing their resilience

R- um it feels like that needs picking apart a bit more doesn't it

BI- Is it something you would have liked people to say to you, you are doing a brilliant job, don't be unkind to yourself....

R- Yes, what was the question again,

BI- What could be the negative impact of your experience?

R- yes that's the one I worry about but I worry about it less when I read The Neuroscience of Psychotherapy because he talks about how we process difficulties and how we create a healthy narrative around it and he talks about the neurobiology of that so how that is healing because it creates pathways in the brain, so when you have been traumatized you have memories that come from your lower brain so your amygdala and lower brain processes that may have cut off access to your higher brain so when you are discussing something you are actually creating healthy pathways and processing what has happened.

BI- So do you think that's a healthy thing when you intervene?

R- Part of my head argues that and part of me argues the other side…. I guess I'm not…. I think its something you have to be careful about, you must find it too?

BI- Yes sometimes I think I know what I would want to do with that in therapy and try to bracket that because I guess I'm thinking you said I'm a fixer, what does that stop in a negative way you as a researcher

R- right that's a good question, (pause) and actually ethically I think you do actually have to say its ok you know and not… because you are still there and you are still a person..

BI- Isn't that in one of the papers that she thought she crossed a boundary into therapy and actually they said well actually you did cross a boundary but if you had stuck to your research agenda it would have been insensitive, to not kind of talk openly and honestly and acknowledge what they had been through and you are offering a supportive listening opportunity which is what they most need at that time, so you just cross a boundary into supportive listening.

R- Yes I think that's how I feel because I feel like you still have to be a person with another person

BI- Who has stepped up to talk to you

R- Interestingly the women that I have spoken to have just completely opened up and it feels like it just tumbles out and they all.... I think actually all of them have said I'm so grateful to be able to talk about it

BI- That's so interesting I had the same thing everyone said its quite cathartic, that was quite therapeutic

R- yes and they said 'I thought it would be difficult but I've really enjoyed it' sort of response, and I asked my pilot interview about how it was for them and if they had any concerns for women going forward and one of my supervisors said oh but you wouldn't do that for your interviews but actually I do always ask them, are you ok and if it was ok for them to talk about that and they all say no its been really good I've enjoyed it.

4. <u>What could be a positive impact of your experience?</u>

R- I thought just that I find it quite easy to talk to people um on a one to one, put me in a party and I'm not happy but (laughs) but I do find it really interesting talking to people so I think that's a positive. I'm really interested in what people have got to say so....

BI- So it's authentic for you

R- I think that works well and it doesn't bother me if there is a baby vomiting over my foot or something, I'm fine with that, because I think some people might find that tricky if they've got a toddler running around or interrupting where as it doesn't bother me its fine

BI- It's interesting that you are comfortable with that, did that happen in interviews?

R- Yes it has done, the virtual ones actually we have done them in the evening and that works really well and they usually have someone looking after them, one I did in the day and she had to get the baby up, baby was having a nap and then she had to get them up and then other ones when the children have been there, its fine.

BI- Is there anything else that might have been positive

R- I don't know, I mean having some insight and experience in to the subject I guess can go either way can't it, which is why we are doing this, um so its good in that if we didn't have insight into the area we wouldn't be looking at it, um possibly, there are researchers that do research into things that

they don't care about but I would personally find that quite hard, I wouldn't be motivated I don't think in the same way

BI- So what do you think your…. obviously you have got your own interest, how might that shape the data?

R- that's the question isn't it What assumptions are you making? I know that one of the things that I read and that I have to be careful about is that I don't base my themes around my questions so I need to be quite careful about that, because obviously that's my feeling then

BI- That's you shaping the research before you have got the answers?

R- But then saying that there are some things like sleep that just come up again and again, so I think that that is just there anyway

BI- Do you have a sort of relationship with sleep, struggling to sleep or ….

R- I don't think so, I mean I know I was tired when mine were little I do relate to that but what I didn't know until I looked at the literature was that there is an increased vulnerability for mental health when people are sleep deprived and that comes up in the literature so I was aware of that when I interviewed the women.

BI- Yes I think that that is something because I've done a pre literature review and you kind of go into the literature a bit with the literature in your head.

R- And I had to do that because I didn't know what coping was, I mean I know what coping is but I didn't …. actually its huge, I had to do a massive delve into the theory behind coping and looked at Anna Freud and Defenses of the Ego and how the philosophy of coping has developed. And I felt that I had to do that because otherwise they might tell me something and I wouldn't recognise it as coping, so

BI- Was there anything that you were surprised by when they talked about coping?

R- I haven't unpicked it completely, it's a bit of an on-going process, but certainly I think an assumption by a lot of people is that coping is positive but it might not be, so you might drink a bottle of vodka but that's…. so that is part of your coping mechanism but it might not be part of resilience. So there's quite a lot of unpicking, so the defenses of the ego, so your internal defenses so they are part of your coping as well, so when you are looking at what Freud and Anna Freud would have talked about, so it could be something like avoidance, or it might be positive self-talk or it might be re-framing or you know…. but all these things are part of coping so um so I've still got to come down some sort of line because I've given no information to the participants about what I think coping is, so I have to listen to what they say, and of course that is dependent on what they think it is.

BI- So that locates it within them and that takes out your ….

R- But I might pick up things that they say, because I've looked at the literature that they might not realise is one of their coping strategies. But I think a lot of them have been quite reflective as they have spoken, and a couple of them said oh I didn't realise that I'd done so much, which is lovely

BI- Which is why they have found it so useful

R- So that's ok, but I've got a lot of unpicking to do and I don't know if I will ever get there….

BI- No you definitely will and I'd love to read it

R- Well we will have to share….

5. How is your research affecting you in a personal way?

R- Yes that has surprised me it has been quite difficult at times, a bit similar to your journey, but it has thrown up quite a lot of thoughts and feelings in me, about how I've dealt with things or coped with things, or not and the way that my psychological make up has developed. Which I have sort of bracketed off as a separate um journey, but it has been much more than I ever anticipated

BI- Its become more personal?

R- Yes much more personal, especially the neurobiology because it just like Ding ok so that's why that happened Ding So ok that's why I that goes like that, Ding oh yes I definitely do that and I've just been like oh …. you know (sigh)(laugh)

BI- I think that's brilliant though, but it can be quite seismic….

R- Some of it has, and its just been…. and just by co-incidence on Facebook some people that I was friends with as a young teenager have reconnected and that's just gone…. because I'm avoidant by nature I just didn't think about it then suddenly I'm Oh my God

BI- It's all falling into place

R- and somebody suggested a reunion and I was like but I went out with him and how would I feel about that and how would he feel about that and then I'm like its ok I mean we were really young we didn't do anything

BI- But its really personal when you are talking about such personal topics, you know you are a mum, you've got these experiences....

R- So that bits been a bit painful sometimes but also for me a bit positive because its answered some questions, some of them I didn't know I had but I definitely you know when you are talking about guilt and shame that are part of our make up um but because its uncomfortable we push them away um so I think part of personally I've been doing Yoga and I've looked a lot into…. because when I was working I was really interested in DBT which is half based on Eastern Philosophies and Buddhism and Yoga is part of Hinduism and so part of my work has been looking at …. in terms of psychology its what they call the bottom up approaches, so your talking therapies are your top down approaches when you are making links from your higher cortex into your lower brain and your bottom up approaches like Yoga work from your somatic, making connections from your lower to your higher brain through the physical movements and how you calm and all that sort of thing

BI- That's self soothing and things like that, and have you been doing more things like that as your research has progressed

R- Yes its just combined I'm doing a Yoga therapy course, I find it really valuable it really links in with coping, its like everything sort of fits

BI- Will there be a space for that reflection? That personal journey feels really relevant

R- I've written up a chapter on Yoga and Eastern Philosophy, it will get edited out it might, but that's ok I'm not bothered because for me it was part of it

BI- So it seems it is really personal or it is having a personal impact?

R- Yes and I don't think I anticipated that

BI- I wonder if that will play a part in your analysis?

R- I think that one of the things that I liked about doing this was .... so one of the points that I put down was that doing this was to enhance the researchers capacity to complete thematic analysis and form a further data set, I came across that somewhere and I really liked that because I thought in a way that's why we are doing this isn't it so that you become more strongly reflective um

BI- So do you mean to do a thematic analysis of your own.… what you are bringing to the research?

R- I wasn't going to do that, I see this as part of adding value to the process, so that…. one thing that I read recently was that you have to be strongly reflective, so its that awareness isn't it and because I do believe part of IPA is that I am part of the research, I'm in there with them and I can't take myself out, I don't want to take myself out, I just need to be aware of leading, or not leading I guess.

BI- Yes because I always think of myself as at the start of the interview but actually it's the whole way through and its that iterative process, it would be unexpected if either of us came out unchanged in a way because the whole point is that you go round.… gain more reflection into the research, and also you don't know what you don't know until you do it.…

R- And every time you meet someone and have an interaction that changes who you are…. or it should do if you listen....

BI- And then reflect…. does that feel? Is there anything else affecting you in a personal way?

R- I don't think so.... I mean there's all the stuff about feeling you're not good enough to do it.... there's all that which is just annoying, I'm like just go away that thought.…

BI- You kind of hope that everyone has that.…

R- I think so well they talk about it…. imposter syndrome

BI- Well I spoke to someone who was a couple of years ahead of me on the DPsyche and I was asking what do I need to …. do I need to take this to my supervisors and she said look its your research you are the one who's doing this, who is producing this, own it and make it your own.…

R- Yes I e-mailed the chair of the ethics committee directly because I thought I need to do this I need to know if I can carry on now (Covid 19)

6. <u>What are your concerns about you as a person doing this research?</u>

R- I can't remember what I was thinking when I wrote that (pause) maybe that's all around not doing a good enough job or not being up to it? Or maybe it being too personal, like you maybe it maybe being more personal than it should be , but maybe that's about …. when you are in the data …. maybe we are immersed in the data…. maybe that's what we are experiencing in that way, you said about being an insider researcher....

BI- Because we are in it, its interesting you said concerns about you as a person doing this research....

R- I might have been thinking about my need to fix stuff…. I might have been thinking about that actually, which we talked about already in terms of the children, they have to experience the emotions sometimes..

BI- Does that come from when they are miserable you are miserable

R- or that you feel that that you failed as a parent if they are not ok, you are not doing a good enough job.… but sometimes when bad things happen, they have to go through that.… and one of the things that has come up a lot with the mums, and I know it's a social media thing as well, but nearly all of them have talked about it that 'its ok not to be ok' and 'its ok to ask for help' because they are the big ones, because I think they feel bad about not being ok..

BI- How is that reflected in your experience

R- um maybe I think it's not ok to be not ok?

BI- Yes and having this realisation of quite painful moments as you are reflecting, can you allow yourself that? Can it be part of the process?

R- Funnily enough it came up the other day, like I said one of my things is to be a bit avoidant, just forget about it, move on, um and I do the daily Calm App and shame came up on that and it was quite interesting because it said that shame is such an uncomfortable emotion that we just naturally push it away, but actually we really need to embrace it as our teacher and be compassionate towards ourselves within that emotion, so I think a lot of what I'm learning through the yoga and the Buddhist thinking, that side of it is around accepting emotions and being compassionate towards ourselves. So I guess that would be what I would take?

BI- Have you looked into compassion focused therapy Paul Gilbert which is based in Eastern Philosophy and Neuroscience, I think it would be really up your street. It would match with your interests really well, it's a modality that I have started using

R- That sounds really interesting and I did… on the back of being interested in DBT I did train the trainer in Emotional Coping Skills and ran training for staff to use with clients and I think that got me thinking about what is coping, what do we mean by it?

BI- Where does it link to distress tolerance? Is that the same as coping?

R- Its part of coping isn't it, it could be a coping strategy

Bi- Is there anything we have not covered?

R- I'll ask you the question you asked me, Is there any reflection on what I've talked about?

BI- I think it is relevant, fascinating, useful research that you sound well positioned to be tackling, you sound like you are very in it....

R- Maybe that's true for both of us really we are more in it than we realise

BI- Yes I'm definitely having that reflection I'm really enjoying talking about my research, which I haven't for a while, its given me energy to talk about it.

Because the Bracketing interview was a two way process the questions posed by the other Bracketing interviewer were also considered.

- **What motivated you to conduct this research? Any assumptions you have had?**

The assumption within the research question itself was considered that surviving adversity would lead to the development of coping mechanisms. This remains an assumption but the

participants added their own dimensions to this, which have been considered within the data.

Challenges?

These were felt to include: time; personal priorities; being challenged within the research process; and personal emotional responses to the participant data and the literature itself.

Benefits?

The benefits included personal understanding and making sense of my own life, and being able to contribute to the data set.

Vested interests?

This was a challenging concept in some respects because personal goals and research goals can be intertwined, success of the project has personal and research implications. Possibly the personal journey is important too and that's ok?

- **What is your relationship with the phenomena at hand? How much do you feel/imagine as an insider researcher?**

  The researcher found that studying coping led to the examination of personal coping mechanisms and defense strategies and also to reflection on seeing others cope in healthy and less health enhancing ways.

- **Is there anything you hope to get from the research? If so why?**

  Hopes included being able to contribute to the literature due to the investment in the subject matter.

- **Any expectations of the interview process. Any expectations of the data?**

  Expectations included looking forward to talking to women and hearing their stories and surprise at how open and honest women were within the interview process. Nervousness was mainly centered on the technical aspect of recording and transcribing but these were diminished with experience.

Expectations of the data were less easy to define, and the process of analysis was found to be illuminating.

- **What was your experience of the interview process? Anything unexpected?**

  The interview process was found to be humbling in terms of the willingness of participants to trust and share their personal emotions. This led to a sense of pressure to honour this and do a good enough job with analysis of data and communication of findings. Content was recognised as challenging at times when participants expressed difficult thoughts and emotions towards their children and the detail within the ethics application on the management of risk was found to be re-assuring at this point. One mother discussed having thoughts of harming her child but was able to differentiate between having thoughts and at the same time knowing that she would never act upon them. Several mothers had accessed considerable psychiatric support.

- **Anything unexpected?**

  The level of enthusiasm of participants for the research was unexpected and encouraging. The comments around finding engaging in the interview process as a source of relief and release, being able to talk openly about this difficult aspect of their lives in confidence, was gratifying.

Appendix k. Study recruitment flyer

You are invited to take part in research into How Mothers with Mental Health Difficulties Cope…

We are looking for…

Mothers who have experienced mental health difficulties - before becoming pregnant, during pregnancy, following the birth, or following a difficult birth experience - and have a child aged 0 to 2 years old

Whats involved…

You would be interviewed for about about an hour at a place convenient to you.

We want to know…

- Your views on becoming a mother
- How do you cope when things are difficult
- What ways of coping you would like to pass onto your children

[redacted]

Get in touch…

Diana Skibniewski-Woods
E: [redacted] T: [redacted]
College of Human and Health Sciences, Swansea University

Swansea University
Prifysgol Abertawe
College of Human and Health Sciences
Coleg y Gwyddorau Dynol ac Iechyd

This study has been approved by the Research Ethics Committee, College of Human and Health Sciences, Swansea University,

If you have any queries about this study, please contact supervisor:
Professor Amy Brown
a.e.brown@swansea.ac.uk
Department of Health, Policy and Social Sciences,
Swansea University, Singleton Park, Swansea. SA2 8PP

Appendix I. Example of interview transcript

	R- How old are you? P- 37 R- Partnership status? P- M R- Children? P- M aged 24 months (on Monday). R- Did he enjoy his birthday? P- Oh yes he loved it we had family around and he just enjoys being with everyone, and he goes from person to person and he enjoys being with people R- he's a sociable boy P- Very sociable, very sociable yes R- So tell me a little bit about yourself and being a mum? P- Er being a mum? Well I work, I work full time, er I have my boy, I have my hobbies, er well what do you..? R- yes so you are working full time and you went back to work..? P- um he was 11 months so I was off for about 10 days before I gave birth, and I was off then for 11 months, um to absorb the joy that's motherhood, although after, I think it was after about two months, I went in to work to ask if I could go back, to work sooner part time.. R- Did you feel like you wanted to? P- yes I was having help from P….. the .. as um, what's it called the peri-natal.. prenatal help, um I started going down hill quite a bit, um but as everyone says, you know motherhood is hard, so I thought this is… this is it you know, all these thought and feelings are just normal, um when I did go back to work, it was a (laughs) a blessing, an absolute blessing! And you know as everyone says I loved my boy..but then.. R- Of course.. P- But going back to work was a godsend, it was a godsend, I should have gone back.. I sort of wish I'd gone back sooner really, um but I didn't know as much as I do now, um although we still know very little, that's why this study's being done, but I wish I had known more, I think it would have helped my mental health if I had gone back to work sooner. R- Did you have any worries before you had the baby that it might effect your mental health? P- um no not really um I .. part of me… I um have	"Absorb the joy of motherhood" ironic Felt the need to return to work, social convention ever changing Understanding what is normal when to worry Returning to work was helpful Repetition of need to return to work Repetitions of need to return to work Insight Early trauma?
Expectations of motherhood Understanding what is normal anxiety and what is abnormal anxiety Returning to work		

Previous mental illness	been dealing with Bulimia for years, since I was 11, so that's 26 years now so it's a long time, so in the last.. in my early 30's I put into place coping mechanisms and everything and um … R- Can you tell me a bit more about that?	
Yoga	P- Um yoga, I trained as a yoga teacher, that was a big thing, I work as a (job described) so that's quite stressful, and I found that found that I was recommended, try yoga, try yoga so no no but when I did, it opened up a new life	Yoga was helpful
	R- it changes your life doesn't it?	
	P- yes everyone thinks its you know weird music and um loads of slang words but it really changed my life so I did yoga and then I trained as a yoga teacher um training for the (name) marathon you know so I was keeping myself busy and then resting enough as well, um just to keep stress levels as bay. I've got ulcerative colitis as well, (name of disease)	Finding something that works Keeping busy? Way of coping, avoidant coping. Trying to manage stress levels, physical manifestation of stress.
Ways of coping Avoidant keeping busy	R- Is that related to stress?	
	P- um it can be triggered by stress	
	R- Not caused by but triggered by	
	P- yes for me I find that…. I find that if there's a prolonged stressful period of my life then um the colitis will flare up which was resulting in hospital stays and stuff and all that which is another reason that I started doing yoga	Self-knowledge
	R- That's quite serious then isn't it?	
Self awareness Self reflection Recognising the need for change Pivotal moments	P- Yes its quite intense, um I was told one more hospital visit would um result in a colostomy bag so that's when I thought I need to change my life so the yoga, I changed my diet, and my lifestyle and everything so I was quite not rigid, but I changed my life style, I changed my way of living and that um helped a lot, it changed my life and then… I didn't realise how much it did really until of course I had my son and I got married as well. Everything happened in a short space of time so now..my.. I was last on down the pecking order you know the last… everything else came first really…	Pivotal moment that inspired life changes "I changed my way of living" how we can recognise the need for change, the need to change how we cope.
Bottom of the pecking order	R- I don't know quite how that happens, as a mum we suddenly assume that our needs are last on the list?	Mothers needs coming last
Difficult relationships with partner	P- yes absolutely, at the time my husband didn't help um he's better now that I've sort of crashed, but I found that I didn't have time for…. didn't have time for yoga, didn't have time to go out or… he still doesn't sleep, he's a particularly bad sleeper, um he'd be up 15-20 times in the night and I was breast feeding as well, and I was doing all the shifts so I was… you know yes it was tough so…	Partner not supporting new Mother Sleep deprivation
Sleep deprivation 29 mentions	R- well they torture soldiers with sleep deprivation but nobody talks about it with mum's	

	P- its um yes very difficult I find it very very difficult R- Tell me a bit about how it affected your mental health?	Sleep deprivation experience of
Reality Responsibility Imagined motherhood v what is	P- um within… as soon.. as soon as my son was born and he was put on my stomach, I just looked at him and thought Oh my God, I've made a terrible, terrible mistake, I can't cope with this level of … um responsibility? That I have to keep him alive, I .. I felt immediately er oh my god I don't know you, I can understand how people can put children up for adoption, um it was just total panic, um I didn't leave the house for the first six weeks, and it was.. it was just overwhelming. I had to leave the house just once and but had a massive anxiety attack in the car, um I kept thinking that my son was dead, um all the time, all the time I thought he's going to die, oh my god I've suffocated him, he's going to die in his sleep, it just constantly.. R- Really frightening	Shock at the reality of baby's arrival, how common is this? Shock of recognition of level of responsibility! Extreme distress "total panic" Intrusive thoughts Extreme anxiety Concern for the baby
Intrusive thoughts extreme anxiety Fearing for baby's life Traumatic in of itself	P- yes he's going to die or something's happened um and that level of anxiety's still there I still, worry every morning when I go in and think oh my god thank god he's still alive, um my husband thinks I'm quite… like 'oh you worry too much' and you know because there is so much about cot death and blanket suffocation and toy suffocation and then oh there's just and now he is chewing through… he's got a dummy and you know he started chewing through it, so the teat's are starting to break and I've just got this constant thing that he's going to be sleeping and the teat is going to break off and he's going to grind his teeth in his sleep and he's going to chew it and the teat is going down his throat and he's going to die. (laughs) its pretty constant, there's always something you know… R- I wonder, do you find that now he's getting older you are a bit less anxious than when he was very tiny, I know you've got this new worry but?	Ongoing intrusive concerns foe baby Spectrum of normal to extreme distress No validation from partner This level of anxiety is traumatizing in of itself
Keeping a human alive	P- um yes yes I just think right ok well I've managed to keep him alive this far… R- this long P- and he's um because you worry so much about their… you know, they roll over, about… breathing was a massive worry so I think.. R- and of course they emphasize that any way in health care so that may not have helped you? P- yes the first, my midwife was away for two weeks after I gave birth so I had a temporary girl come in, I kept asking them, I kept asking at the hospital to check for tongue tie, I just asked over and over, can you check, and they would be yes	Being reassured Balance of communicating safe practices to mums and causing high levels of anxiety Not being listened to

Anxieties of health professionals Balance of information and raising anxieties	yes yes we'll check, um and it was only it was two weeks, my nipples were bleeding, they kept telling me he's losing weight, this baby's dangerously underweight, and my god you could suffocate him because he's too close to your bed and you could accidently throw your duvet over him in the night and kill him and looking back on it now I think she… I don't think the midwife had the right mentality um I think she put a lot of…. There was already anxiety there but don't think she helped the situation…	Was the midwife anxious too?
	R- it sounds like she was anxious too?	
	P- yes oh she was like 'oh my god this baby is really dehydrated' and any way it turned out that he was um he was very badly..he was like the most tongue tied you could be really, his tongue was pretty much formed to the base of his mouth so when that was done then, oh my god, I felt, oh Jesus he's pulling so strongly..	Failure to act on mothers concern, mothers are the experts on their own child!
Failure to listen to mothers concerns about her own child	R- Was that sorted quite quickly?	
	P- yes well.. within two weeks, because the health visitor came and my midwife came back from holiday and my health visitor was visiting on the same day and they both came in and said I think he's tongue tied but nobody's checking, he can't move his tongue, and she said oh my god I don't even need to open his mouth I can tell so they got on and helped straight away and within… I think it was within a week, so about three weeks..	
	R- so that didn't help, it was a tricky start, you were in pain?	
	P- no, yes I was feeding round the clock, um yes for 24 hours and he was constantly on and then of course he'd dose off and then he was on trying to feed again, poor little bugger, yes so it was quite, sorry, I'm went off at a tangent really..	Major stress factors Moving house New marriage Pregnancy Existing mental illness Change of medication Unsupportive GP The coping stress fulcrum is unbalanced towards stressors
	R- no not at all, so how did you get help, did you ask for help or did they sign post you?	
Stressor/Coping Fulcrum	P- er the Perinatal, I had, I had my er, when I was six months pregnant um my um we moved, we'd moved, and I was on antidepressants for my eating disorder um I'd… um we only moved in together me and my husband, the day we got back from honeymoon, um so I needed to sign in with the surgery and I was running out of my medication so I went to the GP. I said look my anti depressants are going to run out, um and she started telling me about the dangers of anti depressants for the unborn child and saying 'do you really want to be giving your child brain abnormalities' and and um 'its going to um affect the growth of his lungs and his heart, do you really want to be doing that to you unborn child' and I thought no of course I don't and	Is GP anxious? Serious consequences

	the GP kept telling me you know if I put you back .. if I give you a prescription for your anti depressant your basically.. not killing your child… but you know giving him deformities and all that kind of stuff. Um so I left the surgery without… just really stopping dead off my anti depressants and of course my bulimia came back ten fold R- But there are anti depressants that you can take when you are pregnant, its strange that she couldn't go down that route P- No she was very much she said lets see how you are after the baby's born, so of course I was.. my eating disorder kicked back in then and my um my midwife sort of said 'look this has happened' um she um got in touch with the consultant and I was consultant led then after that but that and put back on the anti depressants um thank God so.. R- Were you put back during the pregnancy? P- yes I was put back on the anti depressants during the pregnancy um of course he's fine, a beautiful little boy. R- So was becoming a mum different to how you expected it to be?	Picking up the pieces Getting the right help Ho do you know as a new mum whether what you are experiencing is normal or not?
How hard can it be? Reality of mothering in the UK today, how much support do mothers get?	P- ur yes it was much harder, much much harder than I thought it was going to be, um (pause) the constant level of worry, and I didn't realise that.. um other mother's experience that too, its only through social media that I started to.. R- yes because they say that don't they that really all mums have these thoughts about sleep and breathing and all these general anxieties P- Um I didn't… I just thought… you know you just think it's… it's just me, you know when every one talks… R- I suppose it depends how distressing it is? And if we didn't worry then they wouldn't survive would they, there is a certain nature that makes us worry.. its what inspires us to be very careful..	
Instinct	P- No when you hear a baby cry regardless to whether its on you, you will start to lactate, because its right ok lets get the baby fed, it is that nature that does kick in, its strong, very strong… the old mother bear.. R- do you think your anxiety was more than an average mum?	Nature, instinct and motherhood, concern for the baby again
Fight/Flight Anxiety	P- Yes, um it was… it was incredibly heightened, my fight or flight was um at a… well just constantly running, very high and I wasn't able to do yoga or the yoga was a cause of massive arguments between me and my husband so I ended up stopping with it then, stopped doing that…stopped it and it was… you know I realised it was such a big crutch in my life. I'm back doing yoga now, yes	Lack of understanding of needs of mother by the partner Doing what works

	um I'm back trying to create… R- Create balance? P- Yes and I guide my life back into um a decent sort of balance really, um yes but its been very… very hard, very very hard um with .. between the lack of sleep as well, and of course people are always very 'have you tried this' and 'this is what…' and 'that's why' and 'have you tried putting a rusk in his milk before bed', oh god and you are just thinking.. and yes people … you try and do everything don't you, you know, you'd pay any money, you do anything, and you try everything to get them to sleep and um Yes me and my husband alternate every other night now, rather than me doing every night, whether he sleeps or not, we always alternate so that's…	Repetition sleep deprivation Getting help
Being broken before the need for help and support is recognised	R- You've come to some sort of solution really P- Yes but I feel like I had a breakdown I feel that I've had a breakdown before it got.. before we got.. I got… R- Before the realisation that you needed help P- yes yes yes R- Its quite hard to ask for help isn't it P- Yes yes because you're supposed to be seen as you know everyone paints a picture you know of um perfect mum and you know there and I don't know how mothers don't sleep I don't know how women cope with it its just like running on … I don't know I think I got used to just moving at.. half a personality, just going around.. just not finding anything funny, not funny, anything joyful just functional just purely functional, just like a zombie, just keeping my organs going, um my brain sort of ticking over but, yes my cup was empty, you know everything else was just.. just getting through the day really. I did end up um having meningitis um back in (date) um and going into hospital for a week, and before then I thought I'm going to have.. I'm going to have a nervous breakdown, whatever that is, but I ended up having meningitis, I was off work for a bit, I got better but that was the straw that broke the camels back really, just crap R- its interesting really its almost as if your body's not strong enough? P- Everything was broken really, every thing was just.. yes… everything was just…(pause) fell apart R- um so you have told me a little bit about how you felt when you first became a mum, did it change the way you saw yourself? P- Yes yes um I've always been um laid back just taking things as they come, um but… I think I'd started to … yes I was always laid back in work, I was always considered to be the chilled out one	How bad can it get before it is acknowledged that the mother needs more support Expectations pressures of Profound experiences of running on empty Physical consequences of exhaustion, not proven but experiential "broken" again
Expectations of idealized motherhood		
Physical consequences of exhaustion		

Undiagnosed conditions	um a bit of a joker, a bit of a clown, but when I became a mother then I realised I wasn't chilled out at all I became very very anxious with everything with every task, before doing something like washing the dishes I'd see ten tasks that needed to be completed before being able to wash the dishes, everything became incredibly overwhelming, it just… I felt like its really changed me as a person um so I'm trying to get that back really.	Probable OCD undiagnosed
Loss of personal identity	R- So you almost like lost who you were? P- Yes, I feel like my um I've lost my… not my identity but I've lost (pause) who I was, um the laid back, chilled sort of person, I feel like I'm always pretty uptight just waiting for the next bad thing to happen, um you know I've been diagnosed with post natal depression and anxiety by now so I know things for that and I take beta blockers to stop the panic attacks and now before I'd think what is a panic attack, how can you have that? How can you worry about something that's not going to happen, and now, you know everything… just things can trigger me off…. you know shopping in the supermarket, carrying things in and just putting them on the table, its really changed me	Loss of self Negative thoughts, imagine the worst, possible protective measure to account for the unexpected Seeking support of the right kind
Imagining the worst as a coping mechanism		
Self care difficulties	R- So everything is harder really? P- yes much much harder R- What about talking care of yourself is that something that you struggled with? P- Yes yes um I still struggle on weekends as well um (pause) I find I'm not showering every day… yes is that what you mean, levels of self care? R- yes yes P- um I can really sort of let it go…	Self care difficulties, time, lack of motivation to care for self?
Bottom of the pile in the needs hierarachy	R- so that we are not bottom of the pile but we are coming up and our needs are… we are recognizing our own needs as well P- I yes its um I do… I try and get my nails done.. I try and get my hair done and stuff and um its getting a bit better now but it was very much well I just looked like shit all the time, you know and I would always make sure that M clothes were um.. I put something on insta-stories.. instagram the other day you know I got his little folded cardigan out and I got the little de-bobbling machine and everything making sure its looking perfect and my own clothes I just… pick it up off the floor, I just like.. I … its just covering my body and that will do, as long as he's not going… as long as he's clean and brushed and he's got all the things he needs and his needs met then I can just.. (sigh).. you know sometimes you feel like as a mother (pause) you are the child's shadow, that's how I felt like,	What does this say? I am unimportant? Bottom of the pile again Still providing high standards of care for the baby Disfluency noted Mother feeling visibly upset to say this out loud

Support networks	and not actually… sorry I'm going to start crying… R- It's ok don't worry P- you're existing but um he is my life now and I'm just a sort of a shadow, attached to him, making sure that everythings, everythings done um and… R- That's your job P- yes he brings so much joy to the family, um (pause) yes its hard, its hard (very quiet),(distressed) R- Its still hard everyday P- umm (in agreement) R- Every day a new day? P- Yes a new day (laughs) I'm very lucky that on a Monday, my parents pick him up from crèche, and he sleeps up with them overnight so every Monday night at least we can have a decent nights sleep.. R- ok that was my next question actually about what helps you adapt, what's helpful. So that's helpful there? P- My mother can't see because my mother has suffered from ill-health, she's got crones disease, so its in the family the bowel disease, and um she said that she would look after me and get up at 5 o'clock and make sure that I was ok and the way that she would cope then was she used to sleep all through Saturday. So she knows that little M still doesn't sleep so just by having him on that Monday night, um its just a (sigh) a breather a good catch up with… I don't know, everything really, you know, I didn't finish work until 8pm last night so its long days as well so just being able to get a chance to catch up and… yes my parents are um my parents… um I am asking for more help now aswell, um R- well done P- yes buts its taken… for me to have a breakdown.. but I shouldn't really have to have a breakdown for people to go … R- you need help P- yes yes yes R- So tell me a little bit about him as a baby, what was it like getting to know him, how did you find that, you said your first reaction was ….?	Loss of self ? slip up but not joy to us all, pressure to facilitate joy to the family? Support networks What actually helps Repetition sleep deprivation Repetition sleep deprivation Being able to ask for help Being broken before you get help
Childbearing and being a woman	P- yes um I'd always it was quite, it was a bit of a shock, because I knew I'd always wanted a child I had this massive hole, a baby shaped hole in my life, and when I was in my early 30's I started saying up, I called it my IVF savings account, because I didn't know whether um I would be in a relationship with men or women and I thought if I end up in a relationship with a woman, as my life partner, you know we're going to need to pay for IVF to go down the baby route or if I ended up on	Women and inner desire for a child

	my own, I'm going to have to pay to do it on my own so, I didn't think I'd end up married to a man I thought I'd end up either with a woman or single doing this, and it was something that I wanted to do so badly that I started and I thought ill just save more and ill do it, when I'm in my late 30's I'll do it, so it was always something that I desperately wanted, and I thought this baby shaped hole in my life will complete me, so when the hole was filled with the baby and I just thought 'Oh my God, I've made a terrible mistake', so all the years of yearning for the child, so I just… thought this is what I wanted this is what I was desperate for and he's here… healthy and he's gorgeous and I just couldn't stop thinking what do you want are you ever going to be… happy and …are you…. you know this is, this is the pinnacle of what you wanted and now he's here um you know I'm never going to be happy with my lot so its and its quite hard to get over that aswell really… R- It sound like you were judging yourself quite harshly there because our imagination is always different to reality isn't it? P- yes um yes and because I was this laid back person chilled and yes we'll do this and we'll do that and I also ended up a very different person so I was struggling to get um you know I struggled… R- so when his personality started to become clearer, tell me a bit about that, as you started to get to know him? P- he's got a very strong personality, he's a proper little character, he's very loving um and I do count myself very lucky that he's, he is how he is, he's always laughing, and a proper little boy boy, like a little Tasmanian little devil boy, you know, everything, with his toys, you know he wants to get involved and he's wants to be always doing and everything at a 100 miles an hour, um um and he makes me laugh, he makes me laugh its just the sleep has always been a major thing um I was battling with… which I was talking with my counselor, I felt over the years that I was letting myself, where I thought I was being laid back in a relationships, I started to think maybe I was more of a walk over, and I had let people talk to me or behave towards me in a certain way, and then as M's personality starting getting stronger and because he's a toddler, I was struggling to differentiate between toddler behaviour and asshole ex partners behaviours. So there's been a bit of conflict… R- What an insight that is, adults behaving like toddlers you know stamping and wanting their own	"baby shaped hole" need for fulfillment as a woman? Fantasy v Reality Disappointed in self, loss of illusions, questioning the provision of happiness in life itself Insight understanding of own psyche Loss of personhood I get a sense of struggle for this mum to know and accept her child is ongoing, use of conflicting language Revelation of previous partners abusive behaviours and similarity between toddler behaviour and abuse. Fear of toddler but managed to work out that normal toddler behaviour is not normal adult behaviour.
Learning from adversity Reflexivity		

Light bulb moments	way and where as its part of a toddlers transition and growing up we hope that adult partners don't behave like that P- Yes and I realised, I just clicked one day and realised that I'm so scared, I'm so scared, that I was going to let him walk all over me and that he was going to grow up to be an asshole. When I was finding it so challenging but now I've sort of let that go and think he's not going to grow up to be an asshole he's just being a toddler, you know when they throw something or doesn't want to do something so that's only since I managed to get on to the counseling so what's that about a month ago, yes.. so that's been R- So that's taken a long time P- Oh yes that's been a massive change in mindset really R- And its about how we support them to become a better person	Pivotal moment of understanding
Helping Child to develop emotional strength and intelligence	R- And I will try and say I know you are upset, I recognise that.. R- You are recognizing his emotions P- Yes yes yes so you know um you know I always try… my mother always talked to me like I was a mini adult, um when I was younger, and I was always try and explain things to M like we are just going to finish watching… whatever he's watching u-tube or on the pad… and then we are going to turn it off and get dressed because we are going out in the car, so I always try and make sure that um I'm talking to him all the time so that he knows what's going on. R- So that he's got that understanding P- Yes and so he's less likely to.. you know so if I just go over and press off and close it he will be like what's going on, so you know, we are going to do this now so remember I told you, so we are really close, really close. It was massive after I had the meningitis though, he didn't want to know me, and um I was ill and our relationship really broke down to nothing, it was pretty hard and it felt like he just hated me and my husband was just felt awkward because he just shut himself M my boy just shut himself off from me really um R- Was that after you were in hospital? P- He didn't see me for the 10 days and when he did I was very very weak and I was spending a lot of time in bed and um you know I was still the one getting up with him in the night, making his food and packing his back and stuff and he just didn't want to … he would go to anyone except to me, I would pick him up and he would just scream and cry, it just broke my heart really um so that	Wanting to help the child develop healthy emotions Learning experienced from adversity Loss for child Anguish at loss of relationship with child, affecting mental health
Re-build child as		

motivator	definitely didn't help um as my mental health sort of spiraled down.. but now we're brilliant. He's really fab he's mam mam mam, and he comes to me and he grabs my hand to show me and sit me down with him and we play a lot…	Rebuild
	R- I suppose looking back on it, that's part of his coping, because he lost you while you were in hospital, so he just put the shutters down.. and you had to re-build it	
	P- yes and I had to work really hard, you know to get that um, to re-build that relationship was very tough..	Working hard as a parent
	R- And its all about the rebuild they say that's what makes us strong..is how you do that..	
	P- yes because he, I was off work for 4 weeks I think and the week before I was supposed to go back to work, he ended up having a fit in the house, his temperature shot up, he had a fit in his room so we ended up having to go up to the hospital and everything so that was really scary, um so it was just (pause) yes trying to get through that then, I just felt like.. yes so his temperature was just 39 40 and I was just constantly trying to bring it back down and didn't sleep for days was just upstairs and then you know he'd perk up during the day and then at night you know how they are so, um so again I did all the night shifts and everything um so that didn't help um..	Sleep deprivation caused by child's illness, still going it alone
	R- Gosh you've had a tricky old time haven't you… so um what do you find easy about looking after him, what do you find easy and what do you find difficult?	
	P- um what do we find easy? He's just got such a lovable personality you know and he's just got this gorgeous, you know I'm his mother I'm biased, smile..	Child as motivator
	R- That's your job	
Enjoyment of child	P- yes yes absolutely (laughs), he's a lot of fun, and I just love watching the way his.. his mind is making sense of the world and um you know he's starting… he's starting to involve me and my husband in his games, hell get a fire hydrant and he'll be like 'shhooch' and try and spray us with water and stuff, he's always trying to… he wants to play with us all the time, you know, and he's, yes he's funny and we start laughing and yes and I'll be weak with laughter and he's throwing himself at me and I have to keep catching him and I'm just weak because of laughing aswell its just… he's fun a lot of fun, he's a real sweetheart, yes..	Enjoyment of child as motivator Enjoying child
	R- And what do you find difficult?	
	P- um sleep, lack of sleep, it is getting better, um some nights he does sleep through, um most	Sleep deprivation repetition

	nights he's up once or twice, and there are some nights where I've not slept at all, and I just get up in the morning and I haven't… you know my fit bit hasn't even registered, as I haven't slept, you know I haven't slept at all, um so that's difficult and then if he, you know what it's like, because he'll go back to sleep and then I'll just be right ok and I'm still trying to wind down and ahh then get have to get back up again R- Are you feeding him in the night? P- he'll have some.. I'm trying to stop giving him a bit of milk um that will be that last.. the last thing I'll try and do, my husband will just keep giving him milk, so we are not quite on the same page as to what to try and do, my husbands getting better, um because now he's doing night shifts as well, he was more 'just give him what he wants' but I was 'yes but he's going to keep waking up you know for milk" thinking yes ill wake up at two o'clock in the morning and here's a little chocolate biscuit or cake, that's not what we give him but you know as a person you'd just think oh I'm going to wake up at that time every night. R- Rewarding the behaviour? P- yes you know my husbands seen that now, you know, shit, if I keep giving him milk he's going to keep waking up for a lovely warm bottle of milk, so yes…	Trying to get back to sleep after being woken Co-parenting difficulties Partner support
Being in public Exposure being judged Raised anxiety in public Unable to gain support from attending groups	R- What else is difficult about looking after him? P- um (pause)(sigh) being in public and um before having him I, I'm a very introverted personality, I don't embarrass easily but I keep to myself, and because I always was just me I could go at any point you know get myself out of there, first of all I was very chilled and now since having him I always feel very exposed um even though no one gives a shit, I always feel very judged, just anxious, very anxious when other people are around um I almost feel like my parenting is being judged (pause) yes, yes, (laughs) judging…	Feeling exposed in public and unable to get away as when alone. Feeling judged. anxious
Own mindset and good and bad days	P- So um what's the difference between a good and a bad day for you two together? P- um (pause)(sigh) a good and a bad day it would its now realising that its just down to my mind set really, I think if I'm having a good day I can just go 'there we are then, you can just sit there' and 'oahh' he'll cry and have a strop and I'll just deal with it, but if I'm having a bad day myself then I really struggle with his behaviour then. He's not doing anything wrong you know he's just being a toddler, um R- And he's got to cry sometimes.. P- YES God yes, I keep saying he's so good and	"my mind set" is what determines a good or a bad day. This affects ability to cope with normal child behaviours

	he's got such a great personality um if I'm just tired, yes I get very tired, having to… instead of just being able to go and have a lie down and get some sleep, you have to just keep going and you know keep feeding and changing them, just keeping them alive.. it can be very tiring trying to keep.. keeping a person.. a toddler alive..	Tiredness, is this exhaustion just due to sleep deprivation or is it to do with emotions as well?
Stamina related to relentlessness	R- Yes one of the mother's I interviewed called it 'relentless' and I thought ooh yes P- Yes its like trying to put a lasso on a tornado… he's just like all over the place and he's just .. and when you're tired its just (sighs) its just really hard keeping going all day	Stamina related to relentlessness
Ability to comfort ok	R- Tell me about comforting him, how do you find that, was it something you found easy or difficult? P- um easy easy you know I just want to go sweeping in and give a little cwtch yes I just want to make sure everything is always ok in his life	Comforting
	R- So where do you think you learnt that? P- From my mother, my mother is very nurturing, very yes very loving towards me, yes definitely my mother yes she a great mum	
	R- So who supports you in caring for him, we talked about this already a bit and you said your mum and dad and your partner is stepping up and doing some nights.. P- My in-laws help as much as they can, my mother in law had a stroke about six years ago, so she's not able to do much but my father in law um he's brilliant, he's just retired as well, he will take him, he takes him every Friday um because I started having um counseling on a Thursday morning he'll come over and to be with M and watch him for the session and ill come back and	Support networks Two year plus gap between health services knowing about mental health issues and receiving a talking therapy
	R- that s lovely that he comes to you and you don't have to…. And he's in his own routine.. P- Yes sometimes I come back and M's having his nap and just yes.. and he loves him… R- Anyone else that you find helps? P- yes my cousin sometimes will step in urr with crèche if my parents can't pick him up in time my cousin lives just behind and she's got three children and the youngest F is 6 and she loves M so, so yes	Support networks and what is supportive coming to own home to care for child so mum can attend appointment for counseling is valued as fully supportive
	R- you didn't get involved in any groups or anything like that? P- mother and toddler groups? Um yes I sort of did but I just… this ahh.. I just felt really exposed umm R- It raised your anxiety rather than lowering it? P- Yes and you know in all fairness my husbands friends, wives and girlfriends were saying come on come out to these groups, you know I could never relax around them and I thought no you know	Unable to find support from groups due to own feelings of inadequacy, exposure, feeling judged by others, inability to relax in a group situation, raised anxiety

Unsolicited advice and the effects of What is helpful be inquisitive Be practical	that's no good… R- It's not helping P- Its not helping, its not helping at all R- What do people do that's helpful, so you've talked about coming here and helping look after him, and what do people do that's not helpful when they are trying to be helpful but just not.. P- They just say 'have you tried this' and 'have you tried that' and you just think oh my god I've tried I've tried everything you know and its just um "I did it like this', 'I did it like that', um yes I think especially when you've… when you are already doubting yourself, somebody giving… my, my and its my issue when somebody is giving me advice I think they think I don't know what I'm doing, and I… that's always been… because I've always been capable I suddenly thought to myself I'm not capable.. R- Its come up a few times actually unsolicited advice s what a few mum's have said, its quite challenging P- so what would be better, because I suppose peoples intentions are right, it just doesn't help does it? P- Oh my god because I find myself like, just because… if I see somebody struggling I want to… if I um um say do you want to make a cup of tea? Do you want to sit down? Do you want to go and have a shower? Or do you want to um do you want to go out for a walk on your own, just helping giving the mother some time alone rather than give advice would be just…? R- it would be more helpful P- Oh god yes, and all somebody coming around and just being in the kitchen doing dishes.. R- Instead of hogging the baby isn't it P- Yes absolutely you do the baby, I'll….you know fold some laundry or something, and now whenever… I went out to see a friend who um had a baby and I knew that she was struggling, I saw it in her eyes, and I took him a little toy but I made a bag for her, a bottle of wine, um you know and hand moisturizer as I found that I was constantly (mimes hand washing) I was so worried about germs even if I like accidently brushed the cat, just little stuff some small things just sitting there and saying I'm here and just reach out whenever you want really um I'll suggest apps that I've found.. R- Oh yes what sort of Apps? P- There is one called The Night Feed and its for, its been set up by a mother, um she did the video when she was feeding her second child, and its um something… she made it easy to scroll through	Unsolicited advise Affects of unsolicited advice "I'm not capable" What is helpful, be inquisitive, ask, practical things, understanding, acknowledgement of how difficult it is. Helping others Anxiety, intrusive thoughts Apps helpful not feeling alone at night

Loneliness of night feeds	with one hand, um and there's stuff like little stories and a forum just so people can say 'hi, anyone else awake out there?' you know, its quite new because that's when people tend to feel the loneliness really..when I was feeding M throughout the night I had an alarm that would go off every 7 minutes so if I nodded off the alarm would go off just to make sure I was awake you know. Which again is a form of Chinese torture (laughs) just torturing myself, er and for someone just to say 'it's hard!, its hard!' and not just go 'isn't this amazing', you know	Sleep deprivation, loneliness at night Setting alarm to ensure doesn't fall asleep
	R- Not do this do that do the other but say actually it's really tough…. P- Yes look it's tough just… yes R- What makes you feel cared for?	
	P- um (pause) when somebody lets me sleep and says 'go on go and have a lie down' um and when somebody just says 'you go and take some time out, I've got this', not like 'what's this what's this what's this?' but its easier now with a two year old, he's … um um just somebody saying 'I've got your back' you know yes that's it really just let me sleep and knowing someone is there to help not just emotionally but do the dishes…	Feeling cared for- meeting needs, time to self, sleep, practicalities, admin Sleep
	R- Pick up a washing up brush or something, practical help? P- Yes practical help, (pause) the day-to-day admin life it can make such a difference yes. R- so thinking about times that have been difficult, can you tell me about how you coped, what helped you carry on when things were difficult? P- (sigh) um what sort of in what way?	
Reasons not to kill yourself, protecting the child from trauma	R- How did you carry on… because you did carry on? P- yes um in all honesty a friend of mine I was in school with we had grown up from 3 year olds, um killed himself last year and it was devastating and has had a massive knock on effect to you know, his family, his daughter, his wife and everyone that knew him, and knowing the devastation it caused to his family is what's stopped me from killing myself to be honest, so that's.. R- Because you care about them?	Trauma of friend who killed themselves and effect on loved ones as inspiration not to kill self
	P- Yes I don't want my family to go through what his family went through you know and I don't want M having that burden thinking 'oh my god my mother killed herself because I was born and it set a knock on effect..'' I don't want any… its not why I would have done it but I don't want him… R- To feel like that? P- To feel like that, I don't want that weight on his shoulders, thinking maybe if I hadn't been born,	Protecting child from emotional damage As a motivator

	she wouldn't have… she wouldn't have killed herself so that's sort of… yes that's what keeps me going really. Its been… its been intense but um R- you feel like it's a bit of a battle? P- ye um its getting there, its getting there. R- so what helps you move forward and be strong? P- (sigh) (pause) um just doing the leg work doing the day to day, (pause) um so what are my… what are my crutches? R- So what helps you? What motivates you? What makes you want to go forwards and be strong? P- um (pause) R- or what things have you been able to put in place that are helping?	Struggling to keep thinking about the questions lots of pauses and sighs
Benefits of physical exercise	P- um working out um training making sure that I um (pause) you know I work out and train and (pause) R- You mentioned yoga, are you getting back to doing that? P- Yes um R- Is that just doing classes or teaching? P- Its just doing at the moment I did um I've stopped taking any of my classes since I had meningitis, I used to build up… because I lost a lot of weight when I was in hospital, and I just needed to get back up so I covered for friends um a few times but um… R- How did that go?	Phyysical exercise benefits to mental health
Being an empty cup	P- (sigh) it wasn't .. it wasn't… I'm not ready for it to be honest with you and… it's not fair on the students because you are giving so much of yourself and it's a safe environment for them and you want to be as nurturing as you can and when you are struggling with your own empty cup that is the saying its difficult to pour from an empty cup so I just I … I need to build my physical and mental strength back up by doing my own yoga and doing training and yoga sessions. R- You said work is helping? P- Work um yes errr (pause) R- Its mixed is it? P- Yes well it's a little bit mixed because there's lot of pressure, but I am finding at the moment when I am in work it is easier, um and when I'm not being in work I'm reading, um I… it was almost like I forgot how to read, I used to be a massive reader, and then I found I was just struggling.. R- Reading is wonderful isn't because all that chatter in your head stops because you are engaged..	Recognition and acknowledgement of own emotional state Self awareness Empty cup again
Physicality of	P- yes because I was constantly sort of flicking through my phone, flicking through my phone… so also I just needed to… so I've got back into reading	Smart phones v reading benefits

books	and I make sure I've got physical books rather than reading on a kindle.. and I know people who have loved reading and have loved a kindle but I think for now I need the physical.. I need the physical books so I'm forcing myself to get back into reading.. R- What do you like to read? P- oh my gosh it can be anything really any sort of self help, I've been reading about the menstrual cycle, um there's another great one I've read several times called Man Versus Toddler, its so funny, the father wrote one originally called Dummy, about a man um dealing with baby and its now just toddler and its just laugh out loud and it makes you go oh just toddlers are such little ass holes. R- Sense of humor? Sense of humor is helping? P- Yes and um stand up comedy, I used to watch a lot of stand up comedy and um audio books, novels as well, My Not So Perfect Life, um sun lounger reading. R- so what's your inspiration, what keeps you going… in a way you have said its M, in the way that you said you are protecting him?	Humor
Self talk Timing	P- Well um that.. um … It will, um it will it will get better I just keep telling myself it will get better, it will get better..	Self-talk and time
Being your own friend	R- Self talk? P- I just keep going through what I would be telling a friend, um I'm listening to happy things just trying to be practical and doing the leg work, going to the gym, yoga, reading, that all the people say you need to be doing, a healthy diet, getting out for fresh air, listening to happy things, just do all the stuff that people tell you to do. I'm listening to an audio book aswell called how to live Danishly, a woman had to move to Denmark and its supposed to be the happiest country in the world and she goes through how to live Danishly, things she's noticed, um and everyone she interviews she asks them how happy they are and the lowest she gets is an 8. Um you know people are like oh I'm a nine or a ten, you know all these Danes are happy its really good I'm listening to that at the moment.	Being your own friend
Self care Understanding what it is and when to do it	R- What makes them happy? P- um there is hygge, hygge is a style a comfort, lighting candles, warm blankets, having friends round, having cuddly evenings.. R- Nurturing yourself? P- Nurturing, hygge would be hot chocolate or a glass of wine, cookies, a warm jumper, they are involved in a lot of clubs, activities, work life balance. On average Danes work 18 days a month	Self care- understanding what it is, how we do look after ourselves, has everyone got this knowledge?

Resilience picking your self up and trying again	and not much more that a 30 hour week and you know for Danes, if they are in the office after everyone else has gone home, its well why aren't you being more productive with your time, if you are productive you can finish at half past two like everyone else and go home. Its not about beating themselves up, being seen to be there its about um well looking after yourself and … its really really good I'm really enjoying it its truly interesting. R- So looking back on your past experiences of coping what do you think looking back you would recognise as a coping strategy, it could be a good thing or a bad thing? P- What I did or wished I had done? R- Either, I think its quite interesting looking back it might be something that is not viewed positively but is part of our trying to cope, I mean even Bulimia, I don't know much about Bulimia but I imagine that its part of a person trying to cope with what's going on inside? P- um (long pause) um my relationship with my husband wasn't very good at the time, um I wish I'd… I wish I'd addressed that, to help and um possibly gone back to work sooner so that I'd have had money and um could have paid for a bit more me time, um so yes I'd have paid some money for him to go to a child-minder so I could get my yoga in so I could have helped myself more. Um I would say not relied on other people as much not that I.. not that..(pause) What do you see as your positive coping strategies? P- um That even when I'm at the very bottom I will still try and pick myself up, I will still try and tick off the things that I know are going to help, still getting a training session in, still drag myself off to a yoga class, even though I don't want to, when I'm there I might hate it, and after I finish I might not like it, but I've got the chemicals, the feel good chemicals in my body, firing so I know it is going to help. R- So you have got quite a strong will really, you like to be healthy, maybe that thought of being healthy is a real motivator for you? P- Yes Yes I've done it before, I just think I just want to enjoy life again so I am working really hard at doing as much as I can to enjoy life again really and having the stand up comedy the funny audio books ready to go so I can put them in so I force myself to listen to them to get.. to find… to pull out a laugh or something, yes I am pretty strong willed. R- Is there anything you'd say to other mothers on the back of your experiences? P- (sighs) God to try and help? Um (pause) I don't	This was avoided too hard? Personal relationship difficulties Reflecting on what works Resilience- picking your self up and trying again Understanding things that can help Knowledge of brain and mental health The work of mental health Wanting to enjoy life again Humor

	know for me comedy is a massive thing it was on my birth plan that I wanted to when I was in labour that I would have access to stand up comedy um (pause) ask for help, find a mothers group, but I didn't because its not for everyone really, (laughs) (pause) um (slower pace, thinking) try and.. get a part time job or some way of making money, and I know a lot of people say that the benefits that they get .. its not worth… its not worth it because the government will give you the money, by the time you've paid for child care you are not getting any money back, but just to try and get your own identity… R- Funnily enough another mum said to me she had to completely re-build her identity after having a baby and maybe we…we don't really talk about that really P- I yes um I think yes trying to get some kind of part time job, even if when you are working the money is paying for the child in crèche or something you are just breaking even but you are getting away from baby it gives you for me work it gives you a break. R- some people really need that don't they P- Yes I know I did, I should have gone back to work sooner, really, it would have made me stronger.. R- Your instinct was telling you to go back but other things were stopping you P- yes it was only after two months.. R- do we listen to our instincts enough? P- No I was just reading those… you wont get this time back, and this time is so precious and everything and I should have gone back to work, maybe three days a week and I should.. I should have have insisted that my husband helped and if he wasn't going to then I needed to know, am I doing this on my own or if you're not helping, we are not doing this as a team we need to…. just stand your ground, look after yourself. For some reason I keep saying you can't pour from an empty cup, I never use that term really I read it a lot um yes I should have gone back to work sooner and insisted… so then I'd have had money and I'd have been working as well so I wasn't just yes I wish I'd got the balance back sooner, and I think that would have helped my mentality..my mentality… my state of mind aswell I deserve my space in the world.. R- yes yes and I mean it sounds like its been pretty tough for you and all credit to you isn't it for getting through that P- (laughs) It broke me on the way but yes I'm fine, I got there, I'm still here so.. yes	Work, having a break, different stresses, a break from what? Baby or anxieties around keeping a baby alive, the responsibilities? Realisation Self empowerment, Self belief, Respecting rights of self as well as others "I deserve my space in the world too" Pivotal thinking Being broken

Recognition of own achievements	R- Thinking in terms of what you would like to pass on to him now in terms of coping and resilience from everything you've been through and learnt from, what would you like to pass on to your son? P- erm I want him to erm to know that he is not responsible for other peoples emotions, um I want him to stand strong and have his space in the world, um to be sensitive but be um (pause) not let people walk over him really to um yes be strong and fair..and um.. R- I really like that not be responsible for other peoples emotions and that feels like something that you have suffered from, people trying to impose responsibility for their own emotions on you.. P- I absorb other peoples emotions too much and um I don't want M doing that, I want him to be supportive but he doesn't have to take them on, they don't need to weigh down on his shoulders. Um and I think the way that his personality is now, he's… I'm really proud of how he's coming on.. R- how do you help him with that do you think? P- um (pause) if he, if he falls I um he's oops a daisy he a tough little cookie but if he's upset I try to say 'show me what's upsetting you' or.. R- Spending time recognising his feelings? P- Yes recognising his feelings, not trying to brush them off and say 'come on now up you get' um but just to 'I know you want to sit down and watch the ipad and that would be lovely but we need to do this and then .." just trying to say come on, I know its… understanding and showing that I understand his emotions. Um and not trying to suppress them and try and create and be um and see empathy.. yes empathy I suppose… R- Anything else that you would like to tell me about your experiences of being a mum? P- um god it's the hardest job in the world isn't it, it is really really hard, um R- It's the most important job in the world.. P- its I don't.. there's the balance between people saying I don't want to scare young mothers off, you don't know how hard it is until you… you have no idea until you are a mother. I wish there was a way you could give people an insight into it.. R- I sometimes wonder.. I don't think our culture supports mothers very well P- No not at all I've been reading about um how different cultures… about how .. in some countries the mother isn't allowed to leave the house… R- For 40 days.. P- Yes and she isn't allowed make any of her own cooking, do any of her own cooking, that baby is	We are not responsible for other peoples emotions Insight from adversity? Helping the child's emotional development insight Acknowledging own achievements Helping emotional understanding, intelligence, resilience of child Creating empathy in child "really really hard" Parenting description Informing others

How we treat mothers in the UK	looked after by the family and the mother is allowed to let her body heal properly.. R- we don't even do that do we P- no people are .. and the mentality of even my best friend was like 'I'm not going to let this change me' I'd like people to be a bit kinder… sorry I'm not finishing my sentences… um there is so much pressure on women, to be back up on their feet, and you see women carrying their babies out in slings and their babies are two days old and … just be mindful of other people and not every ones going to be having a great time of it really I don't know just keep your self to your self.. My husband had two weeks off paternity, he slept for most of it and would go out to the gym, um they just have no idea, there should be some serious work shops out there for men, for partners because you have stitches or c section and you need to be .. that woman on instagram says 'pull up the draw bridge' and just look after your self. You don't need to be traipsing around… when we got back from hospital, my sister in law and my niece and my husbands grandmother were at the doorstep and ahh it was terrible, every one just wanted to be there I didn't know my ass from my elbow really. Women should be just put on a massive pedestal after everything they have gone through, and um if people aren't coming over to clean, bring food, or help with the baby then you are not entitled to be there. I know that's harsh but that's how it should be when a woman' s had a baby, because women just push through and battle on because you think that's what everyone else is doing and you think that's what I should be doing being the bottom of the pile, you know women are cracking and imagine when women are having babies I find that women are already working the hardest they can, they are already at full capacity, between work and being expected to be this person and be that person and then you have a baby on top of that and its just oh my god you know, so yes that motherhood yes.. R Thank you so much that's been amazing you have so much to offer with your insight, I can see who you are, you just need to re-discover that person.	Are we kind to mothers in our society? Social expectations of mothers and mothering How husbands/partners support and understand the needs of mothers Social support overkill whose need is it anyway? Social respect for motherhood What women do Push to the limits More household duties Can we have it all no probably not This says it all really we are in trouble
Women and pushing to the limits		

Appendix m. Phase one study- Initial case study approach moving on to initial cross case analysis between two cases.

Ava is 28 years old, and is married with a one child a boy (M) aged 22 months. The interview was conducted virtually at an arranged time, whilst the participant was at home: this was due to the geographical distance between researcher and participant. Ava experienced the birth of her child as traumatic; there was significant concern over the baby's falling heart rate prior to the birth, a forceps delivery followed, and subsequently a post partum haemorrhage. Following the birth Ava was only able to have a brief cuddle with her baby prior to being taken to the operating theatres for complex suturing, she communicates a frightening picture of her birth experience in this extract, with multiple adverse factors.

> *his heart rate kept dropping, um so I ended up having forceps, and then, which turned into a third degree tear, and like I said they weren't sure if it had gone into my bowel, um but they couldn't stop me bleeding, um and they couldn't sew me up in the delivery room, so they had to send me straight off so I think I got a ten second cuddle* (p.9).

Ava supplies a list of events in quick succession; there is a feeling of nothing being within Ava's control here she is a passive participant in events that include separation from her baby immediately after the birth.

Becoming a mother for Ava did not match her expectations and her assumptions about what she would be like as a mother, did not materialize in reality.

> *I thought I'd be that mum, who would be so laid back, can do everything, when actually, I couldn't* (Ava, p. 2)

Ava describes being aware of the possibility of post-natal depression, but had no idea of the intensity of feeling she would experience.

> *and then hit day three or four for me was like hitting rock bottom* (Ava, p.2).

The phrase 'hitting rock bottom" communicates a level of pain and distress that are hard for Ava to bear. The emotional intensity of her experiences appears overwhelming and confusing for her.

> *I felt horrendous guilt, erm M might be lying on the carpet having a lovely play on his play mat, and I want to get up and go and make a brew, he's absolutely fine he's enjoying himself, but I didn't dare leave the room.* (Ava, p.4).

The emotion described as guilt could indicate that Ava feels that she has compromised her own standards in some respect, it is painful and "horrendous" (Ava, p.4) to her. Ava describes very high levels of anxiety, which appear to be traumatic in themselves.

> *even if he was asleep in his Moses basket I'd sit next to it watching, I wouldn't go for a wee, I'd hold it and hold it and hold it, do you know what I mean?* (Ava, p.4).

Ava's use of the word "watching" has the implication of careful protective observation; she is unable to leave the baby unwatched, through "watching" she is offering her baby protection. It is fearful though and Ava is unable to attend to her own basic needs.

Ava found that returning to work was helpful for her and was supportive of her coping abilities; she particularly references the adult social support that she was able to access at work.

> *going back to work, probably saved me a little bit, I was ready, I was ready for that little bit of adult and (pause) yes adult conversation and company* (Ava, p.8).

Work gave Ava a sense of having a break from motherhood, as she struggled,

unable to understand how her mind was endeavoring to cope with experiences that are disorganising for her. Ava describes the change for her where she can look forward to picking M up from nursery.

> *I was ready for that break and I think it's nice to be at work in the day, excited to pick M up from nursery and see him, so I think that's definitely changed our good and bad days* (Ava, p.8).

The balance between good and bad days was tipped positively by this change. One thing that Ava found unhelpful from supportive adults was the attempts to take the baby away rather than offer practical help.

> *a lot of the time people came round just for cuddles and actually never picked the hover up for me* (Ava, p.12)

At times other people taking the baby away was perceived as predominantly distressing, describing a time early on Ava is aware that her husband can not understand the way she is feeling.

> *I just cried at anything, and mother and father in law popped round and I had M and somebody made a cup of tea and I just literally sat there in silence with M on me and normally you'd think she's going to hand the baby over at some point, but I physically couldn't let him go that night. And H (husband) was so cross with me once they left cause they came round obviously to see M nobody else because that's what people do that early on, and H seemed, was, so cross with me after cause I just couldn't let him go* (Ava, p.8).

Ava is unable to get a sense of coherence for herself; her world is not manageable at this moment. She is unable to speak or engage with the normal social interactions that are expected of her and her husband is unable to understand what she is going through at that moment. Ava feels that her visitors are really only there to see the baby and not her; but she feels unsafe and this sense of lack of safety extends to the baby. Only she is able to keep her baby safe, you can sense the birth experience of danger to herself and the baby coming through her narrative.

> *I just couldn't hand him over, like at all and it was almost like um like a safety thing like, only I can keep him safe right now… If I hand him over something is going to happen…(*Ava, p.8).

There is a sense of unease and fearfulness again for Ava and she is clinging on for survival, she is coping in her own way with deep and disturbing feelings of lack of safety.

Ava describes receiving advise from others and how it affected her, sometimes making her question her ability and parenting decisions.

> *I think I'd be doing something and they would be like ooh what are you doing? And I'd be right what am I doing wrong, and I would change my ways* (Ava, p.10).

Ava interprets the question "what are you doing" as she is doing something wrong, she feels that she is doing something wrong and indeed this may have been the intention of the speaker. Later she describes a particular experience of being given advice.

> *and I just remember feeling so belittled by her, her advice which wasn't necessary…..it really upset me because I thought, am I doing it wrong, is this what she told me to do?….. I just remember that being really, really undermining, and not what was best for me and my baby at that time…. now things… I just think I'm doing it my way, I've got that strong minded, if someone was to turn round and say that to me now I'd be like no that's my way* (Ava, p.15).

Ava reinforces her feeling of being undermined by repeating "really" twice and is able to reflect and recognise that it was not what was best for her and her baby. She is able to use the experience later as a point of resilience, she learns through the negative experiences to re-build confidence in her decision-making and be able to say what her own preference is, developing her coping from passivity and confusion to becoming more self reliant and assertive.

Ava's midwife suggested that she see the GP for medication for her acknowledged depression, but Ava does not want to, she attempts to be in control of her mental health herself by working around the problem.

> *that's not my answer. My answer is trying to control it, work round it, completely* (Ava, p.3).

Ava hopes that she can help herself and take control of her mental health; she acts proactively and describes attending classes and the supportive networks that she builds through attending them. She feels strongly that they are helpful, enough to recommend them to other mothers and describes the benefits for her of social referencing.

> *Definitely classes, anyone in my area, I will write down every single class that I went to, and pass it over to them, because you meet new mums, you are hearing their stories, you are seeing their babies develop at the same time as yours, not that you compare but you just see the developments from one baby to another. I'm still in touch with quite a lot of mums that I met at kind of classes* (Ava, p.3).

The growth of her sense of agency, enabling her to reach out and offer support to other mothers. The mothers are also able to offer support to each other at times that the outside world may not be available, when she is up at night feeding her baby.

> *those friends who message, at silly o'clock, they see you are on WhatsApp or anything like that and they message you, well I can see you're up, hope you're ok* (Ava, p.3).

Other support structures that Ava feels have helped her adapt to motherhood include family networks. However she expresses some difficulties in asking for the help that she needs and ambivalence about the help when she receives it.

> *yes don't get me wrong if I had said to them please will you do this for me, they would, but its harder to ask…….*
> *Some days I would say yes it made me feel cared for but other days I'd think, why*

can't I do this myself, why do.. why am I getting help, I don't need that..I can do it.. (Ava, p.15).

The help can be perceived as undermining or judgmental of her abilities to cope, Ava is sensitive to the nuance of unspoken and unexpressed dialogue that she explicates from the acts of help that she does or does not receive. A sort of unspoken internal dialogue, that coats her coping needs.

Ava describes the lack of sleep as affecting her ability to have a good day, her tiredness affects her mood and her ability to cope the next day and look after the baby.

I think it all depends on my mood for some reason, whether I've had a rough nights sleep and am overtired (Ava, p.8).

Ava recognises the importance for her of having time to be herself, on her own. This is a break but appears to be more than that for Ava; it presents as recognition of her personhood outside of being a mother, the need to be alone for a few moments, to be who she is, a gift of time for herself.

I think its just giving yourself an hour even half an hour, 20 minutes, to sit and just be with yourself or have a long shower or go into the conservatory and have a cup of tea on my own (Ava, p.4).

Ava initially cites giving her self an "hour", this is reduced to "half an hour" then "20 minutes"; there are thought processes behind this reduction, possibly the practical demands of parenting may not allow a whole hour, but even 20 minutes could be enough time to benefit from being "on my own" (Ava, p.4). A separate person, alone for a few precious moments, seeking her alone identity?

Although at times Ava needs to be on her own and be separate, Ava see's her

baby as a source of strength, she see's it as an achievement that they are tied together in relationship and that she can not now imagine life without him.

> *that realisation of, that I've made this human, he's mine, that realisation of I didn't, I couldn't imagine what life was like without him again* (Ava, p.13).

Her baby is her reason to cope and that life is unimaginable without him. Ava is aware that she has found ways to cope and this is important and helpful to her.

> *realising that I can cope, and taking that step back and saying that it's ok* (Ava, p.14).

The knowledge that she has coped through difficult, frightening and challenging experiences becomes a source of strength and resilience for her.
Ava describes her ability to be open about her struggles.

> *I was always very open, I'd sit there and go right I'm going to cry now, and I'd cry about crying or I'd feel emotional about feeling emotional. Um or I'd feel anxious about feeling happy, or anxious about feeling sad* (Ava, p.16).

Ava describes heightened emotions that frighten and frustrate her, but she finds comfort at times in being able to tell others about how she is feeling. On one occasion she receives a message of support from a family member that she finds validating and supportive. The message read-

> *its ok not to be ok, but also its ok to tell people, um all the time that you are not ok text them every day, if they message you, you ok, don't lie don't say you are when you are not* (Ava, p.16).

This message is specific, it instructs, don't cover up how you are feeling but also acknowledges that it can be hard to say "every day" that you are not ok. There can be pressure from other people to not be burdened with unhappiness and pretend you are

well when you are not. Ava values this and describes how she wants to pass this on to her son, she is able to recognise this as a point of resiliency and a form of coping that could help her son.

> *definitely I would like to pass on to M that it's ok not to be ok, if there is any point that you need something, or need some help, it's ok* (Ava, p.16).

Ava has been able to move forward from her earlier ambivalent feelings about asking for and receiving help. She is able to be reflective, identifying that the ability to ask for help will be an important skill for her son's coping abilities. She displays protective feelings for her son and there is a beginning of a feeling of coping together for her, as a dyad with her son.

Cross case analysis of the first two interviews

The second participant is Beth, she is 27, married with a little girl (F) aged 18 months. Beth has a history of trauma describing being abandoned by her own mother when she was three; she received a diagnosis of pre-natal depression and post-natal depression. Beth relates how she feels about her expectations of being a mother and her feelings that motherhood is "relentless"(p.2); the word brings connotations of something that is harsh and unforgiving.

> *I don't think there is one single person that can say it was exactly what they thought it was going to be, because I think it was unbelievably relentless* (Beth, p.2).

Beth describes her negative feelings about motherhood that are hard to hear, but she wants to be heard, she emphasises the depth of her feelings by using repetition of "ever".

> *I think that…some of the pressure that I put on myself as a new mum was that I never ever ever wanted to do that, but I completely resented being a mum for a long time, I just did not enjoy it at all, it felt like I'd just made the biggest mistake of my life…(*Beth, p.7).

Beth articulates a physical reality of motherhood for her and how much she needed help.

> *I'd be in that absolute time of need, covered in breast milk, just in yesterday's clothes, and you know desperate for someone to help me* (Beth, p.1).

There is a feeling that she can not believe that she has a daughter with levels of disassociation that are possibly avoidant defensive forms of coping.

> *it took me about eight months to really come to terms with the fact that I had my daughter, and she was mine because I didn't feel like I deserved her* (Beth, p.2).

Deserving your child is a somewhat strange concept, but maybe a more common one for mothers, but not talked of; it denotes a sense of low self-esteem possibly and feelings of being unworthy at this point in Beth's narrative.

The struggle is enveloping her mentally, physically and emotionally, Beth differentiates between the physical and mental struggle identifying that the thing that is hardest for her is losing her sense of her own identity. Like Ava she finds it a struggle to maintain an identity outside of motherhood, but goes further and feels that she looses who she was and has to start again.

> *looking after the child is the easy bit, It's losing yourself* (Beth, p.3).

Later she expands on this, while still emphasizing the sense of loss of herself as a person.

> *you have to re-invent yourself, you have to say goodbye to the person that you were before, completely and then re-build your life* (Beth, p.15).

For Ava is feels more of a transition, or a cumulative identity, she expresses a sense of growth rather than a loss.

> *it was almost like the next level up, adulthood, and the realisation of the responsibilities that you have with having a child* (Ava, p.2).

The word "responsibilities" does not appear to be negative in this context, but rather a recognition of a fact. However there is a feeling of growth for Beth from being a mother.

> *I think that's just part of being a mother that I've just learnt to be more resistant, more flexible, more patient* (Beth, p.12).

She is developing in ways that she would not have if she was not a mother.
Both mothers experience overwhelming emotions, Beth here describes 'guilt' which resonates with Ava's previous description of "horrendous guilt" (Ava, p.4).

> *I just felt complete guilt every time that I couldn't do something, and some thing stupid like remembering to drink a glass of water (distressed voice) because I didn't have the time to do it and (sniffs) I just felt completely overwhelmed all of the time and it was really really difficult* (Beth, p.7).

Beth experiences traumatic and violent emotions towards her child that lead to her seeking therapeutic support. It is distressing to relate them but Beth was clear that she felt others needed to know that the reality of being a mother was not the idealized concepts that she felt were often shared. In this way she uses her experience to help others and this cognitive restructuring is a form of coping for her; she wants others to know that they are not alone.

> *I went to an IAPT (Improving Access to Psychological Therapies) service em and I remember saying to the woman, and I remember feeling at the time, that I hadn't told anyone but I wanted to pick her up and smash her against the wall most days, and it's not because I hated her, it's just cause, I had a… I was feeling really horrible, and I wanted to disappear constantly. It makes me upset now but at the time it just seemed logical to just run away or hurt her...(*Beth, p.6).

Beth recognises that she has been placed "at the bottom of the pile" (Beth, p.7) and identifies a turning point for her when she starts being able to attend to some of her

own needs for “time” to herself. Like Ava this has the feel of a ‘gift’ as she phrases it “allowed myself to have”.

> *There was a turning point erm and I started swimming, I started getting into a routine, I put my daughter into nursery when she was 11 months old and I started swimming and painting actually, and I just allowed myself to have, I think it was something like four hours a week where I did nothing* (Beth, p.5).

It it’s a massive step forward for Beth as she allows herself time to do things for herself, but we can question why she still calls it nothing, in some ways does she still feel that doing something for herself is nothing. Who is valuing this for her if she isn’t? Nevertheless it is a start for her of active coping strategies that can support her mental health and well-being.

Like Ava, Beth finds comfort in mastery; she identifies that practical concerns when dealt with will make you feel better, this demonstrates a form of problem-solving coping with insightful emotionally focused coping.

> *If you’ve got someone saying ‘oh you need to get out the house’ or you need to do something’ it’s like ‘no actually, I need to sort my life out, because I’ve got all these things that I used to be able to do before I had a child, and I can do them and know that I can do them, when I’ve done then I will feel much better about it* (Beth, p.13).

Beth gives real solid practical coping advice here, organization, being realistic, achievable goals that will make her feel better, more in control; she demonstrates strategizing, planning, and action that will give her a sense of mastery.

> *I think that being organised is one of the key things, but soft organisation, like being realistic about the amount of tasks that you can get done in one day, and you know, even if its just one thing, like if you need to get the shopping, on any day of the week, plan that one day and make that your one task for the day* (Beth, p.13).

Beth speaks a lot about her support structures of her partner, female support network and family, groups; the nested support structures are evident as in Ava's story. Beth articulates what makes her feel that her partner is supportive to her.

> *even though I am going through a hard time I've still got somebody that just accepts me for who I am and whatever happens you know that underneath it all, that its ok, he's still going to be there for me* (Beth, p.10).

The feeling of acceptance and not being judged is vitally important for Beth to feel supported by him.

The things that are supportive are similar to Ava, Beth gives examples of practical things.

> *Allowed me to have a shower, (laughs) maybe watched her whilst she slept* (Beth, p.10).

Beth conveys a sense that one of the reasons that she copes is because she has to protect her child.

> *I mean that I, I can't hurt my child, I wont do it, I have to carry on, cause I'm the only one that can be her mum* (Beth, p.11).

This statement is absolutely full of meaning, Beth places boundaries on herself and on her own behaviour, she understands that she is her child's only mother and this is helpful to her to carry on when she is finding it hard.

Beth appears to be able to say easily what her coping mechanisms are, she has a large number and variety, here she lists a few and has a sense of humor looking at life from the baby's perspective; what will bother the baby or not rather than what is expected or socially acceptable.

> *eating the right food eventually, not eating so much damn cake, I used to eat so much, um napping is essential as a mother I think, being organised, knowing that it's ok to keep your baby in a baby grow all day, you don't have to get them dressed, they don't care (laughs)* (Beth, p.13).

These very practical coping skills incorporate self-soothing emotional coping in the eating cake, which develops into a healthier recognition of the need to eat well.

Beth also acknowledges her need for sleep and is able to say it confidently as a need for all mothers, demonstrating a developing knowledge of legitimacy of needs; in its way this is a cognitive re-structuring for her. The last one is prioritising, Beth is able to see that her baby doesn't mind wearing a baby grow all day and if this helps their day go a bit more easily, it's a good thing, she is finding new options, new ways of coping in her own way.

> *if you are having a hard time, when you've recognised that you are having a bad time, stop putting pressure on your self, just concentrate on one thing at a time, and prioritise* (Beth, p.13).

This extract is an example of emotional coping, the recognition that she needs to stop putting pressure on herself, especially because she is struggling. In this next extract Beth describes the use of cognitive self talk, where she is able to contextualize her situation and understand that it is time limited and will not last for ever.

> *I used to just repeat things to myself in my head, you know like 'it's not going to be for ever'* (Beth, p.11).

Beth has a large repertoire of coping strategies by the time of the interview when her child is eighteen months old. She does not perceive these as coming from her experiences of adversity when asked "what ways of coping came out of your past

experience of coping with difficulties" she replies "Absolutely none, none no"(p.12). However at another point she can see a connection.

> *it was the dread from my own experience of being a child that drives me as well to be better* (Beth, p.11).

However with Ava you get a sense that her developing confidence in her general ability to cope is more important that her specific coping strategies.

> *I think being confident in your coping mechanisms of knowing what's best for you* (Ava, p.15).

In "knowing" Ava (p.15) communicates an awareness of her self-knowledge and that this is important and helpful for her.

Both Mothers undergo adversity in their early experiences of motherhood, Beth's experiences in some ways are more extreme and the help she receives from professional support services are more complex. It is interesting that Beth subsequently develops a large repertoire of coping skills of which she appears to be cognisant, having knowledge and awareness of these to the point that they appear to be fairly easily brought to mind and expressed. Ava appears in some ways less able to identify her coping strategies as readily, but they are definitely there and are wide reaching.

Appendix n. Participant feedback letter- draft

Participant feed back from study-

Understanding the lived experience of mother's coping mechanisms in the face of mental illness: An interpretative phenomenological analysis.

Dear Participant,

The study was conducted in three phases and the results were written up in individual themes for each study. All names and identifying factors have been changed or omitted so that participants cannot be identified.

Phase one study

Theme one- Mothers' lived experience of coping
Theme two- Learning the importance of self-care
Theme three- Losing selfhood: Reclaiming selfhood
Theme four- Identifying effective support
Theme five- Passing on coping

Phase two study

Follow-up interviews with the phase one mothers

Theme six- Being open and honest and asking for help
Theme seven- Maintaining self care needs and identity
Theme eight- Children as motivators
Theme nine- Rebalancing through Covid-19 lockdown

Phase three study

Theme ten- Things not spoken about
Theme eleven- The importance of nested support structures
Theme twelve- Owning mental health
Theme thirteen- Learning through experience and adversity
Theme fourteen- Co-parenting and mental health

The summary of the study results are as follows. I can send a link to the whole thesis at a later date for anyone that would like more detailed access.

Summary of study findings

This study was able to give voice to women's lived experiences of coping with motherhood and mental ill-health.

11. Coping was in many instances a very practical affair for the mothers, tending towards soft-organisational strategies with a sense of needing to achieve mastery and a sense of coherence in terms of 'my life is manageable'.
12. Mother's emotional coping strategies predominantly featured self-talk with the mothers using rationalising self-encouragement to support their emotions, "It's not going to be forever" (Beth, p.11). The mothers described aspects of emotional self- regulation such as "riding the wave" (Chloe, p.21), and "just walking away sometimes" (Beth, p.11). Other forms of emotional coping included support seeking; however the vulnerability the mothers felt in seeking support was poignant and can be considered critical for service planners to take into account.
13. There was an emerging significance for the mothers in being able to have a sense of their own mental health, when the mothers were able to recognise the significance of how they were feeling, they could move on to an acceptance which was enabling to the process of taking back control.
14. There was a strong theme of experiencing a journey in motherhood which contained elements of self-neglect, as the mothers prioritised their infant's needs above their own leading to feelings of being "bottom of the pile" (Dawn, p.23), to one of self-realisation that they were unable to function in a balanced way without the ability to meet some of their own basic needs.
15. For some mothers there was a feeling of the loss of self as they transitioned from pre-motherhood to the incorporation of children into concepts of self, with the additional complexity of mental ill-health which can also involve a loss of self in some respects, "I've lost who I was" (Dawn, p.8). However motherhood could also transform identity in a positive way, creating a sense of meaning and connection, providing a healthy life focus and a sense of normality in every day life, creating meaning particularly outside of mental illness, "it made me feel I had a purpose" (Faye, p.3).
16. The mothers demonstrated protective instincts towards their children, which were partly based on their own experiences of adversity. They all demonstrated a desire to pass on 'coping' to their children. The range of coping skills and strategies that that the

mothers tried to pass on was intrinsically linked to their own skills and abilities. The coping skills and strategies that they themselves have found to be successful are the things that they felt confident to pass on.

17. The mothers were able to identify effective support that for them was inclusive of encouragement, thoughtfulness, checking in behaviours, feeling accepted and believed in, not feeling judged and a sense of holding of their difficult emotions. Practical support was valued and included things that supported day-to-day living, such as cooking, washing, shopping, cleaning and supporting parental sleep deprivation. The ability to seek support from intimate and wider sources creates the structure of nested support, which can provide a safety net in terms of effective support.
18. There is a bi-directional coping relationship between mother and child, which create a coping dyad. The literature suggests that mothers are typically highly motivated to care for their infants with hormonal factors at play. Maternal infant co-regulation is created by both participants of the dyad, infants also support their mothers coping with behaviours such as smiling "she'll turn around and smile and that's enough sometimes just to get through" (Faye, p.19). The mothers are also able to be inspired by their children's developing personalities, some mothers described finding the ability of their children to live in the moment, the ability to not hold on to sadness and be happy in the moment. The mothers demonstrate a joy and fascination in their children that is able to support their parenting.
19. When considering the phenomenon of coping, it is clear that lived experience of not coping is difficult and sorrowful "and I had a really bad day, everything just made me cry" (Ava, p.8). Where as coping is a kinder more uplifting experience "I've achieved something and also I'm not overwhelmed, you know that's a big achievement (Faye, p. 19). Having a sense of coherence seems integral to coping, my life is understandable, my life is meaningful, my life is manageable.
20. In terms of planning for health and social care practice, supporting coping skills by building on existing strengths makes sense. Recognising that individuals are unique and have potential for strength and competence can offer a self-compassionate stance that can take account of individual vulnerabilities and coping choices. Being aware of and caring towards the suffering of the self can support the use of more positive coping styles including emotion focused and problem focused coping, and an increase in coping self-efficacy.

The contribution of the participant mothers in this study has been greatly appreciated and we hope that the study honors your contribution. The study is in the final stages of editing now so will be submitted later this year, some elements will be submitted for publication with the intention of supporting service provision for mothers who have mental ill-health.

If you have any further questions or comments please let me know,

Thank you so very much,

[redacted]

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