Portfolio volume 1: Major Research Project

Mothers' Decision-Making About Medication for Mental Health Difficulties: A Grounded Theory Study

Volume 1

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Abstract

Aims: This Grounded Theory study aimed to capture the social processes involved in mothers' decision-making around psychotropic medication.

Method: Semi-structured interviews were conducted with 15 participants who were mothers who had been prescribed medication for mental distress when they had children below the age of 18 living with them.

Results: Analysis via Grounded Theory found three processes informing medication use: *Managing Conflicting Identities*, *Balancing Needs*, and *Seeking Integrated Care*. Categories and subcategories capture how mothers tried to manage the conflicting identities of the perfect mother who copes and the stigmatised identity of medication user; how they made decisions around medication that allowed them to balance their own needs with the needs of their children; and how they sought collaborative care from professionals, and wanted their mothering taken into account in medication consultations. The study joins a growing body of research on the psychosocial motivations for medication decision-making, and demonstrates that mothering contributes complex relational and identity factors, including a consideration of the needs of potential future children.

Implications: Recommendations are made about how maternal and mental health professionals might better meet mothers' needs, including understanding their concerns about stigma and identity, the relational nature of their decision-making about medication, and the way they take desired future children into account in their medication decisions. Suggestions are made for future research with more diverse samples.

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1 Introduction

1.1 Overview

My research explores mothers' decision-making about medication for mental health difficulties. The introduction will start with an explanation of my epistemological position and reasons for undertaking this study, and introduce the terminology used in it. I will then give an overview of the current status of medication for mental health difficulties and the clinical guidelines regarding it. This will be followed by a summary of the qualitative research on users' experience of psychiatric medication.

I will then examine the specific issues that face mothers in relation to psychiatric medication. The findings of a metasynthesis of qualitative research containing insights into mothers' experience of medication will be summarised, before the introduction concludes with the research aims of the current study.

1.1.1 Epistemological position

I have a critical, social constructionist stance towards social and psychological knowledge, believing it is discursively shaped and historically contingent and can be used to further the interests of the powerful (Burr, 2003; Gergen, 1996). I have a particular interest in how this (and denial of it) shapes the lives both of women and those experiencing mental distress. I believe that the social and political causes of mental distress are obscured by the current diagnostic system, explored further in section 1.1.3 below, and that psychosocial explanations of distress should be prioritised in research and treatment, including the operation of power in people's lives, as outlined in the Power Threat Meaning Framework (Johnstone & Boyle, 2018).

However, although my critical perspective on diagnosis and medication inevitably informs this study, and some challenges for me around this are explored in Appendix Q, I am interested in this piece of research in understanding mothers' own views of medication and the social processes that inform their decision-making around it.

I am a mother myself and have a prior academic and clinical interest in mothering.[1] While realising that a research focus on mothers can perpetuate a cultural stereotype of the mother as primary parent, also explored in section 2.8, I am concerned by the psychosocial pressures placed on women who parent currently, which can be detrimental to their mental health (Johnstone & Boyle, 2018), and interested by recent arguments that the experience of motherhood produces a particular form of subjectivity (Baraitser, 2008).

Despite a commitment to social justice and interrogations of my assumptions, I am middle class and white, and aware that this leads to blind spots in my perception of social issues and power differentials. Some steps taken to mitigate these are explored in Section 2.8, and the subject is also returned to in the Limitations section.

1.1.2 Terminology used in this study

I have chosen to refer to the research in the first person throughout (for example, 'my research'), in acknowledgement of the influence of my own intellectual and cultural assumptions on the findings, and my belief that no research is neutral or uninflected by the researcher's own stance.

Because of my views on the medical model, instead of the terminology of disorders, I will use the terms 'mental distress' or 'difficulty', as recommended by the Division of Clinical Psychology (2015) and preferred by some service users (Beresford, Nettle, & Perring, 2010). I have put psychiatric diagnoses in inverted commas, except when terms used can also be understood in a lay sense, such as depression and anxiety. I use 'intervention' rather than treatment, as recommended by Cromby, J., Harper, D., Reavey (2013), given the latter's association with medication treatment.

Because the concept of a 'side effect' as distinct from a medication effect is problematic (Moncrieff, 2008), I have placed 'side effect' in inverted commas

1 I completed my masters research on mothers' experience of early puberty in their daughters and am currently doing a specialist third year placement in a mother and baby unit.

throughout except when quoting the participants' own words. For brevity I will shorten psychiatric medication to medication throughout unless otherwise specified.[2] Where medications are named for their targeting of psychiatric disorders (for example, antidepressant), it would be consistent to place them in inverted commas, or use a generic term, but a decision was made not to do this, but rather to use the common terminology, partly for simplicity's sake and partly because different types of medication, even if they don't target disease, often have different drug actions.

1.1.3 The medical model of distress and psychiatric medication

There have long been competing understandings of the causes of mental distress, and of interventions that might reduce it. An in-depth consideration of the historical complexities is beyond the bounds of this study, but in the west today understandings of distress fall broadly into those which emphasise psychosocial factors and those which take a more biological approach. Psychosocial understandings might emphasise the role of the early relational environment, as in psychoanalytic theory (Fairbairn, 1952), or the role of the social and economic environment – the latter supported by correlations between distress and adverse experiences (Hughes, Bellis, Hardcastle, Sethi, Butchart, Mikton et al, 2017), poverty (Elliot, 2016) and inequality (Pickett & Wilkinson, 2010). More recent approaches have combined these factors – as well as innate biological responses – in an understanding of distress which focuses around a response to the threats paused by different forms of power (Johnstone & Boyle, 2018). By contrast, the medical model of distress, arguably the most dominant at present, models its understanding of forms of psychological distress on physiological diseases, seeing experiences of distress as symptoms indicating underlying disorders, as captured in its system of psychiatric diagnoses (World Health Organisation, 2018; American Psychiatric Association, 2013).

2 Some argue for the use of the term 'psychiatric drugs' because 'medication' implies a substance that cures a disease (Guy, Davies & Rizq, 2019). However, the term 'medication' has been chosen as the term for this study, partly because it seemed more in line with the participants' own language.

Until the 1950s, psychiatric medication consisted of organic compounds, generally seen as effective for their sedative effects (Guy, Davies & Rizq, 2019). A new generation of synthetic psychoactive substances was developed from the 1950s onwards, and used as medications targeting specific 'disorders', starting with the first generation antipsychotics and the tricyclic antidepressants in the 1950s. These were followed in the 1960s by medications including the second generation antipsychotics, and the benzodiazepine tranquilisers and, in the 1980s and 1990s, by new medications for 'bipolar' disorder, and new antidepressants– the serotonin reuptake inhibitors (SSRIs) and serotonin and noradrenaline reuptake inhibitors (SNRIs). This resulted in the outcome that psychoactive medication became regarded as curing 'disease' (Guy et al, 2019). In fact, it has been demonstrated that this process of the development and marketing of new medications led to a mutually reinforcing relationship between medications and psychiatric 'disorders' (Healy, 2004, 2006, cited in Moncrieff, 2014). For example, an increase in interest in 'bipolar disorder' in the 1990s coincided with the concept of 'mood stabilisers', and the new antidepressants lead to a greater emphasis on 'depression' rather than 'anxiety'.

It has been persuasively argued that the idea that 'psychiatric disorders' are due to chemical imbalances that can be rectified by medication is ungrounded in scientific evidence (Deacon, 2013; Moncrieff, 2008; Davies, 2017). Instead Moncrieff (2008) has argued for the replacement of this 'disease-centred model' with a 'drug centred model', which accepts that psychiatric drugs can be helpful because they suppress some aspects of distress – through sedation for example – although they can also have detrimental intellectual, emotional and physical effects. Although the latter are termed 'side effects', Moncrieff argues that they are instead actual drug effects.

1.1.4 Current status of medication

Whatever one's conceptual stance on mental distress and drug action, empirically there is a mixed picture on the efficacy of psychotropic medications, including low effect sizes (Leucht, Helfer, Gartlehner, & Davis, 2015), and methodological issues with drug trials (Cromby et al, 2013). There are also increasing concerns about over-

prescription of medication, and withdrawal effects[3]. Despite this, most mental health services adhere to the medical model of psychological distress, and recommend medication as one of the main treatments. In the UK, the National Institute for Clinical Excellence (NICE) includes pharmacological interventions in its treatment recommendations for most diagnoses given to adults, including 'eating disorders' (NICE, 2017), 'post traumatic stress disorder'(NICE, 2019), 'depression' (Shepherd & Parker, 2017), 'generalised anxiety'(NHS, 2019), 'psychosis and schizophrenia' (NICE, 2014) and 'bipolar disorder'(NICE guidelines, 2019).

Seven of the top twenty most prescribed medications in the UK are drugs commonly given for mental health conditions, and antidepressants are the third most prescribed medication, after medication for hypertension and high cholesterol (Leucht et al., 2015). A quarter of the UK adult population was prescribed a psychiatric medication in 2018 (Guy et al, 2019).

Examples of the four main categories of medication and the difficulties they are prescribed for are found in Table 1[4]

Table 1

Categories, Uses and Types of The Main Psychotropic Medications

Category	Prescribed for	Types
Antidepressants	'Depression' Also: 'Anxiety' 'Phobias' 'OCD' 'Eating disorders' Physical conditions	Selective serotonin reuptake inhibitors (SSRIs). Fluoxetine Serotonin and noradrenaline reuptake inhibitors (SNRIs): prescribed for more severe depression and anxiety. Tricyclics Monoamine oxidase inhibitors
Mood stabilisers		Lithium Carbamazepine

3 Currently the subject of a Public Health England review, and an acknowledgment of severity by the Royal College of Psychiatry (Guy et al, 2019).
4 Information taken from the MIND website, where a complete list of medication names and further details can be found.

	'Bipolar disorder', 'mania' and 'hypomania'. Also: 'severe depression'.	Lamotrigine Valproate Asenapine
Antipsychotics	'Schizophrenia. Sometimes for 'bipolar disorder'. Also: in low doses for insomnia and 'anxiety'.	Aripiprazole Haliperodol Risperidone Quetiapine
Sleeping pills and minor tranquillisers	'Severe anxiety' insomnia.	Benzodiazepines. Non-benzodiazepine anti-anxiety drugs.

1.1.5 Quantitative research on medication use

Alongside clinical trials, the majority of research into all types of psychotropic medication until recently has been research which seeks to understand low rates of adherence. For example, 30-60% of those starting antidepressants are estimated to stop taking them prematurely (Buus, Johannessen, & Stage, 2012), and approximately 50-75% of those taking antipsychotic medications do not take them as prescribed (Moritz, Hünsche, & Lincoln, 2014). Regarding taking medication as a rational choice in order to address the 'symptoms' of 'disorders', it uses the weighted language of compliance and non-adherence (Salzmann-Erikson & Sjödin, 2018). Its findings attribute non-adherence to medications of every type to lack of efficacy (Byrne, Regan, & Livingston, 2006) and concerns about dependency (Byrne et al, 2006; Anderson, Kirkpatrick, Ridge, Kokanovic, & Tanner 2015). Problematic 'side effects' have also been given as a reason for non-adherence by those taking medication of every type (Byrne et al. 2006; Salzmann-Erikson & Sjödin, 2018; Wade, Tai, Awenat & Haddock, 2017). These have been found to include nausea, dizziness, and insomnia, poor concentration and lack of motivation (Haslam, Brown, Atkinson, & Haslam, 2004); fatigue and sedation (Angermeyer, Löffler, Müller, Schulze, & Priebe, 2001); blunting of emotions (Goodwin, Price, De Bodinat, & Laredo, 2017) emotional instability (Hughes, Lacasse, Fuller, & Spaulding-Givens, 2017), and emotional flattening or indifference (Moncrieff, Cohen, & Mason, 2009).

1.1.6 Qualitative literature on medication use

A drive to develop a more nuanced understanding of medication users' reasons for adherence and non-adherence and their experience of medication use more generally has led a growing body of qualitative studies on the subject, the body of research within which my study is situated. These qualitative studies show that people draw on a complex set of psychosocial concerns when making decisions around medication. This section provides a narrative overview of this qualitative research to date. In their review of the literature on managing antidepressant use, Malpass et al (2009) organised their findings into a decision-making process, including liaison with professionals, and a meaning making process, involving navigating the challenges to identity entailed by taking medication, processes which they labelled respectively 'medication career' and 'moral career'. These processes appear to be broadly applicable to the qualitative literature on the experience of using all forms of psychotropic medication, and I have therefore used them to organise this summary of that literature.

1.1.6.1 'Medication career'

1.1.6.1.1 Agency and expertise

Rather than deciding whether or not to use medication as being a one-off 'event', those taking all types of psychiatric medication have been found to engage in experimentation, improvisation and trial and error around their medication (Brijnath & Antoniades, 2017; Verbeek-Heida & Mathot, 2006), with recurring cycles of stopping and starting (Schofield et al., 2011), and adjusting doses or taking breaks from medication (Bülow, Andersson, Denhov, & Topor, 2016). 'Adherence' is not a static practice but involves agency, and leads to expertise about their difficulties and medication (Schofield et al, 2011; Geyt et al, 2017).

Part of this process of managing medication is an active weighing up of 'symptoms' and 'side effects'. Users assessed the total impact of their treatment, framed in terms of a core concept of 'well being' (Carrick et al, 2004). Some felt medication

was the 'least worst option', despite 'side effects'. Some described varying their medication-taking practices according to the effects of both their difficulties and their medication on their quality of life (Hon, 2012). Some directly compared the effects of their medication with the effects of their difficulty (Price, Cole, & Goodwin, 2009), and some viewed medication as both a facilitator of and a barrier against reconnecting with life (Kartalova-O'Doherty, 2011).

Users of medication appear to make decisions relationally (Shoemaker & Ramalho De Oliveira, 2008), taking into account emotions and relationships rather than using rational 'cost-benefit' thinking (Tranulis, Goff, Henderson, & Freudenreich, 2011). Some reported they took medication in order to perform their social roles (Malpass et al., 2009), to reduce emotions such as anger that impacted their relationships, to gain stability and participate in activities of daily living (Salzmann-Erikson & Sjödin, 2018) and to reconnect with others (Kartalova-O'Doherty & Tedstone Doherty, 2010).

Others varied their adherence in order to balance 'symptoms' and 'side effects' so that they could live well for themselves and others (Gibson, Brand, Burt, Boden, & Benson, 2013). Some worried that emotional blunting masked their problems and had an unhelpful impact on family life and parenting (Price et al., 2009). Some described the interference of medication with activities that gave life meaning and purpose (Deegan, 2005), and described its interference with 'personal medicine' – the individual ways people increased their own wellbeing, including relationships (Deegan, 2007).

1.1.6.1.2 Relationships with professionals

Dissatisfaction with professionals is a dominant theme in qualitative studies into the use of all types of medication. Participants prescribed all types of medication complained of a lack of collaboration and communication with professionals (Harris, Brooks, Lythgoe, Bee, Lovell & Drake, 2017; Byrne et al., 2006; Lorem, Frafjord, Steffensen, & Wang, 2014), and a lack of support (Gale, Baldwin, Staples, Montague, & Waldram, 2012) and stability (Gibson et al, 2013). They complained of a lack of

acknowledgment by professionals of the negative impact of medication, which led to their feeling powerless and having limited choices (Morant et al, 2017). Some reported feeling pressurised or coerced by professionals into taking medication (Tranulis et al, 2011; Morant et al, 2017; Salzmann-Erikson & Sjödin, 2018).

Complaints about being given inadequate information by professionals recur throughout the qualitative literature. Service users felt uninformed about issues including 'side effects', dosages, and length of course (Salzmann-Erikson & Sjödin, 2018; Gibson et al., 2013; Anderson & Roy, 2013; Garfield, Francis, & Smith, 2004). This subjective view about a lack of collaboration and information has been supported by analyses of medical consultations (Fosgerau & Davidsen, 2014; Seale, Chaplin, Lelliott, & Quirk, 2007; Malpass, Kessler, Sharp, & Shaw, 2011).

Conversely, those who experienced joint decision-making with professionals report more positive views of medication (Jaffray, Cardy, Reid, & Cameron, 2014; Van Geffen et al, 2011; Gibson et al, 2013).

1.1.6.2 'Moral career'

Consistent with Malpass et al's (2009) finding of a second set of considerations around antidepressant use comprising a 'moral career', the literature on the use of psychotropic medications of all kinds finds considerations of identity and self and concerns about stigma (Higashi, Medic, Littlewood, Diez, Granstrom, De Hert, 2013; Roe, Goldblatt, Baloush-Klienman, Swarbrick & Davidson, 2013; Tranulis et al, 2011; Wade et al, 2017), leading to concealing of medication use (Knudsen, Hansen, Traulsen, & Eskildsen, 2002). Users also experienced discomfort and a feeling of abnormality connected with psychiatric diagnosis (Byrne et al., 2006; Schreiber & Hartrick, 2002).

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Participants worried about the effect of medication on their sense of self (Anderson et al., 2015; Garfield, Smith, & Francis, 2003). They experienced a tension between their psychosocial understanding of distress and a biological model linked to medication that could reduce stigma (Buus et al., 2012). And they become caught up

in paradoxes: between feeling fully human on medication, but also feeling different from the norm (Bentley, 2010); between a damaged and inauthentic self requiring medication and an authentic and healing self seeking help and developing medical expertise (Pestello & Davis-Berman, 2008; Stevenson & Knudsen, 2008).

The majority of the studies described above are unisex and do not specify parenting status, but both women and parents confront particular issues with mental health and therefore medication as explored in the following two sections below.

1.1.7 Women and mental health

Although it is outside the scope of this study to consider them in detail, gender differences in mental health have been well documented; for example, depression and anxiety, and 'eating disorders', affect more women than men (WHO, 2002; Kohen, 2000). Internationally women are prescribed medications such as antidepressants at twice the rate of men (Read, Cartwright, Gibson, Shiels & Magliano, 2015; Schultz & Hunter, 2016).

A range of explanations have been given for this gender difference. Historically, women have been seen as having greater biological vulnerability, or less effective coping mechanisms than men (Fullager, 2002). Some researchers have attributed the discrepancy partly to different gender norms in emotional expression, whereby men are expected to be stoical and women more expressive of emotions, leading to women being more likely to express their distress and gain a diagnosis (see Emslie, Ridge, Ziebland & Hun (2007) for a summary of this literature). Trauma focused perspectives emphasize the impact on mental health of the high levels of trauma experienced by women, including child abuse and sexual violence (Tseris, 2013). Others have argued for an intersectional approach, pointing to the fact that women tend to have lower economic status, and that there is a link between poverty and mental distress (Pilgrim, 2010). Feminists have pointed to the stressful nature of women's everyday lives, with their primary responsibility for childcare and domestic

responsibilities, and have argued that medicalized understandings and treatments of women's depression disempower women in making both personal and social changes around gender inequality (Gammell & Stoppard, 1999). Consistent with the insights into women's parenting roles above, the literature on parental mental health is dominated by research on mothers (Social Care Institute for Excellence (SCIE), 2009). An outline of this is given in the next section.

1.1.8 Parental mental health

It has been estimated that 68 per cent of women diagnosed with a 'severe mental illness' are parents (Royal College of Psychiatrists, 2016). Two thirds of women who meet criteria for 'affective disorders' are parents (Nicholson & Clayfield, 2004) and suicide continues to be a significant cause of maternal mortality in the UK (Oates & Cantwell, 2011; NCCMH, 2007). Those commissioning mental health services – and the quality frameworks they follow – tend to focus on assessing and treating individuals, rather than families. (SCIE, 2009).

The samples for the growing body of qualitative literature on parental mental health again consist mainly of mothers. A review (Dolman, Jones & Howard, 2013) divided its findings into experiences of motherhood and experiences of services. Themes in the former included that mothers experiencing mental health difficulties experience stigma because of the tension between 'good mother' norms and guilt at not being able to cope as a mother, and they fear custody loss. They are concerned about the impact of their distress on their children, about the possibility of genetic inheritance, about the influence of their distress on their parenting and about their children experiencing secondary stigma. They express feelings of isolation, and identity issues, both positive and negative, arising from combining mothering and mental distress, including the centrality of mothering to their lives. In relation to their experience of services, mothers expressed difficulties with interacting with staff, a need for practical help, information and peer support, and the desire to talk to somebody sympathetic.

Participants also complained of a lack of focus on their specific treatment needs, and two out of twenty three papers included participants' comments on the way medication side effects impaired parenting. The next section examines the clinical situation for mothers where medication is concerned, and concludes with the lack of direct qualitative research on mothers' experience of medication, leading to the final section of this introductory chapter: a metasynthesis of findings on mothers and medication.

1.1.9 Mothers and medication

Mothers appear to have been an integral part of the story of psychiatric medication. Researchers have traced the way specifically maternal 'disorders' have developed in tandem with newly developed medications since the 1950s (Metzl, 2003; Metzl & Angel, 2004).

All of the current clinical guidance in relation to medication and mothers focuses on the perinatal period (NCCMH, 2007).[5] Beyond the perinatal period, there is no specific clinical guidance for mothers on medication use. However, clinicians have expressed concern about the interaction between medication and mothering in general, specifically the effect of 'side effects' on parenting ability (Seeman, 2017; Seeman, 2018), and about the difficulty of distinguishing between the impact of distress and 'side effects' on parenting (Thomas et al, 2003).

Despite the findings on the relational factors medication users take into account, and the number of mothers experiencing distress, most of research into mothers

[5] The guidance on medication use in the perinatal and postnatal period involves very little clear-cut guidance. Instead a complex weighing up is recommended for clinicians and mothers – of risk to the foetus's development, risks to the new-born and breastfeeding infant and benefits to the mother, taking into account both the mother's prior experience of medication, and the risks to both the mother and child of 'relapse'. The guidelines acknowledge that there is very little data on the safety of antipsychotic and antidepressant medications during pregnancy and breastfeeding, but nonetheless advises taking medication during pregnancy and breastfeeding if there is a risk of 'relapse'. The guidelines involve very little universal advice, other than not prescribing anticonvulsants and benzodiazepines at all, and avoiding prescribing lithium in the first trimester.

and medication, both quantitative and qualitative, is around pregnancy and the immediate perinatal period. Qualitative findings show a reluctance to take medication (Battle, Salisbury, Schofield, & Ortiz-hernandez, 2014), often because of concerns about breastfeeding (Ugarriza, 2002) and about stigma and social discourses around being 'bad mothers' if they were to take medication while pregnant (Bennett, Boon, Romans, & Grootendorst, 2007; Hippman & Balneaves, 2018). Studies also found dissatisfaction with professionals; confusion and uncertainty, and mothers engaged in a complex process of decision-making around their medication (Bennett et al, 2007; Stevenson et al, 2016; Lupatelli, 2015; Stevens et al, 2017).

Postnatally, a study of different interventions for 'postnatal depression' found that women felt medication was the only treatment available, and wanted other options (Byatt et al., 2013). Research has also found mothers with the difficulty would prefer talking therapy with someone non-judgmental rather than being prescribed medication (Dennis & Chung-Lee 2006; Battle et al 2014)

There is only one paper directly on mothers and medication beyond pregnancy, a qualitative study connected to a trial for antidepressants for 'postnatal depression' (Turner, Sharp, Folkes, & Chew-Graham, 2008). It found initial reluctance to be randomised to antidepressants because of concern about 'side effects', dependence and stigma, and the difficulty of approaching doctors for help. It also found concern about being viewed a bad mother if taking medication, and about the impact of medication on their ability to parent. Some participants' views became more positive after taking antidepressants.

There appears to be no other direct research specifically into mothers' own experiences perinatally or beyond, despite the fact that being a mother might impact the complex decision-making described above in the qualitative literature on medication. This finding during the literature scoping stage led to the decision to pursue my research question.

However, despite the absence of direct research into mothers' experience, there are moments in both the literature on service users' experience of medication and the growing literature on parental mental health when mothers talk about medication, or when those prescribed psychiatric medication talk about mothering, which shed an interesting light on the research question. In order to explore them, I conducted a metasynthesis.

1.2 Metasynthesis

1.2.1 Introduction

My initial aim was to conduct a metasynthesis in the form of a thematic analysis of raw data found on the topic as a result of a search of the literature. However, during the search process described below, I found many papers which included second order analysis of their data on medication and mothering. A synthesis of these second order analyses would enable me to produce 'middle-range theories with greater explanatory power' (Barnett-Page & Thomas, 2009, p.5). I therefore made a decision to focus on those studies, excluding those that only contained raw data on mothers and medication, in order to conduct a meta-ethnography. This form of metasynthesis aims to create 'third order constructs' from the authors' second order constructs, in order to arrive at a 'reconceptualization'(Britten, N, Campbell, R, Pope, C, Donovan, J, Morgan, M, Pill, 2002). A final selection process of papers was then undertaken, using exclusion criteria described in Appendix B, before the meta-ethnographic analysis was conducted.

1.2.2 Method

The initial aim was to conduct a search for raw data and authorial commentary on mothers and medication in two main tranches of qualitative literature – the literature on parental mental health, where mothers reflected on medication use as part of their experience of parenting with a mental health difficulty, and the literature on the experience of taking medication for mental health difficulties, where mothers were included in the sample and reflected on their medication use in relation to their parenting. Because it was not possible either via title or abstract to know whether papers contained this information, I employed a broad initial search strategy, followed by several filtering stages, as described below.

1.2.2.1 Sources

Citation tracking using Google Scholar and manual reference searching were conducted on the papers containing raw data on mothering and medication that had

been found in the course of the narrative review, and this process continued throughout, particularly with review papers.

The following sources were searched:

- Pub med
- PsycINFO
- CINAHLplus
- Google Scholar

1.2.2.2 Search strategy

Terms concerning parental mental health were searched in combination with terms concerning treatment and medication, and terms concerning psychiatric medication use and psychiatric treatment experiences were searched in combination with the terminology of parenting and dependants. Searches were filtered for peer reviewed journal articles, and publication date after 2000. The search was conducted between July and November 2018. The search terms used can be found in Appendix A.

1.2.2.3 Selection process

The stages of selection for the meta-ethnography are shown in Figure 1. The rationale for both the initial inclusion and exclusion criteria for which titles and abstracts were screened and the later exclusion criteria imposed once a meta-ethnography was decided on can be found in Appendices B and C.

After screening titles and abstracts for the initial criteria above, I searched the papers for raw data or direct consideration of the research question by authors using a word search. I searched papers on medication experience for words relating to parenting or mothering, and those on parental mental health were searched for words relating directly to medication. This was an iterative process in that new search terms were added based on terminology encountered in the literature – for example, participants' use of terms such as 'pill' – and because it became clear which research foci were more likely to produce findings on mothering and medication (see

Table 2 for these foci, and the words searched for). However, I continued to err on the side of caution, conducting word searches when there was any possibility of findings.

Table 2

Word Search for Metasynthesis and Research Foci Likely to Produce Findings

	Literature group	
	Medication and treatment experience	Maternal mental health
Words searched for	Pills Drugs Tablets Medicine Medication Treatment	Mother Child(ren) Parent(ing) Baby Caring Son Daughter
Research foci likely to produce findings	Experiences of interventions or 'treatment'. Impact of interventions or 'treatment' on relationships, particularly family relationships	The different facets of parenting with a mental health difficulty. Experience of 'treatment'/interventions Experience of services
Research foci unlikely to produce findings	Psychological interventions Other very specific interventions, or intervention settings. Phenomena not related to interventions, such as more philosophical/existential considerations around mental health or recovery	Parenting interventions, or parenting services more broadly. The child's perspective or difficulties Specific client groups where the focus of the research was on this specificity

Approximately 220 papers, quite evenly split between papers on medication experience and parental mental health, were searched. 47 papers were found which contained data or authorial discussion of mothers and medication.

I read these and produced a summary table with a column containing raw data about medication and mothering, and a column containing authorial comments. It became clear that while some papers had only fragments of raw data on the subject, unanalysed by the authors, others contained mothers' considerations around medication in their analysis. At this point, because it was felt higher level findings would be of more value in this under-researched area, I made the decision to conduct a meta-ethnography.

At this stage 28 papers were removed on the basis of the second set of exclusion criteria, as shown in figure 1 (see Appendix C for more detail).

1.2.3 Search results

19 papers remained.[6] Their detailed characteristics can be found in Table 3.

The studies were published between 2002-2018. Approximately 80% were conducted in English speaking countries including North America, Australia and the UK. although two of the studies conducted in the USA sampled from a Hispanic population and were partially or wholly conducted in Spanish. The remaining four were conducted in South Africa, Norway, Hong Kong and Malaysia.

6 To make sure no insights were missed into the topic at this stage, the raw data of all 47 papers was checked to make sure it contained nothing unique on the subject of mothers and medication that was not replicated in the higher order analyses, and the findings of the papers deemed not to be of high enough quality were checked to make sure there were no themes that would not otherwise be included. Neither was the case.

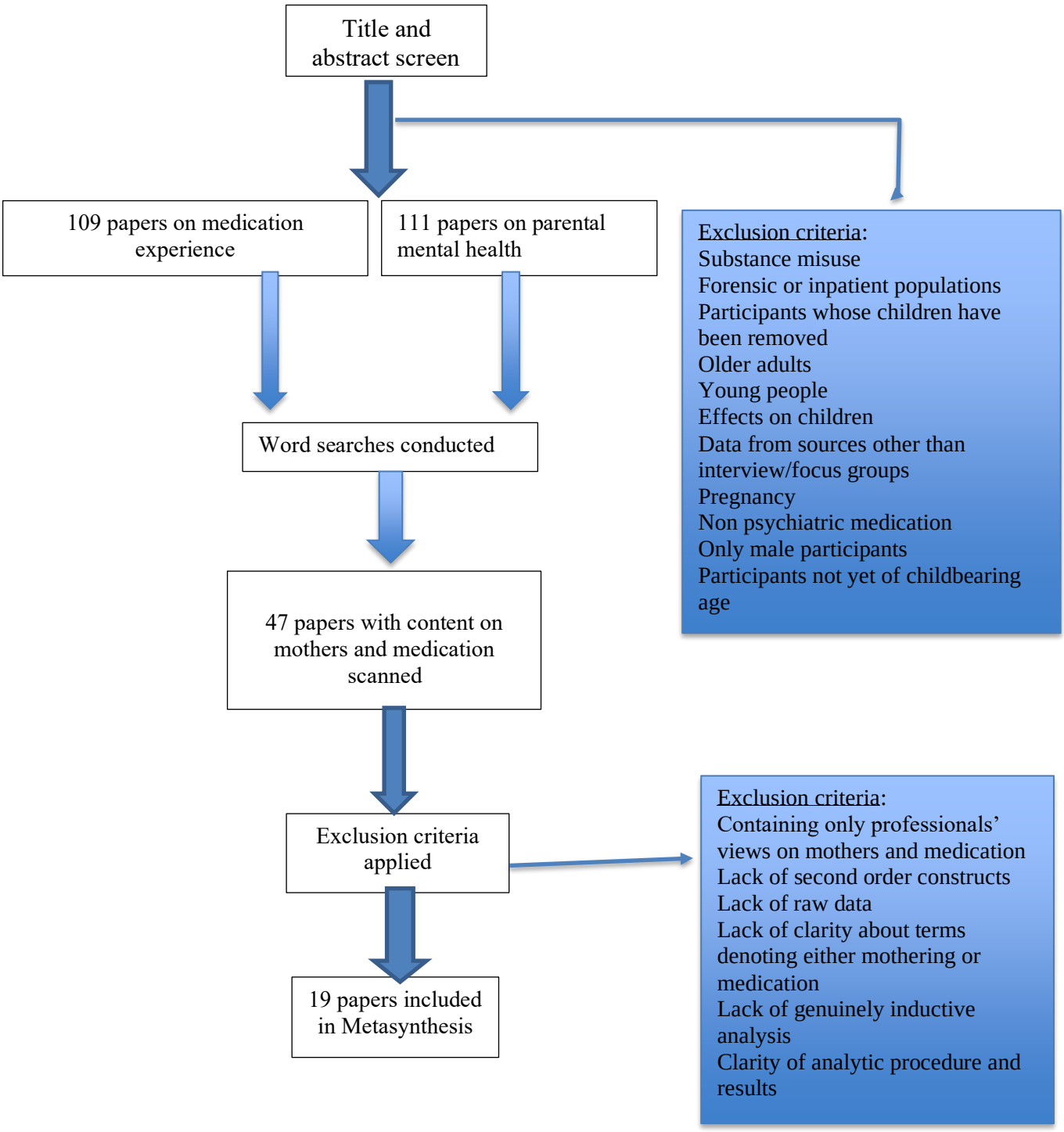

Figure 2 Selection process of papers for metasynthesis

Table 3

Metasynthesis papers and their characteristics

*The authors' diagnostic terminology has been retained throughout.

Paper title	Research focus	Location	Sample characteristics	Medication type	Date collection	Methodology	Analysis
(Bartsch, Roberts, Davies, & Proeve, 2016)	The experience of parents with a diagnosis of Borderline Personality Disorder*	Australia	11 mothers and one father with a past and/or present diagnosis of borderline personality disorder	Not specified	Focus groups	Not specified	Thematic analysis (Braun and Clarke, 2013)
(Bilszta et al., 2011)	Beliefs and attitudes to 'postnatal depression' as barriers to care	Australia	40 women with postnatal depression	Not specified. Antidepressants?	Focus groups	Focus group methodology'	IPA (Smith et al 1999)
(Perera, D, Short, L, Fernbacher, 2014)	Being a mother and living with a mental illness	Australia	8 mothers with a diagnosis of mental illness and at least one child under 10	Not specified. Antidepressants?	Semi structured interviews,	Grounded theory	Constructivist Grounded Theory
(Holopainen, 2002)	The experience of seeking help for postnatal depression	Australia	7 women with postnatal depression	Not specified. Antidepressants?	Semi structured interviews,	Phenomenological method, Creswell (1998)	Phenomenological analysis method, Creswell (1998)
(McMullen & Herman, 2009)	Women's decisions to stop taking antidepressants	Can ada	6 women aged 23-39 with a diagnosis of depression, 1 mother. All began a course of antidepressants,but	Paxil	Semi structured interviews,	Discourse analysis (Wetherell 1998)	Discourse analysis

			chose to discontinue.				
(Sword, Busser, Ganann, McMillan, & Swinton, 2008)	Women's care-seeking experiences after referral for postnatal depression	Canada	18 women with postnatal depression	Antidepressants	In depth semi structured phone interviews	Socioecological framework of health services utilisation used as orienting framework for data collection (Sword, 1999)	Content analysis for Qualitative descriptive approach. (Sandelowski, 2000).
(Chan, Ho, & Bressington, 2018)	Experiences of self-stigmatisation and parenting in mothers with severe mental illness	China (Hong King)	15 mothers with severe mental illness	Not specified	Semi structured interviews,	A qualitative exploratory research design (Sandelowski 2000, 2010)	Thematic analysis (Braun & Clarke, 2006)
(Cogan, & Twamley, 2014)	Experiences and needs while parenting with a mental health difficulty in a rural areas	Ireland	6 mothers using a mental health service in rural Ireland.	Antidepressants;others not specified.	Semi structured interviews,	IPA	IPA (Smith & Osborn, 2003
(Ho, Jacob & Tangiisuran, 2017)	Barriers and facilitators of adherence to antidepressants	Malaysia	30 patients, 50% of them female, diagnosed with MDD and taking antidepressants for at least six months	Antidepressants	Semi structured interviews,	Grounded theory	Grounded theory
(Tjoflåt & Ramvi, 2013)	Experiencing parenting with bipolar disorder.	Norway	6 parents (n=5 mothers, n=1 father) with bipolar disorder	Lithium	Semi structured interviews,	IPA (Smith & Osborne, 2003)	IPA
(Rampou, Havenga, &	Parenting experiences of mothers living	South Africa	10 mothers diagnosed with a	Not specified	Semi structured interviews,	Explorative qualitative reseach	Qualitative analysis drawing

Madumo, 2015)	with a chronic mental illness		chronic mental illness'				on Creswell, 2009.
(Diaz-Caneja & Johnson, 2004)	The views and experiences of severely mentally ill mothers	UK	22 mothers with a diagnosis of a serious mental illness.	Not specified	Semi structured interviews,	Qualitative methodology (not specified)	Thematic analysis. (Richards & Richards 1998)
(Heron et al 2012)	Women's information and support needs during recovery from postpartum psychosis	UK	6 mothers with postpartum psychosis	Olanzapine; others not specified	Semi structured interviews,	Service User Researchers led qualitative research	Grounded analytic induction approach (Silverman, 2006)
(Turner, Sharp, Folkes, & Chew-Graham, 2008)	Women's views and experiences of antidepressants as a treatment for postnatal depression	UK	27 women with postnatal depression, randomised half to counselling, half to antidepressants	Antidepressants	Interviews	Part of RCT. Qualitative approach (not specified).	Framework approach.
(Patel, Wittkowski, Fox, & Wieck, 2013)	Illness beliefs in mothers with postnatal depression	UK (England)	11 women with postnatal depression.	Antidepressants	Interviews	Grounded theory	Charmaz's (2006) Grounded Theory
(Maxwell, 2005)	Women and doctors' accounts of their experiences of depression in primary care	UK (Scotland)	37 women attending their GP with symptoms of depression.	Antidepressants	Interviews	Qualitative methodology (not specified)	Constant comparison method (related to Grounded theory)
(Abrams & Curran, 2009)	Barriers to service use for postnatal depression symptoms	USA (Latino)	14 mothers with postnatal depression.	Xanax; others not specified	Focus groups and individual interviews.		Grounded theory

(Deegan, 2005)	Resilience in people with psychiatric disabilities: the importance of 'personal medicine':	USA	10 men and 19 women with severe and persistent mental illness.	Not specified	Interviews and focus groups	Phenomenological analysis following Giorgi. Participatory action element: focus groups about analysis	
(Martinez, I., Interian, A., Guarnaccia, 2013)	The role of the family in antidepressant adherence	USA (but conducted in Spanish)	30 Latinos, 80% women, receiving antidepressants.	Antidepressants	Focus groups	Grounded theory	Strauss & Corbin's (1998) Grounded Theory

Only three studies stated their epistemological position explicitly.[7] The remaining sixteen had an implicitly realist epistemology in that they took for granted the medical model of distress and the reality of diagnostic categories. This lack of critical perspective on their own epistemology led to some questionable conclusions and data collection by researchers in some studies, explored further below.

1.2.3.1 Analysis

I followed the seven steps recommended for a meta-ethnography: reading, relating, translating, synthesising and expressing (Lee, Hart, Watson, & Rapley, 2015).
The link between medication and mothering comprised only a small part of most of the papers included, but the whole papers were read, in order to understand the authors' analytic approach and the context of their broader findings. The sections relevant to the focus of the meta-ethnography were read repeatedly and notes were made of concepts and themes. This 'active reading' has been regarded as one of the most vital parts of metasynthesis (Lee et al., 2015).

The papers' analysis in relation to mothers and medication was summarised, and any further statements made about this by the authors in the discussion were also summarised. These 'second order constructs' were entered into a table (extract in Appendix E). A separate table was created of raw data for each theme (see extract in Appendix D). [8]

7 Two were constructionist (McMullen & Herman 2009; Deegan 2005), one critical realist (Maxwell, 2005) and the epistemology of one was unspecified, although it took a phenomenological approach (Cremers et al., 2014).

8 Some of the raw data suggested further scope for analysis in relation to the research question than was captured by the authors' second order constructs. I decided not to not conduct my own analysis of this primary data, partly because without the context there was a danger of misreading it, and to instead focus on creating third order concepts out of the second order concepts.

Mindful that synthesis does not stem from coding, but from ensuring those codes are 'assembled into a novel whole' (Sandelowski, M & Leeman, 2012). These themes and the raw data were then studied, and memoing was done of links between the themes. Conceptual maps and diagrams were also drawn, linking the themes in order to arrive at third order constructs (see Appendix F). Different forms of this process of translation of second order concepts into each other are recommended, depending on how consistent studies' findings are. Despite the different research foci of the studies I selected, their findings turned out to be consistent with each other, and I therefore used 'reciprocal translation', which involves translating the concepts from different studies directly into one another, in order to produce overarching concepts (Barnett-Page & Thomas, 2009).

It became apparent that there were many dilemmas in the studies' constructs, where participants were torn between different ways of seeing or acting. I therefore tentatively used the concept of 'dilemmas' as a working third order theme to organise the analysis. In the end it fitted all of the second order themes and was retained.

Services were originally a separate theme cluster, but an overarching concept of 'medical versus relational' related them conceptually to the dilemmas. Inspired by Grounded Theory (Charmaz, 2006), a primary process was generated from this overarching concept.

It has been argued that meta-ethnography is 'enhanced' when researchers find their 'place in the text' and 'explain this place to readers' (Doyle, 2003, p.331). As someone critical of the medical model, I found some of the adherence papers' interpretations of their participants' statements (Patel, Wittkowski, Fox, & Wieck, 2013), and bias towards medication (Turner et al., 2008) ethically and epistemologically questionable. I tried to be mindful of how my own stance might influence my analysis of the findings. For example, I realised that some of the

participants' more positive responses to medication had been left out of the analysis, and subsequently inserted them in the write up.

In the interests of transparency and faithfulness to the original studies, an attempt was made to maintain language of original terms and concepts (Doyle, 2003) in the theme titles and the write up.

1.2.4 Results of the metasynthesis

Three dilemmas were found for mothers making decisions about medication for mental health difficulties, and these were subdivided into 8 themes, as shown in Table 5.

The primary social process was: **Managing dilemmas: encountering the medical model of psychiatric medication within the relational identity of mothering.**
The distribution of themes can be found in Table 4.

Table 4

Distribution of Metasynthesis Dilemmas and Themes

Dilemma	**Balancing difficulties and medication effects**			**Facing a dilemma between stigma and mothering**		**Wanting support that acknowledges mothering**		
Theme	Adhering in order to mother	Discontinuing in order to mother	Searching for a balance between recovery and mothering	Struggling with shame over not coping without medication	Struggling with a stigmatized identity on medication	Having difficulty accessing interventions	Wanting mothering brought into consultation	Needing a space to talk
(Abrams & Curran, 2009)		X		X		-	X	X
(Bartsch, Roberts, Davies, & Proeve, 2016)	-	-	-				X	
(Bilszta et al., 2011)	-	-	X	X	X	-	-	-
(Chan, Ho, & Bressington, 2018)	-	-	-	-	X	-	X	-
(Cremers, Cogan, & Twamley, 2014)	-	-	-	-	-		X	X
(Deegan, 2005)		X	X	-	-	-	X	-
(Diaz-Caneja & Johnson, 2004)	-	-	-	-	-	-	X	-

(Heron et al 2012)			X	X		X	X	X	
(Ho, Jacob & Tangiisuran)	X					-	-	-	
(Holopainen, 2002)	-	-	-	X		-	X	-	
(Martinez, I., Interian, A., Guarnaccia, 2013)	X				X	-	-	-	
(Maxwell, 2005)	X			X	X	-	-	-	
(McMullen & Herman, 2009)		X				-	-	-	
(Patel, Wittkowski, Fox, & Wieck, 2013)	-	-	-	X	X	-	-	-	
(Perera, D, Short, L, Fernbacher, 2014)			X	-	-	-	-	-	
(Rampou, Havenga, & Madumo, 2015)		X	X	-	-	X	-	-	
(Sword, Busser, Ganann, McMillan, & Swinton, 2008)	-	-	-	-	-	-	-	X	
(Tjoflåt & Ramvi, 2013)			X	-	-	-	-	-	

(Turner, Sharp, Folkes, & Chew-Graham, 2008)	-	X (concern in advance about side effects).	-		X	X	-	X

Table 5

Metasynthesis Dilemmas and Themes

Dilemmas	Themes
Dilemma 1: **'Difficult to weigh up': balancing difficulties and medication effects in order to function as a mother**	Theme 1: 'If I get sick, how am I going to take care of them? Taking medication because my difficulties stop me mothering Theme 2: 'You're not my mom any more': Discontinuing because medication effects stop me mothering Theme 3: 'There are both advantages and disadvantages': searching for a balance between my difficulties and medication effects in order to mother
Dilemma 2: **'A no-win situation': The dilemma of stigma and shame versus versus functioning as a mother**	Theme 4: 'We don't like to think we can't cope on our own': struggling with shame over not coping as a mother without medication Theme 5: 'You've got that stigma': struggling with a stigmatized identity as a mother on medication
Dilemma 3: **'Not the right help': Wanting mothering acknowledged in interventions**	Theme 6: 'Catching a bus is something that would be a nightmare for me': the difficulty for mothers of accessing interventions Theme 7: 'Not understanding that we had needs as a family': wanting mothering taken into account in medication consultations Theme 8: 'A substitute for really listening': feeling mothers need a space to talk

The results are explored in more detail below.

Managing dilemmas: encountering the medical model of psychiatric medication within the relational identity of mothering

1.2.4.1 Dilemma 1: 'Difficult to weigh up': Balancing difficulties and medication effects in order to function as a mother

Mothers from 10 out of the 19 studies complained about the effect of medication on their ability to parent effectively. The main concern, found in 9 of the studies, was the effect of sedation: mothers reported feeling tired, sleepy and unable to concentrate. But mothers also expressed concern about the emotional impact of their distress on their children, and about their inability to function at all as mothers because of their mental health difficulties. Some reported finding medication helpful for this. It was as if mothers experiencing distress were faced with a set of weighing scales between their distress and the effects of medication, and finding a balance between them allowed them to mother. Participant data in some studies focused on the decision-making on one side of the scales or the other, as represented in the first two themes. But the majority of studies with this theme presented it as an ongoing balancing act, fraught with competing considerations, as found in the third theme. Sometimes it involved a difficulty with distinguishing distress and medication effects. Both in theme titles capturing the dilemmas mothers face, and in their explanation of their analyses, the authors of these studies used phrases such as 'difficult to weigh up','dilemma about prioritising', and 'difficult to maintain a balance'.

1.2.4.1.1 Theme 1: 'If I get sick, how am I going to take care of them?' Taking medication because my difficulties stop me mothering

Mothers in this theme described taking medication in order to be able to care for their children. A Malay mother (Ho et al, 2017) explained:

> I am a single parent. I need to take care of my five children; I need to bring them up […] if I get sick, how am I going to take care of them?

An American Latino mother reported that she took antidepressants after realising the parentifying effect of her difficulties on her children (Martinez, I., Interian, A., Guarnaccia, 2013):

> To see that the responsibility that I had with my handicapped boy, my youngest boy was taking on, to see that it was they who were already bathing him and feeding him because I spent my time crying, lying in bed, that was what made me [take medication].

The implicit moral stance of some of the accounts above was made explicit by the researchers in a Scottish study of women's antidepressant use (Maxwell, 2005), which found a theme of 'moral actions' in its participants' accounts of accepting antidepressants. One participant said:

> I felt I would have taken anything if it helped me because I didn't like the way I was and I had no patience, even with the older one.

1.2.4.1.2 Theme 2: 'You're not my mom any more': Discontinuing because medication effects stop me mothering

On the other side of the scales, mothers chose to discontinue medication because of the effect of 'side effects' on their parenting. An American mother who had been taking an SSRI reported her daughter's complaints as a reason to discontinue (McMullen & Herman, 2009):

> I had jitters and other… problem really with sleeping just about right around the clock trying to be a mom but I couldn't. And my daughter… hearing my daughter say you're not like my mom. You're not my mom any more. You're

> always sleeping. You never wanna go out with me. You don't wanna go to the park. You want to do nothing. And that really was sad for me. Made me upset. So I just said that's it. I will never touch another med again.

Several mothers worried about their inability to do domestic tasks because of the sedating effects of medication. For example, a South African mother reported (Rampou et al., 2015):

> I took medication for a year only and stopped them because they made me feel sleepy, and I cannot cook for my children, nor wash their clothes, nor help them with their schoolwork.

1.2.4.1.3 Theme 3: 'There are both advantages and disadvantages': searching for a balance between difficulties and medication effects in order to mother

Most mothers who expressed this dilemma described being engaged in an ongoing process of weighing up difficulties and medication effects, recovery and mothering, as captured in this third theme. One of the difficulties mothers appeared to face in this process was separating their difficulties from medication effects. One mother under the theme 'Symptoms prevent caring for children' (Rampou et al., 2015) said:

> I'm always tired […] I sit almost the whole day doing nothing. I don't know whether [it] is the medications.

UK mothers with diagnoses of 'postpartum psychosis' drew a distinction between 'clinical' and 'social' recovery, complaining that medication contributed to recovery, but that sedation interfered with mothering (Heron et al, 2012):

> I was on a very high dose of Olanzepine and it just knocks you out and makes you into a complete zombie … My husband really needed me to be awake enough to get my baby dressed and you know, do that kind of stuff

An American mother (Deegan, 2005) captured the balancing act of this theme when describing how her decision-making about medication required a process of ongoing adjustment, rather than a dilemma resolved once and for all:

> I did not feel I was a good mother because I did not have the drive to take care of my kids. I took them to daycare because I just had to sleep. I slept and slept on that medication. So I quit taking it *at times*. [my italics]

As in Theme 2, domestic duties again came up in this study. One mother who felt caught in a dilemma over medication described the 'side effects' of medication as making her 'hyperactive', which made it difficult to carry out 'day-to-day' activities such as nappies and dishes (Perera et al, 2014, p.175).

Chan et al (2018) captured their participants' indecision and the anguish of the weighing up process under the theme 'Doubting myself', and under the catch-22 subtheme entitled 'Treatment affects motherhood and motherhood affects treatment'. And under their theme 'Prevent Relapse and Maintain Motherhood' a Chinese mother changed tack when her own dislike of medication effects came into conflict with her concern about her child:

> It was too tiring. I told my doctor I didn't want to take that much (medication)…He helped me to titrate it to half a tablet. But I am actually taking one whole tablet now, and have to take it daily (to keep my emotions stable to parent my child). If I missed it for 2-3 days, it would start to get worse.

Norwegian mothers with diagnoses of 'bipolar disorder' expressed the difficulty of balancing their own mental health needs, including via medication, and their parenting responsibilities, captured by the authors under the theme 'Balancing bipolar and parenting'(Tjoflåt & Ramvi, 2013). One of their participants vividly

expressed the complex emotional considerations mothers take into account in this balancing act between recovery and the effects of medication:

> Lithium […] has made a tremendous difference; I don't feel so depressed now […] it's a bit inhibiting I think; yes, my kids should have experienced a little recognition, but on the other hand, I'm pretty balanced and I don't feel angry. It would take a lot to make me angry, so there are both advantages and disadvantages.

Overall, this first dilemma conveys what a fraught arena mothers prescribed medication enter, in both wanting to function in their role as mothers, while also struggling with both distress and medication effects.

1.2.4.2 Dilemma 2: 'A no-win situation': The dilemma of stigma and shame versus functioning as a mother

The first dilemma concerned weighing up the practical functioning required of mothers versus their mental health needs. This second dilemma, expressed by mothers in 7 out of the 19 studies, concerned the more existential and social issue of identity. Mothers expressing this dilemma seemed to feel that medication was necessary in order to function, but it necessitated acquiring both a damaged sense of self because unable to cope as a mother (Theme 4) and a shameful and stigmatised identity as someone with mental health difficulties (Theme 5). As in Dilemma 1, the language used by the authors in their analysis of this dilemma denoted agonised decision-making, including words such as such as 'struggle' and 'battle', 'ambivalence' and 'uncertainty', and theme titles such as 'Antidepressants: the lesser of two evils' and 'No-win'.

1.2.4.2.1 Theme 4: 'We don't like to think we can't cope on our own': struggling with shame over not coping as a mother without medication

Mothers in these studies appeared to associate medication with weakness, and this seemed to feel at odds with how they wanted to be as mothers. They expressed feeling they should be able to 'cope' as a mother without medication, and this produced a dilemma when they wanted to take it in order to function.

In their study on the illness beliefs of mothers diagnosed with 'postnatal depression' Patel et al (2013) captured this in the theme 'Antidepressants: the lesser of two evils', titled using participants' own words. The two evils were 'Only solution. At crisis point' and '"Scary" weakness'. One of their participants explained the link between medication and weakness:

> I'm not the sort of person who easily gives in to things. If I can possibly do it without the drugs, then I must be a stronger person.

Needing medication therefore appeared to have an effect on their participants' sense of self as mothers. The dilemma was resolved through a third subtheme, 'Pragmatism', when antidepressants were decided on as the lesser evil.

The authors of a study on 'postpartum psychosis' (Heron et al, 2012) reported that although their participants felt medication was necessary, it had a negative impact on their 'sense of competence' as mothers (p.159). The authors of a study on 'postnatal depression' (Bilszta et al, 2011) reported that their participants felt 'shame' (p.49) about not being able to cope on their own. One stopped taking her medication at times because of this:

> That was another issue for me really to get over, was the fact that I did need help in the form of that medication. It was very hard for me to accept that, and I still feel very bad sometimes that I have to take it.

One low income ethnic minority American mother rejected medication altogether, in favour of 'handling' her difficulties herself (Abrams & Curran, 2009).

> I threw them away in the toilet.[…] Because as I say, I could handle it. You know I thought that I would handle it. I could handle all the stress and all these things.

The authors of another study (Holopainen, 2002) analysed medication for their mothers as a 'no-win' situation (p.43), as the use of medication reinforced their feelings of personal weakness in being unable to cope on their own.

Participants in another study (Patel et al., 2013) described fearing never knowing whether they were capable of mothering per se, or only because of medication. They weighed this up with their fear of relapse:

> I would like to think I could stop taking it and go back to my normal self but I don't know whether I would want to for fear of going back to that crazed fool.

In what appears a potentially biased interpretation, the researchers speculated that their participants' questioning of the medication's efficacy was a way of easing their inner conflict about whether or not they could actually be good mothers without medication. They also interpreted the mothers' opting for more social and therapeutic interventions as a way of asserting agency over their recovery and therefore again shoring up their self-confidence as mothers.

Maxwell et al (2005) found that mothers believed antidepressants signified failure to cope, and it was only when GP or family offered encouragement that 'alleviated the moral dilemma' (p.67) that they were willing to accept medication.

1.2.4.2.2 Theme 5: 'You've got that stigma': struggling with a stigmatized identity as a mother on medication

The mothers in these studies struggled not only with a damaged sense of self when they took medication, but also with a socially stigmatised identity. A concern with how others might 'see me' came up throughout the data and analysis for this theme, with phrases such as 'being labelled', 'at odds with how they want to be seen', and 'fear of being viewed as poor mother'. Words such as 'normal' and 'stigma' also recur. Mothers often hid or minimised their medication use and difficulties to try to escape this stigmatised identity. When mothers felt they needed medication to function as mothers, a conflict between stigma and functioning ensued.

The authors of a study on 'postnatal depression' reported that their participants felt they needed medication in order to function, but they felt ambivalent about assuming the role of 'patient' and being 'labelled' in order to get medication. They felt mental health was stigmatised, particularly for mothers, and they feared being seen as an 'unfit' mother (Bilszta et al, 2011, p.51).

In another study (Patel et al., 2013), mothers with 'postnatal depression' expressed feeling judged for not being able to mother without medication:

> People will think she needs to be on meds to be a normal mother

Another mother in the same study felt that medication was almost a concrete representation of a stigmatised 'illness' that could therefore no longer be denied:

> If you're not taking the drugs you can kind of pretend you haven't got it but when you are taking drugs, you can't hide behind anything, you have a mental illness that you are taking drugs for and therefore, you've got that stigma.

One Chinese mother did not talk about her medication use for fear of how it would come across (Chan, Ho, & Bressington, 2018):

> I don't know how others might see me, so I would not tell others about it...if you tell others you are seeing psychiatrist and taking medication, it does not sound nice.

One of the same study's analytic themes is 'Stigma of Medications'.

Sometimes the experience of being stigmatized because of mental health and medication use was experienced explicitly by mothers, with several experiencing demeaning treatment by family members. Latino American mothers describe feeling treated in a 'derogatory' way by relations including their children about their medication (Martinez et al, 2013, p.75).

In this second dilemma mothers are torn between taking medication in order to function in their role and losing a sense of themselves as both strong and able to cope, and socially acceptable.

1.2.4.3 Dilemma 3: 'Not the right help': wanting mothering acknowledged in interventions

The first two dilemmas tend to play out in the intimate space of the mother/child relationship and the home. This third dilemma captures the way medical treatment also brings the need to engage with services outside the home. This includes attending appointments when you have dependants. It also involves encountering professionals who don't always engage with the first two dilemmas or provide the support mothers would ideally like.

1.2.4.3.1 Theme 6: 'Catching a bus is something that would be a nightmare for me': the difficulty for mothers of accessing interventions

Mothers in several studies expressed finding it onerous to combine medication-related appointments with their parenting responsibilities without extra support.

Two South African mothers from the same study reported frustration about this (Rampou et al., 2015):

> Things that hurt me a lot are that I don't have somebody who would take care of my children when I'm admitted at the hospital or when I go for check-ups to collect my medication.

A mother with 'postnatal depression' opted for medication because the logistics of counselling were more difficult for her – here medication was seen as a more accessible solution (Turner et al., 2008) :

> I have two children to look after, in my present state of mind as well, like just driving a car and catching a bus is something that would be a nightmare for me. And they said the other option is antidepressants, and they started me on antidepressants.

Another mother interviewed in the same study felt unable to return for frequent monitoring, and criticised the lack of consistency of care:

> I don't want to take tablets. I want to cope with it myself and then I don't have to go to the doctors every few minutes ... whenever I go, I don't ever see the same doctor, so every time I go I have to explain it all.

A third did not want to take medication because of delays in getting a GP consultation for follow ups, and a mother with a diagnosis of 'postnatal depression' in a different study ended up self-medicating because of the long wait to see a psychiatrist (Holopainen, 2002):

> And then I had to wait two months to get into a psychiatrist, so I nuked [sic] on those Valium when I needed them.

1.2.4.3.2 Theme 7: 'Not understanding that we had needs as a family': wanting mothering taken into account in medication consultations

Even once mothers did manage to get to a consultation with a medical professional, in 8 out of 19 studies they expressed disappointment with the approach they encountered. Mothers felt professionals did not meet their specific needs as mothers both in their information gathering about mothers' needs, and their information-giving in relation to medication.

UK mothers felt that the impact of medication on their ability to respond to their children's needs was not adequately taken into consideration by professionals. For one this led to fears that their child needed to assume too much responsibility:

> When I can't get up because the medication has knocked me out, or I feel very unwell, my son has got to be in charge, he has got to know what to do.

But they feared initiating the topic of parenting because of possible loss of custody (Diaz-Caneja & Johnson, 2004).

A UK mother diagnosed with 'personality disorder' found it hard to drive and remember appointments, or to attend to domestic responsibilities because of the effects of medication (Bartsch, Roberts, Davies, & Proeve, 2016), and complained that professionals did not take this into account:

> I couldn't get out of bed and I couldn't drive. I had trouble doing things and my memory wasn't very good. I couldn't drive the car to take my son out to places and sometimes I would forget school activities that I was supposed to attend. I would forget to take meat out to cook tea. I just sat around. I was like a zombie.

The authors of a study on 'postpartum psychosis' reported that their participants felt medication was 'vital for recovery', but it must be 'appropriate and tailored' to their

needs as mothers (Heron et al, 2012,p.159). One participant suggested that her doctor's gender and age lessened his ability to understand her parenting needs:

> The psychiatrist was a young guy not understanding that we had needs as a family.

A mother in rural Ireland expressed frustration regarding the narrow focus she felt psychiatrists had on 'symptoms' (Cremers, Cogan, & Twamley, 2014):

> I don't think I've ever met a psychiatrist who said 'what time approximately do you go to bed? Do you sleep well? Do you have any bit of exercise during the week?'

As well as a critique of the lack of curiosity about their particular situations, mothers expressed frustration at being given inadequate information by professionals about medication. Mothers often expressed frustration at not being communicated with more clearly about 'side effects' and the impact of these on their parenting. They also complained about not being informed about length of course, or the reasons for changes in medication. There was a sense in the data of not being treated by professionals as having a mind, or as having caring and relational responsibilities, and instead being treated as a passive, individual receptacle for treatment.

The authors of a study on 'postnatal depression' reported that their participants complained that GPs and psychiatrists did not provide them with enough information to make their own informed choices about medication. They therefore became anxious when medication made them feel they were 'living in a cloud', and complained they had to 'endure a process of trial and error' to find the right medication and dose (Holopainen, 2002, p.43).

1.2.4.3.3 Theme 8: 'A substitute for really listening': feeling mothers need a space to talk

Some mothers reported wanting a different kind of support than that offered through medication. They described medication as representing a rather cold, clinical, and sometimes impatient form of care, and contrasted it with the kind of more informal, relational, sometimes homebased care they would ideally like as mothers. The words 'listening' and 'talking' came up repeatedly.

Two mothers in rural Ireland (Cremers et al., 2014) felt that medication was prescribed in a rather unthinking way

> I just feel the doctors just want to throw antidepressants
> at me [sobs]

and came without wider support or a sense of being heard:

> I don't feel I've got any support. I feel like I'm constantly banging my head on the wall with doctors and chemists over medication

Turner et al (2008) described mothers diagnosed with 'postnatal depression' as opting for counselling over antidepressants because they felt 'unable to talk to their GP about how they were feeling' and expressed 'a fear of being prescribed antidepressants without being listened to [and] being prescribed antidepressants, not because this was what they needed but because this was what was available.'(p.452)

Similarly, low-income ethnic minority mothers in America felt that when they sought advice from health care professionals they encountered a 'Take a pill' attitude, even though they did not feel medication was a viable treatment (Abrams & Curran, 2009). A second medication-related theme in the same study, entitled 'Medication first', captured how these mothers felt medication was offered by professionals as 'a

substitute for really listening'. The authors reported their participants evoking 'medicalised images of "white coats", "clipboards" and "laboratory testing"' at this point in the data (Abrams & Curran, 2009, p.543).

Mothers diagnosed with 'postpartum psychosis' expressed the same sense of encountering clinical coolness when encountering those managing their medication (Heron et al, 2012):

> They're managing your risk of going high, maybe that's what they've got to do clinically...I wanted a bit more of a human face of it really

In contrast to medicalised care, mothers described the kind of care they ideally wanted. Some expressed the desires for more encouraging, less formal care around medication (Heron, 2012):

> I saw my psychiatrist once every two weeks to check on my medication. It would have been good to have somebody who knew something about it, like a sort of social worker or community mental health worker or something, to visit and just…give you some help and encouragement.

Some mothers diagnosed with 'postnatal depression' saw talking as a better option (Sword, Busser, Ganann, McMillan, & Swinton, 2008):

> I was really not wanting the medicine. I thought that there was, like, other ways of dealing with it, like, talking to somebody rather than being on the medicine.

Low-income ethnic minority mothers diagnosed with depression also expressed a preference for talking, expressed in a theme title 'Talking it out' . And like the mothers above they echoed the desire for a less formal relationship than that they could have with doctors (Abrams & Curran, 2009). The authors reported that

participants described their 'ideal' person to talk to as 'a trustworthy, noncritical woman who takes time to listen and express care and concern' (p. 543).

Two mothers diagnosed with 'postnatal depression' felt that medication 'masked' difficulties and was therefore only a short-term solution (Turner et al., 2008):

> The tablets just block it out ... it's better but it's still there because you haven't talked about it.

In contrast to the omission of their mothering in medication consultations, mothers who did manage to access counselling felt their mothering could be included in talking therapies. Mothers in rural Ireland felt it had provided a 'non-judgemental', 'safe' place where concerns regarding their children could be discussed (Cremers et al., 2014, p. 102).

By contrast, Turner et al (2008) reported that the mothers with postnatal depression who chose medication in a trial did so because they 'needed an emotional "lift"', and said they 'felt no need' to talk to a counsellor. (p.452).

Throughout this dilemma, cool, medical, often masculine, more formal and brief care was contrasted with informal, patient and attentive care. Mothers also expressed a desire for care that took their mothering into account, both in terms of practicalities and in terms of the effects of medication on maternal functioning.

1.2.4.4 Summary of findings

Throughout the studies examined in this metasynthesis, mothers involved in decision-making about medication appeared to have experienced dilemmas both in their parenting, as they weighed up the desire to function with the desire to recover, and also in their sense of self internally and externally as they weighed up an ideal image as strong mothers with a stigmatised identity. It also appeared to produce dilemmas in their relationship with services. They wanted their mothering to be

taken into account, and wanted a more relational approach from services themselves, instead of being seen only via their difficulties. These dilemmas required thought and strategizing: weighing things up, balancing things, sometimes concealing things from others, expressing dissatisfaction with the self and the system.

There was more concern about 'side effects' from participants in studies sampling from those diagnosed with more serious mental health difficulties, perhaps because of the more sedating forms of medication used (although the medication tended not to be specified); and there was more concern with stigma in mothers diagnosed with 'postnatal depression', perhaps because mental health difficulties and medication use represented a difficult new identity for many of them. The participants in the studies came from a diverse range of health services, including those described as having 'challenging service provision'(Cremers et al.,2014, p.100). But all of the dilemmas and themes were represented across all the difficulties, cultures, settings and classes included.

Aspects of mothers' experiences appear to chime with the wider experience of taking medication described in the narrative review of studies on medication decision-making in general, including taking and not taking medication in order to function in roles, the challenges of distinguishing difficulties and medication effects, and medication use bringing concerns about the self and social stigma. But the review has also revealed some dilemmas unique to mothers, including a desire to function in order to care for dependants, the sometimes negative effect of medication on parenting, and the belief that mothers in particular should 'cope', and are uniquely stigmatized if they need medication. Other findings specific to mothers include the fear of custody loss, the logistics of accessing care as a mother, and the desire for professionals to take their unique needs into account and to listen to their experiences as mothers.

1.2.4.5 Limitations

The second order constructs on mothers and medication were only a subset of a range of constructs in each study, and the participants' thinking about the subject rarely seemed to be probed more deeply by most of the researchers in a way that might have revealed more nuanced concerns. The research foci of the original studies perhaps made the dilemma construct more likely, because four studies focused on medication relate to adherence, non-adherence and stopping medication, a framing which might have led to defensiveness or tension in the data. Similarly, the experiencing of mental health difficulties while mothering was perhaps anticipated by the authors of the parental mental health studies as in some ways difficult identities to combine. It might be that different research foci might lead to less conflicted findings.

The high proportion of studies concerning 'postnatal depression' (n=7) suggests that research interest in treatment relating to mothers specifically tends to be focused on the perinatal period, and not in later stages of mothering. Perhaps when mothers have mental health difficulties not directly related via diagnoses to their mothering, they move into a primarily 'patient' identity and their mothering becomes invisible and not probed by researchers or recorded by them in participant demographics. It's noteworthy that combining mothers and medication in the literature searches led most often to postnatal depression studies.

1.2.4.6 Conclusion

The findings of this metasynthesis suggest that making decisions about medication for mental health as a mother involves entering an arena fraught with dilemmas – practical, moral, social and relational.

The findings on medication and mothering in the papers synthesised were often a small proportion of the overall findings, suggesting that the participants had not been probed to explore the subject, but rather that the insights had emerged in the context of broader discussion of treatment (in the parental mental health literature), or of more general motivations and factors influencing medication use (in the literature on medication). The link between medication and mothering was the primary focus of only one of the studies (Turner et al, 2008), one which had a bias in favour of medication use.

My study aimed to fill this gap in the primary research by interviewing mothers who have been prescribed medication for mental health difficulties. I set out to explore in more depth how having dependants informs mothers' decision-making around medication, including how mothers describe others in their lives such as mental health professionals, GPs, partners and children as conceptualizing medication and its relationship with parenting. I aimed to understand the social processes that come into play after mothers are prescribed psychiatric medication, and to engage in more sustained theorising around them than a metasynthesis could allow.

My working research question was:

What are the social processes that inform mothers' use (or not) of psychiatric medication?

2 Methodology

This chapter describes the methodology I have chosen, Grounded Theory, and the reasons for that choice. It then outlines the processes of ethical approval, recruitment and selection of participants, and the data collection and analysis procedures. It concludes with a consideration of my own perspective.

2.1 Grounded theory

Because my aim was to capture rich data, a qualitative rather than a quantitative design was chosen. The research topic contained a number of complex social phenomena, including the family, gender, mental health and general medical services, different understandings of mental distress and different types of medication. Because I was interested in investigating this complexity, rather than exploring the subject at the more individual phenomenological level, a phenomenological approach such as Interpretative Phenomenological Analysis (Smith & Osborne, 2008) which captures in-depth experiences from a small homogenous sample, was therefore not chosen. I have an interest in discourse, and a discourse analysis (Wetherell, Taylor & Yates, 2001) was one potential approach considered, especially given my prior awareness of some of the discourses around both mothering and medication, and the approach's fit with my social constructionist epistemology. But my interest in the topic extended beyond language and positioning. I wanted to capture a range of different perspectives with a view to understanding the broader social processes involved in mothers' decision-making around medication. Unlike less explanatory methods (Wertz, Charmaz, McMullen, Josselson, Anderson & McSpadden, 2011), Grounded Theory, with its origins in sociological research, aims to illuminate complex social phenomena (Chiang, 2001). It originally sought to generate new theories about social processes in a 'bottom up' approach, whereby a new theoretical model is 'grounded' in qualitative data (Glaser & Strauss, 1967). But epistemologically, Grounded Theory has since evolved from its original positivist incarnation (Glaser et al, 1967) to be employed within post-positivist (Straus & Corbin, 1998) and constructivist (Charmaz, 2006) epistemologies.

Grounded Theory was therefore selected as the methodology which would enable me to get a broad theoretical understanding of an under-researched and complex phenomenon. The scoping review had revealed the paucity of research on the topic,[9] and the methodology is suitable for areas about which there is little research or information (Creswell, 2009). Grounded theory has been used in previous research to effectively explore experiences relating to medication taking in different populations (Cormier, 2012).

My design was informed by Charmaz's constructivist version, which acknowledges that researchers are part of the world they are studying and that their theories are influenced by this, and are thus an interpretation rather than a discovery (Charmaz, 2006). I also drew on Clarke's (2008) constructionist approach, which places a greater emphasis on discursive factors, and aims for *theorising* rather than a fixed theory, which fits with my own social constructionist epistemology and enabled me to potentially incorporate discursive factors in my analysis.

Finally, it has been argued that there is an 'epistemological affinity between feminist inquiry and grounded theory' (Plummer & Young, 2010, p.305), particularly constructivist Grounded Theory, because both value the role of human experience in generating knowledge, recognise that knowledge is generated through social processes, define meaning through the interpretation of language, acknowledge the importance of reflexivity, and can promote social change. Constructivist Grounded Theory can therefore facilitate a feminist examination of privilege and power relations (Keddy, Sims & Stern, 2006). This made constructivist Grounded Theory fitting for a study about women's experience, by a researcher with a feminist stance.

9 The timing of the literature review in Grounded Theory research, and whether it should be delayed until after data collection, has been the subject of much debate, with Glaser & Straus (1967) and Charmaz (2006) arguing it should be delayed so that the theory is grounded in the data rather than being 'contaminated' by pre-existing theories (Glaser & Straus, 1967, p.37, cited in Giles, King, & de Lacey, 2013) and others such as Bryant &McGhee et al (2009, 2007, both cited in Giles et al, 2013) arguing it is unrealistic to expect no *a priori* assumptions, and that prior knowledge is helpful for theory development, as long as the researcher is reflexive.

Grounded Theory is not just a method for analysing data, but a methodology which informs every element of project design, including sampling, data collection and data analysis (Flynn & Korcuska, 2018). The main areas of research design recommended by Grounded Theory were followed. In contrast to some other qualitative methods, in Grounded Theory sampling, data collection and analysis are not discrete processes – they are interdependent, and continue until analysis is complete (Charmaz, 2006). The sample is initially open ended, and the interview schedule broad and exploratory, and then through an iterative process of data collection and analysis, both become increasingly focused as the researcher's theory develops. The researcher starts to engage in 'theoretical sampling', selecting participants and data to advance the theory (Charmaz, 2006, ch.8).

2.2 Ethics

Ethical approval was obtained from the University of Hertfordshire Ethics Board (protocol number: LMS/PGT/UH/003404) (Appendix J).

2.2.1 Minimising risk

The main risk anticipated was emotional discomfort or distress for participants due to discussing experiences of mental health and parenting. Ethical approval was granted on the understanding that a flexible and responsive approach would be used to reduce the likelihood of this for participants. A debriefing sheet with the details of support services (e.g. Samaritans) was provided to all participants (Appendix I), and time left at the end of interviews to discuss the experience of being interviewed with each participant.

Some of the interviews took place in people's homes, and the lone worker policies of the researcher's employing NHS Trust were followed to ensure safety.

2.2.2 Confidentiality

Because I planned to recruit partly using my own personal network as a mother, care was taken to make sure I had no prior direct connection with participants.[10]

All data was stored electronically on a password-protected computer that could only be accessed by me. Pseudonyms and unique identifier codes were used to ensure anonymity in stored data as well as in the write-up and any publications.

2.3 Consultation

Service user consultation was gained from a member of a local NHS Trust's service user committee, who recommended additions to the interview schedule – for example, around 'side effects' – and amendments to the recruitment materials that made the language and process clearer. She also suggested recruitment avenues, and later provided additional consultation on the final analysis.

A meeting was held with the lead of a perinatal service in order to get recommendations for recruitment avenues and consultation about the topic, giving useful insights into subjects including service users' concerns around medication.

The interview schedule received peer consultation from members of a methods seminar group. Jargon was removed and the language made more accessible, repetition was removed, and further questions added.

2.4 Sampling strategy

Grounded theory is flexible about sample size, because the number of participants is determined by the concept of saturation, whereby further data collection is deemed unlikely to produce any further contribution to theory development (Robinson,

[10] For example, they were not recruited from the area where I live, in order to reduce the likelihood of encountering them locally, potentially causing embarrassment or concerns about confidentiality related to our coming from the same social network or having knowledge of the health or educational organisations or professionals, especially as given the research topic these might be described in the interviews.

2016). A review of Grounded Theory studies found an average of 25 participants (Thomson, 2011). However, the concept of saturation is arguably problematic within a social constructionist epistemology, with its assumption of the possibility of producing an explanatory theory. For this project the time and scope limitations of a student study also played a role. After consultation with supervisors I agreed to sample a minimum of 15 participants. After I had interviewed 15 participants, my supervisors and I agreed that the consistently long interviews had produced rich data which confirmed the processes that had emerged in analysis, and that there was therefore enough conceptual depth (Nelson, 2017) for me to feel I had reached 'data sufficiency' (Day, 1999) and could stop recruiting.

The aim was to sample a minimum of 15 participants who were mothers and had been prescribed psychotropic medication. A decision was made to include those who had not taken the medication prescribed, and those with any 'type' of mental health difficulty and form of medication or length of use. This was partly because recruitment was expected to be challenging, as this had been the primary supervisor's previous experiences of recruitment from amongst mothers with mental health difficulties. It was also because the aim was to capture the broad social processes involved in making decisions about medication as a mother, and we anticipated that the resulting model would be able to incorporate a spectrum of experience. Because the aim was to explore decision-making about medication while mothering, an inclusion criterion was that potential participants had to have had children under the age of 18 living with them when they were prescribed medication, and those experiencing events that might disrupt parenting, such as hospitalisation or social care proceedings, were excluded. The latter exclusion criterion was also based on ethical concerns around safety and wellbeing.

The full inclusion and exclusion criteria can be found in table 6.

Table 6

Inclusion and Exclusion Criteria for Sample

Inclusion criteria
• aged 18+ • Currently or have previously been prescribed psychotropic medication by professionals such as a GP or psychiatrist for a mental health difficulty. • Can be any mental health difficulty including a short period of low mood or anxiety, or a longer standing or more severe difficulty that might have led to being under the care of mental health services. • The medications prescribed might be antidepressants, mood stabilisers, anti-psychotics/neuroleptics or minor tranquilisers, or any combination of these or other psychoactive medications. • Participants might have taken the medication concerned or might have decided not to take it. • Must be the parent of a child or children who was/were below the age of 18 when the medication was prescribed.
Exclusion criteria
• Currently undergoing social care proceedings. • Currently in mental health crisis – in need of acute mental health care, such as hospitalisation or support from a crisis team

2.5 Recruitment

There were two phases of recruitment. The first phase involved emailing the study details to personal contacts (Appendix M), who posted on social media and circulated to their contacts. Snowballing was also employed. Those interested in participating were emailed the participant information sheet (Appendix G) and encouraged to talk through the study and their participation with friends, family or another person of their choosing. This was followed up with a telephone conversation, to check they met the criteria, and answer any questions they might have. Interested participants were then emailed a consent form (Appendix H). Seven gave informed consent to be interviewed at this stage.

The second phase, undertaken after I had conducted my first seven interviews, involved putting up posters in women's therapy centres, posting a paid-for advertisement on Mumsnet (Appendix L), and a Twitter recruitment campaign (Appendix K). Twitter generated an unexpectedly high response, with 33 expressions of interest in participation. Unfortunately, due to the timelines and scope of the study, it was not possible to interview all those who met inclusion criteria. I direct-messaged all 33 respondents' questions about their experience in relation to the research question, explaining the unexpectedly high response and need to select. In selection, I prioritised those who might provide experiences different from those expressed by the first tranche of participants. For example, because most of the first group of participants interviewed had young children, I selected participants with older children. I also tried to ensure a balance in terms of ethnicity, although unfortunately the participants who met that criterion did not ultimately consent to interview (see Limitations section). At this point I had also analysed my first seven interviews, and the strong response offered an opportunity to recruit in a more purposive way, consistent with theoretical sampling in Grounded Theory (Charmaz, 2006), whereby participants are selected (and the interview schedule amended) on the basis of furthering 'theory' development. For example, I selected a second participant who had decided not to use medication, to find out whether there were commonalities with another participant. The same process as described above in relation to sending information sheets and consent forms was then followed.

2.5.1 The sample characteristics

The participant demographics and other information can be found in table 7.

The average age of the participants was 42, ranging from 32-57. The majority of the 15 participants were white British (n=10), self-identified as middle class (n=13)[11] and in employment (n=12). The majority had one child (n=11), the rest had two children,

11 Although four of those described themselves as coming from a working class background.

and their children ranged in age from 1 to 22, with an average age of 10. The implications of this sample for the research findings will be returned to in the final chapter.

Seven participants had never taken psychotropic medication before becoming mothers. Four had taken medication before becoming mothers, but had stopped taking it some while before, unconnected to planning a family. Four had been on medication long-term before becoming mothers and continued after becoming mothers, some with breaks during pregnancy.

Between them participants were prescribed twenty different medications, from all the major groups. The most frequently prescribed medications were SSRIs.

Table 7

Sample Characteristics

Age at time of interview	**Self- identified social class**	**Education**	**Employed (y/n)**	**Ethnicity**	**Relationship status**	**Age of children at time of interview**	**Medications prescribed (not taken)**
35-39	Middle class	Tertiary	Y	White African	Married	0-4	Fluoxetine
30-34	Middle class	Tertiary	Y	Asian American (UK based)	Married	0-4	Aripiprazole Haloperidol Sertraline
40-44	Middle class (working class background)	Tertiary (diploma)	Y	White British	Married	0-4	Escitalopram
45-49	Middle class (working class background)	Postgraduate	Y	British Asian	Married	5-9	Lithium Quetiapine
35-39	Working class	Secondary	Y	White British	Married	5-9 10-14	Sertraline Fluoxetine Zopiclone
45-49	Middle class (Working class background)	Tertiary	Y	White British	Married	5-9	(Betablockers Antidepressant - not specified)
55-59	Middle class	Tertiary	N	White European	Married Married	18-24 18-24	Seroxat Xanax
45-49	Middle class	Postgraduate	N	White Australasian		15-17	Citalopram Fluoxetine Escitalopram Seroquel Haloperidol

							Aripiprazole
35-39	Middle class	Postgraduate	Y	White British	Single parent	10-14	Citalopram Fluoxetine Duloxetine
40-44	Middle class	Postgraduate	Y	White British	Single parent	5-9	(Antidepressant -not specified)
40-44	Middle class	Tertiary	N	White British	Single parent	10-14 10-14	Lithium Olanzapine Lamotrigine Sodium Valproate Abilify Quetiapine Zopiclone
35-39	Middle class (Working class background)	Postgraduate	Y	White British	Married	0-4	Sertraline
45-49	Middle class	Postgraduate	Y	White British	Married	10-14	Citalopram Fluoxetine Diazepam
50-54	Working class	Postgraduate	Y	White British	Married	15-17 15-17	Citalopram Fluoxetine
40-44	Working class	Postgraduate	Y	White British	Single parent	10-14	Diazepam Venlafaxine

2.6 Data Collection

2.6.1 Interview procedure

The interviews were conducted between October 2018 and April 2019. Seven interviews were conducted face to face, four in participants' homes and three in their workplace. Geographical distance made this difficult with remaining participants, and I therefore conducted eight interviews by Skype. It seemed a good medium for interviewer and interviewee pairs who are both working parents, and have little time to spare travelling, enabling me to widen the geographical range of my sample – acknowledged as a benefit of Skype for qualitative research (Iacono, Symonds, & Brown, 2016) – outside of the southeast where I live.

I was concerned that the lack of direct eye contact with Skype might affect rapport (Iacono et al., 2016). But in my experience it did not have this effect, except when occasionally the time lag affected the flow of the interview; instead it seemed to allow the participants their own reflective space while discussing sometimes painful events.[12] Skype also appeared to allow the participants to initiate their own breaks from the intensity of the interview experience – for example, by moving or making coffee while they talked.

Before the interview, I reminded participants about confidentiality and anonymisation of data, and told them that they could pause or stop the interview at any point, or refrain from answering particular questions. I captured some demographic information, and participants were given the chance to ask questions before the interview started.

After each interview, I checked how the experience had been for them and ensured they had sources of support to turn to if they had a delayed reaction.

12 One participant spoke about how her mental health crisis and recovery was a very private and almost spiritual experience, and I found myself glad that the interface gave her some privacy and that she might not realise I was aware of the tears in her eyes.

2.6.2 Interview schedule

Interviewing in Grounded Theory moves between open and more focused questioning, and back to more open questioning at times, depending on the stage of theorising reached (Wimpenny & Hons, 2000). My literature review and consultation had provided 'sensitising concepts', which informed the areas covered by my interview schedule (Tweed & Charmaz, 2012). My interview schedule was broad and open for the first participants, as recommended (Charmaz, 2006). As I started to theorise, I focused my interviews on the developing categories. I revised the interview schedule before each interview, adding questions relevant to the particular participant, and questions that would help me with my developing categories. I also added questions to probe for gaps in the data reflected on after previous interviews. For example, after realising that the child was quite absent in the data after the first three interviews, I added questions that would enable me to capture more data about the participant's relationship with her child.

Mindful of the sensitivity of the topic for participants, I followed Charmaz's (2006, ch.4) guidance in ending with questions about what the participants had learned and what strengths they had discovered. They appeared to respond well to this positive slant after what had often been emotional or serious interviews.

The first transcript was shared with my supervisors who helped me improve my interview technique in subsequent interviews by encouraging me to use more open-ended prompts and more probing, and to allow the interviewee to follow their own thoughts, coming back at the end to answer any remaining questions.

It was a challenge at times to keep the focus on the research question (see Appendix Q for reflections on this). In order to facilitate this I started to used circular questioning (McNamee, 1988) to uncover what was unique about the intersection between medication and mothering.[13]

13 For example, asking how their medication use might have been different if they hadn't become a mother, how they thought things might be different for fathers, or

I transcribed the first seven interviews myself, and because of pressure of time used a transcription service for the remaining eight (Appendix P contains the confidentiality agreement completed before audiofiles were shared).

2.7 Data Analysis

2.7.1 Memoing

As recommended as a key aspect of Grounded Theory analysis (Charmaz, 2006), I wrote memos throughout the research process: immediately after each interview, while transcribing interviews, during coding and reflection, and while developing my final model. Extracts can be found in Appendix W.

Memoing enabled me to note striking metaphors, reflect on patterns in the data, compare and contrast the participants' experiences, and note points where I held a different view or belief from the participant. It also enabled me to be playful with the data and become deeply familiar with it. As well as writing, I also drew diagrams throughout the process (Appendix V), and created tables showing patterns and 'correlations' in the data. All of this enabled me to step back from my participants' individual narratives and reach an understanding of the underlying processes in the data.

2.7.2 Initial coding

I conducted initial coding on NVIVO for the first three participants (Appendix S), and thereafter on the hard copy of each transcript (Appendix T)[14]. I referred to Charmaz's (2006, ch.5) list of recommended questions for this stage of analysis (see Table 8), and followed her recommendations to preserve action in my codes using gerunds in order

for non-parents, and what difference they noticed between their medication decision-making pre- and post-mothering.

[14] This was partly because I found NVIVO slow to code on, and partly because it made me feel slightly distanced from the data.

to make them dynamic and process oriented, and to 'code the codes' if the codes appeared mundane.

Table 8

Questions Asked at Initial Coding Stage

Questions asked at initial coding stage
What are the implicit views, actions and processes?
What are the tacit meanings and assumptions?
Where is the participants' language problematic?
Where are the tensions between analytic insights and described events?
What do participants suggest, pronounce, leave unsaid, and from whose point of view?
Where are the actions in each segment?
What process is at issue here and how can I define it?
How does the participant act while involved in this process?
What does she profess to think and feel in this process?
Why and how does the process change?
What are the consequences of the process?
What possibilities are suggested by the data?

2.7.3 Focused coding

I produced focused codes in a separate column on the same hard copy of the data. I drew on Charmaz's (2006, ch.6) advice about raising the analytic level at this stage of analysis. In order to ensure I did this, I kept a list of questions in front of me drawn from Charmaz (2006) and Chametzky and College (2016), shown in table 9.

Table 9

Questions Asked at Focused Coding Stage

Questions asked at focused coding stage
What are they doing?
How/what strategies are they using?
How do they understand/talk about what's going on?
What assumptions are they making?
What do I see going on here?
What surprised me?

What intrigued me?
What disturbed me?
What tensions/dilemmas do I see?
Which initial codes serve best as focused codes?
What are the fundamental processes going on?

These questions enabled me to analyse at a more abstract level and to be alert to process. For focused codes that seemed too descriptive or low level, I returned to the questions again in order to push my coding to a higher level. See Appendix T for an extract from the data with both initial and focused coding. At this stage some of my initial codes were used for focused codes and some were combined into new higher-level focused codes.

2.7.4 Higher level coding and theory building

I copied the focussed codes into one Word document and clustered them into higher level codes (Appendix U), collapsing and merging focussed codes together. Because of the requirement for theoretical depth (John, Halley, & David, 2010) and to move beyond description to finding interrelations between concepts (Charmaz, 2006, ch.9), I drew out the higher level codes, and drew diagrams of the conceptual connections between them (Appendix V). I also drew situational maps (Clarke, 2008) (Appendix X) to make sure I was not neglecting any discursive or relational aspects of the data. I also used Charmaz's poles of social processes (Charmaz, 2006, ch.9) to further my analysis, finding powerful-powerless, idealised-denigrated and strain-support particularly helpful.

Originally my analysis was shaped by a chronology of medication use, starting with being prescribed, and including the stages of managing transitions onto medications, managing 'side effects', and managing discontinuation, highlighting how these interacted with mothering. But this presented challenges given the diversity of my participants' different routes through this process and the complexity of the stages even within individuals.

A turning point came when I decided to see all of the decision points involved in taking medication as the 'given' that my research was trying to illuminate in relation to parenting. I then bracketed off the medication decision points and what was unique to mothers' approach to them could then be focused on, and social processes which informed these stages of decision-making as a mother foregrounded. This stage of analysis culminated with three processes, outlined in the Results chapter.

2.8 Being aware of my own perspective

One of the hallmarks of good qualitative research is an openness to other perspectives on the analysis. At each stage of my analysis, I found consultation with peers and supervisors invaluable as a way of honing my interpretation and being aware of the theoretical stance I was taking, and enabling me to hold multiple perspectives on the data. My external supervisor often provided a space to reflect using a more psychotherapeutic and phenomenological perspective, and my internal supervisor consistently reminded me of the wider context of parental mental health, systemic thinking, and a social justice and diversity perspective. The latter was also provided by my university peers at workshops during both coding and theory-building stages of analysis. Ongoing peer supervision was provided with a child psychotherapist completing her own doctorate who enabled me to see the data more through the child's eyes, and through a more psychoanalytic lens. This enriched my perspective on the material, and encouraged me to be bolder and less descriptive in my coding.

Reflexivity, also known as 'sincerity' (Tracey, 2010, p. 840), or 'Owning one's perspective' (Elliot et al, 1999, p. 228) - is one of the key quality indicators of qualitative research, enabling readers to interpret the data and understand the research process in the light of the researcher's own position. Tracey (2010) describes it as 'self-reflexivity about subjective values, biases, and inclinations of the researcher' and 'transparency about the methods and challenges' (p. 840). Guillemin and Gillam (2004) argue that it is not only important for rigor, but for the conducting of ethical research.

I used supervision and a reflective journal to reflect on emotional and epistemological responses throughout the research process, from conception to write up. One of the main challenges and areas of reflection for me was the fact that my research questions combined two contested and discursively loaded subjects – mothers and psychiatric medication. I brought my own stance towards both to the project, with my reservations about the medical model, and views of mothering that included personal, feminist and psychoanalytic elements, and I tried to be mindful of how this might affect my interviews and analysis. I worried that the research focus made assumptions about a connection between mothers and medication that might perpetuate ideas about mothers, and make participants feel there were expectations of them. I also found that I was influenced by the dominant discourses on both during the research process – slipping inadvertently into medicalised terminology, for example. More detailed reflections can be found in Appendix Q, and extracts from my reflective journal in Appendix R.

3 Results

This chapter presents my Grounded Theory analysis of mothers' decision-making around medication for mental health.

For most people who take psychiatric medication, a series of decisions are involved. Although for those experiencing crisis the first stages might be less agentic[15], in general medication decision-making involves seeking support and requesting or being offered medication; accepting or rejecting medication; managing transitions on and off and 'side effects'; managing dosages, and coming off or staying on medication. For some the process involves requesting medication again at a later date and going through this sequence again.

There were several areas of heterogeneity in my sample: some participants experienced the mental distress for which they were prescribed medication only after becoming mothers, and of them some attributed their difficulties either wholly or partly to the pressures of motherhood, whereas for others their mothering and mental distress were seemingly unconnected. Some had been on medication long-term before becoming mothers. Two out of fifteen decided not to take the medication prescribed, one of whom had taken medication in the past. The medication prescribed included drugs from all of the main groups. Some mothers anticipated remaining on medication long-term, others were on only short courses of medication. All but two experienced talking therapy of some description. This sat at different points in the story of their medication use and is beyond the scope of this study.

Within this heterogeneous participant group, three social processes were constructed which informed and complicated every stage of the sequence of

15 The degree of agency could be debated even in those not in crisis, given the power imbalance between medical professionals and service users, which this study sheds light on.

decision-making about medication for all participants: **Managing conflicting identities, Balancing needs** and **Seeking Integrated Care.** The processes and their categories and subcategories are shown in Table 10. The model combining the processes is shown in Figure 2. In the model, the boxes top and bottom capture the contexts within which these social processes take place and which influence them. Although represented separately for clarity, these are interrelated. They include discourses about mothers and medication users, and they include the organisation of services, the dominant medical model which informs mental health interventions, and the family structures my participants' mother within.

In representing the identities of 'Mother' and 'Medication user' in separate boxes, the model represents the way these identities appeared continually hard to integrate for the participants. This is outlined in more detail in the explanation of the processes below. The three boxes between Mother and Medication user represent the settings for the three social processes: in the participants' relationship with their children; around their social identity and relationships with peers; and in their meetings with medical professionals. The arrows at the sides show the process connected with the child and the professionals. The text between the vertical arrows linking these processes with the identities of Mother and Medication show the categories and subcategories found in each social process. The individual processes are shown in more detail, including all of the subcategories, in Figures 3-5.

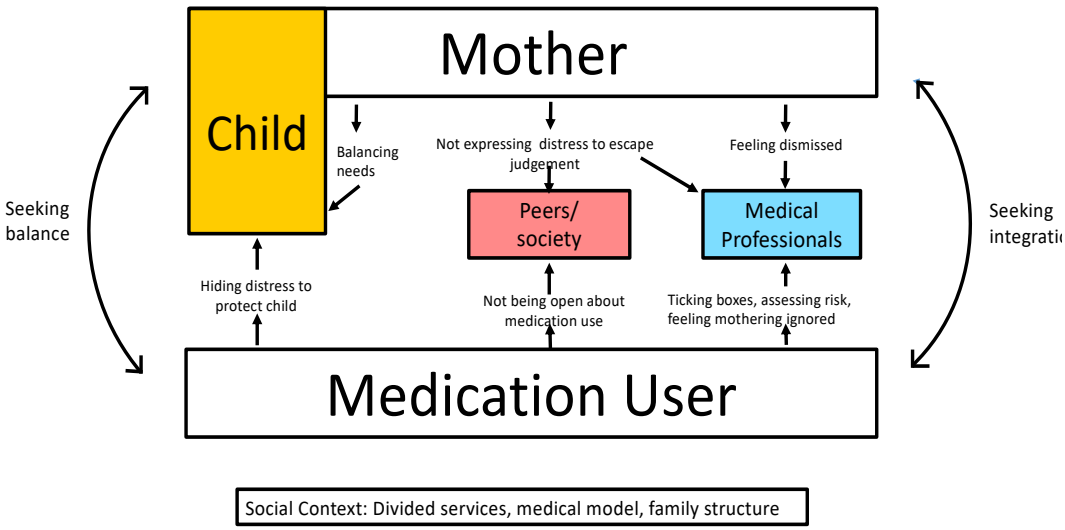

Figure 3 The Grounded Theory Model

The processes, categories and subcategories are explained below, with extracts from the data in which they are grounded, and any variations and exceptions amongst the participants explained. Although they will be presented as distinct processes, their interconnections are acknowledged throughout. To ensure anonymity, pseudonyms have been given to all participants, and their exact professions, the names of their children and their locations have been redacted.

[…] represents words edited out in the data for reasons of space.

Table 10

Processes, Categories and Subcategories of the Grounded Theory Model

Process	Category	Subcategory
Managing conflicting identities	Before medication: caught in a vicious spiral of expectations and reality.	'The judging starts immediately': Caught in a vicious cycle
		'We can't go on like this': justifying seeking support
	After medication: avoiding the clash	'They thought I was gonna be a train wreck of a mother': Avoiding ideals
		'To be a mum that's on medication means you're weak': finding it difficult to be open about medication use
Balancing needs	Ensuring functioning	'I can't just stop the world and fall apart': ensuring maternal functioning
		'Put on your oxygen mask': ensuring own functioning

	Meeting children's emotional needs	'Happy mum happy baby': protecting the child 'To stop, to breathe': being calm and present 'They learn from what you do': being a role model 'She has her own sort of timetable of important things': providing stability
	Taking the pleasures of mothering into account	'It's the best thing ever': child improving wellbeing 'I should have just loved that and treasured that': Regretting lost pleasure 'I wanted another baby': Looking ahead to a new child
Seeking integrated care	Resisting the medical model	'They could be more enriched in

		what they ask you': Ticking boxes 'Potentially poisoning my baby': Grappling with risk
	A mother, but not just a mother	'Just a mother who can't cope': Resisting dismissal 'I wasn't just at home taking medication': Wanting mothering taken into account
	'I trust your judgement': valuing collaborative care	

3.1 Managing conflicting identities

The first process captures the way mothers who become distressed and are prescribed medication for mental distress became caught up in two culturally and discursively loaded and contradictory identities: the idealised identity of mothering, and the stigmatised identity of someone with mental health difficulties. This could lead both to a reluctance to seek support and a difficulty in being open with others about both distress and subsequent medication use. Throughout the participants' accounts, a 'good mother' identity was connected with coping and strength, and the mental distress identity – and concomitant identity as someone who takes medication – denoted weakness and inability to cope. The data consistently pointed to the two identities being very hard to reconcile. The process is represented in

Figure 3. The diagram captures the way there were two groupings of participants in this process. The first group, represented in the *Vicious Cycle* box, described the way social ideals around motherhood and their feelings of failure in relation to these both caused or exacerbated their distress and led them to find it hard to be open about their distress until encouraged to do so by others. The second grouping, as represented by the *Avoiding Ideals* box included participants whose mental health difficulties predated motherhood, and whose expectations of themselves as mothers were not so high, either because their mental health difficulties predated mothering, or because they did not see themselves as the primary parent. They therefore escaped the *Vicious Cycle*. However, the diagram represents the way that despite their different relationship with mothering ideals personally, both groups converged in wanting to protect their social identity from the stigma of being a mother on medication, as captured in the final category, *Finding it Difficult to be Open about Medication Use*. The process is explained in more detail below.

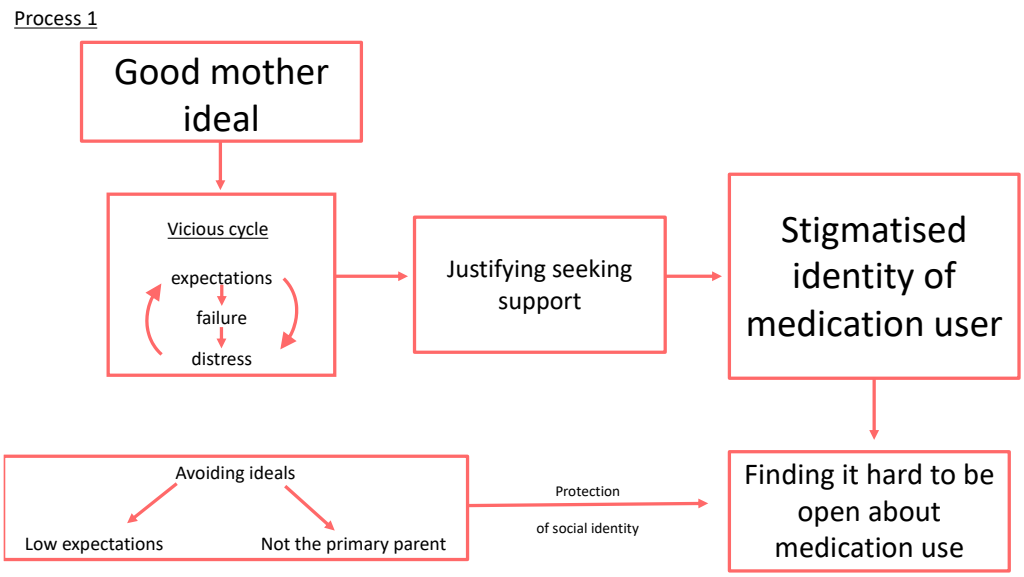

Figure 4 Process 1: 'Managing Conflicting Identities'

3.1.1 Before medication: caught in a vicious spiral of expectations and reality.

The first category captures the way new mothers were often caught in a double bind – the pressures of the mothering role could lead to or exacerbate distress, but because of the cultural ideals around mothers, internalised by mothers themselves, they did not express their difficulties and kept going, until eventually they needed to seek help. This occurred at different stages of mothering for different participants. Athough this process was not directly concerned with medication decision-making, many of the participants felt the distress which led to their being prescribed medication was directly linked to the pressures of this new identity.

3.1.1.1 Category 1: 'The judging starts immediately': Caught in a vicious cycle

Some participants found the transition to motherhood immediately challenging. Some of them expressed the belief that unlike them the ideal mother copes happily with the physical demands of early motherhood such as sleep deprivation; she breastfeeds easily, loves her baby immediately, and feels no resentment about the enormous change to her body and life that motherhood brings:

> Oh I've only had two hours sleep but that doesn't matter. I can live on that! That's fine! The unrealistic view. The idealistic [laughs] (Charlotte)

In contrast to the ideal, participants felt they were 'failing'. The vicious spiral began because they felt 'guilty' about this failure, and worried about being a 'bad mum':

> All that guilt started coming back. Like [sing song voice] Breast is best! La la la! And now you've failed! (Brenna)

Not only did mothers have high expectations of themselves, they reported feeling under surveillance to make sure they perform this new idealised role well. They experienced this from both professionals and family members, especially mothers and mothers-in-law. Husbands are sometimes a source of support in questioning these high expectations. The participants all frequently use words such as 'watching' and 'judging', 'standards', 'measuring' and 'checking'. Several described a double

bind of both being told this should be an instinctual role, but also that there were standards to meet:

> All the midwives were saying “Formula [horrified tone]! You mustn’t use formula.” They all said trust your instincts, but it was expected that your instincts were exactly what they said that they would be. (Lucy)

Some participants enjoyed the early days of mothering, but things became difficult when this new role was combined with work, or when they had to manage mothering alongside other life stresses such as bereavement or relationship difficulties. Some mothers experienced difficulties at both stages. All of the participants for this study worked before they became mothers, and all but two were combining work and motherhood when I interviewed them:

> The stress of work made it harder to be the perfect mom that I wanted to be. (Mila)

Words such as ‘balancing’ and ‘juggling’ and ‘spinning plates’ recurred, and the idea of perfection was again prevalent in their accounts, as are terms such as ‘superhuman’ and ‘superwoman’, but in this process failing to meet an ideal often encompassed several roles, which some participants listed in a sort of litany of failure:

> Nothing was working: I wasn't being a very good wife, I wasn't being a very good mother. I wasn't really functioning very well, at work. (Vicky)

All the participants in this category became caught up in a vicious cycle of failure, judgement and guilt, and became increasingly distressed. Several participants felt that becoming a mother exacerbated or exposed pre-existing difficulties for which they had previously received an intervention, but having children meant they were now no longer able to use previous coping strategies, such as ‘escape’, or sleep and ‘dividing the day into chunks’.

Whatever the origin of their distress, most of the mothers in this subcategory entered a new turn of the vicious spiral when they did not reveal or 'admit' their difficulties because of fear of being judged a 'bad mother' who 'can't cope':

> We're [mothers] the best liars! D'you know what I mean? We don't want anyone to say that we're not coping (Megan)

Mothers of babies reported professionals – often health visitors – assuming motherhood was 'all sunny and rosy', and making comments ('happy mum, happy baby'), which exacerbated their anxiety about revealing their distress. Instead mothers described themselves as 'cracking on' or 'getting on with it', feeling they needed to 'try harder' to cope. Those in the workplace felt the strain of putting on a 'front' or 'performance'.

Participants were not concerned only about judgement of their mothering, but that being open about their distress would lead to the child being removed from their care:

> If I say anything she's going to get taken from me. And that was my biggest fear. (Brenna)

But not being open about their difficulties led to greater distress, and the vicious spiral tightened. Five of the mothers used the word 'spiralled' or 'spiralling', to describe how being caught in this vicious cycle felt as if they were helplessly caught in a downward trajectory.

3.1.1.2 'We can't go on like this': justifying seeking support

Eventually mothers caught up in the *Vicious spiral* reached a point where they sought professional help. Participants often mentioned how concern about the effect of their distress on their loved ones, including husbands, but particularly their children, spurred them on to overcome their initial resistance to seeking support:

> Because I knew that I would do damage to [her] and that's what I desperately did not want to do. I did not want her to bear the brunt of something I was not coping with (Brenna)

Participants also often mentioned that other people urged them to get help. Sometimes this was a friend or parent, most often it was a husband:

> I was sitting on the end of the bed crying and he just said I think we need to… to go and... for you to go and see someone (Eleanor)

It was as if in telling their stories participants still felt some shame about needing help as a mother, and admitting their difficulties – thereby giving up their identity as a mother who copes – and they sought to justify it with the fact that they had hit rock bottom, were harming others, and were urged by others to do so.

For some participants help was not sought until they were in crisis.

> By the time...my husband realized something was wrong, we went to the emergency room and I was completely just sort of gone at that point. (Samantha)

All of the mothers who sought professional support were offered medication, sometimes in combination with counselling or psychology.

3.1.2 After medication: avoiding the conflict

The second category captures the way some participants avoided the conflict between the identity of mother and the identity of someone experiencing distress as signified by medication use. This happened both non-deliberately for some, because they were less prey to expectations around their mothering and more accepting of a

longstanding identity as someone with mental health difficulties; or deliberately, when they hid their medication use in order to protect their identity as a good mother.

3.1.2.1 'They thought I was gonna be a train wreck of a mother': Avoiding ideals

A small number of participants did not attribute their distress to the pressure to be a good mother or juggle roles. Some were women who had experienced difficulties and taken medication for those difficulties long before mothering. It appeared that they had accepted an identity as someone who had experienced severe emotional distress before they became parents, and that this led them and those around them to have less stringent expectations of themselves as mothers, or even negative expectations:

> They thought I was gonna be a train wreck of a mother. (Anna)

Others appeared to feel less pressure from the good mother identity, because they were not the primary parent:

> They have had their father at home as the stay-at-home parent, the go-to parent, the get-up-in-the-middle-of-the-night parent, so, we're different already in that sense. […] So, in many ways, I have been a bit of a distant – I don't like the word "distant," actually, but I've been distant in those kind of traditional being the mum at the gate, being the mum doing all of that, going in the middle of the night…(Corinna)

These participants appeared, because of these factors, to feel less of a clash between the identities. They spoke of feeling it was important to resist the 'ridiculous expectations' and 'social pressures' placed on mothers, and about being careful to meet their own needs when they became mothers:

> [I] didn't want to get down or depressed, and so you know I did things like joined a gym and put [son] in a creche. (Aayah)

And when their children grew older they 'ferried them around' less:

> Some of my children's friends, they're driving their kids everywhere. They go to lots of classes. They're just – You know, there's a lot of pressure. I can't do pressure. (Naomi)

Participants from the first category sometimes expressed this *Resisting ideals* category after experiencing distress and intervention, and later reflecting on the part that mothering ideals played in their distress. They talked about becoming aware that they 'bought in' to a mothering ideology and they often used a tone of mockery to undercut the powerful ideas that led to their distress. They acknowledged what a 'huge adjustment' becoming a parent was, and speak about 'reducing expectations' and 'lowering standards' for their own wellbeing:

> 'I don't think if anyone measured my parenting, it would have been bad parenting. But I think it was me that got squeezed in that process'. (Vicky)

3.1.2.2 'To be a mum that's on medication means you're weak': finding it difficult to be open about medication use

Although the participants had different experiences of motherhood and its connection with their mental health, identity and attitude to interventions, this subcategory captures the fact that most participants found their social identities as mother and medication user hard to reconcile. Participants often mentioned being open with managers and intimates about their medication use, but the majority of participants found it difficult to be open about it with those who knew them primarily via their identity as mothers, especially other mothers.

Participants frequently mentioned how they imagined they would be 'seen' and 'perceived', conveying that their concern was around their social identity. As in the *Vicious Cycle*, the word 'judgement' recurred in the data, and a concern with losing the identity of a 'good mother' who 'copes'. The strong mothering identity was experienced as directly at odds with the 'weak' identity of someone who takes medication:

> As a mum, you should be able to cope, that whatever is thrown at you as a parent you just deal with, and that's what you do when you've got kids. To be a mum that's on medication means you're weak. (Eleanor)

It feels hard to combine them:

> I took medication with serious mental illness and I'm a mother and, you know, should those two go together sort of thing? Am I …is that alright? (Naomi)

There was an almost moral tone to participants' comments around this, with frequent use of 'should'.

There were only a few exceptions among participants to this concern with retaining a strong identity informing participants' decision-making process:

> I wouldn't struggle with – I wouldn't kind of try and be the "I don't need to be… the strong whatever." It wouldn't be a source of embarrassment. (Corinna)

For most participants this difficulty being open applied particularly to other mothers.

> I think the place where I would, I am very cautious is around other parents... […] I don't want to be judged as a, well what do I think they'll judge me as?…. being a bit mad. (Vicky)

Even those who did not feel personally that their mental health conflicted with their mothering identity valued their identity among their peers as good mothers, and did not want this to be affected by the knowledge that they were taking medication. Participants talked about 'people' or 'everyone' thinking they are good mothers, as if envisaging an audience.

> All my family see me as being the slightly mental one. […]I want an environment in which I'm not known for that. And I'm known as being a good mom […] everyone says "Oh you're a really good mom" (Anna)

There was a sense that the identity of good mother and the identity of medication user could not be contained in the same person - as if one identity risked supplanting the other and participants have to choose either one of the other:

> They probably would see me as the mentally ill person, rather than the good mum person. (Anna)

Some participants explained they were more likely to be open with people they were close with or wanted to be close with, as if that more private identity could contain complex and competing identities more easily than the public identity could, which might include being more 'fake'. Participants also expressed a concern about being mocked for being 'on happy pills' as a mother, and mentioned cultural stereotypes of medication, such as 'Hollywood wives'.

But they also described more serious risks: as with mental health difficulties as a mother, participants felt medication use also brought surveillance, and the fear of being seen as 'unfit' brought the threat, again, of losing custody, mentioned by many participants:

> I feel that you're being watched more if you're a parent on medication […] Because you're a risk. (Eleanor)

This threat appeared to subside for some once time had passed, as if the reputation of medication user was no longer attached to their current identity:

> She's thriving, clearly. I'm thriving. Everything's okay. I can now be open about it because it feels like I'm more in a position of safety. (Lucy)

Many of the participants argued against the stigma of medication use by using a physical health comparison, including 'heart disease', 'diabetes', or 'broken leg'. There were multiple mentions of a 'chemical imbalance' or something being wrong in their brain. They argued that this comparison was a reason to be open. However, most still felt unable to be open about their medication use, as if they were not entirely convinced by the comparison, or felt the risk to their social identity was too great. Biological explanations also appeared to lead to feelings of guilt about genetic inheritance by their child of their difficulties.

Six of the fifteen participants described being open because they felt a moral obligation to counter stigma by being open. But four commented on how hard they found it, and explained that they only did it in certain situations, or when the topic arose. Several did it for their children's sake:

> I've been speaking out quite a lot about my mental health and standing up for my own rights with them in mind, you know what I mean? […] I want them not to have to be ashamed of who they are and whatever they are. (Naomi)

Only two of the six felt comfortable combining the two identities of mother and medication user, sometimes after a process of acceptance:

> My whole person includes being [daughter]'s mum. And I don't see that as a role or a hat that I put on. […] I feel like I'm marbled through with surviving

> really shit mental health periods for me […]I'm completely open about [taking medication]. I'm almost proud of it (Alex)

This process captures several vicious cycles and paradoxes participants became embroiled in when they became mothers: becoming a mother could lead to being prescribed medication, because it brought a new identity with social and logistical pressures which can exacerbate mental distress. But mental distress then brought a new identity which clashed with the mothering identity, bringing stigma and shame, and a tendency first not to be open about distress, and secondly not to tell others about medication use. Some escaped the worst of the former, because a more realistic sense of their identity as a parent or as someone with mental health difficulties mitigated the clash; but few escaped the latter.

3.2 Balancing needs

Where the first process took place in the public realm, the second process takes us inside the home, and captures how practical and emotional tasks of parenting influenced mothers' decision-making about their medication. Here, mothers described a balancing act between their own needs and their children's needs, but this was less about reconciling identities, and more about managing an intimate relationship with a dependent and malleable child alongside complex decisions about medication.

The process is captured by the diagram in Figure 4. The separation of 'Mother and Child' and 'Medication Decision' boxes represents how mothers described making decisions about medication from within the context of their relationship with the child. The four-part box in the middle of the diagram represents how this led to a process of balancing, between functioning as a mother and functioning per se, and between the mother's needs and the child's needs. The boxes and arrows representing 'looking back', 'the present' and 'looking ahead', capture the way this balancing act intersected with temporal considerations: when describing their

decision-making about medication participants described looking ahead with both concern for their existing child and desire for a new child, and looking back with regret both for time lost, and at the influence of mothering ideals on their mental health.

3.2.1 Ensuring functioning

This first category captures participants' concern with functioning and the way they make medication decisions – whether taking, not taking, changing, coming off medication or managing dosage and timing – in order to ensure this. Most felt functioning as mothers was imperative; some felt that their own functioning per se was even more of a priority, but this was in order ultimately to function as mothers.

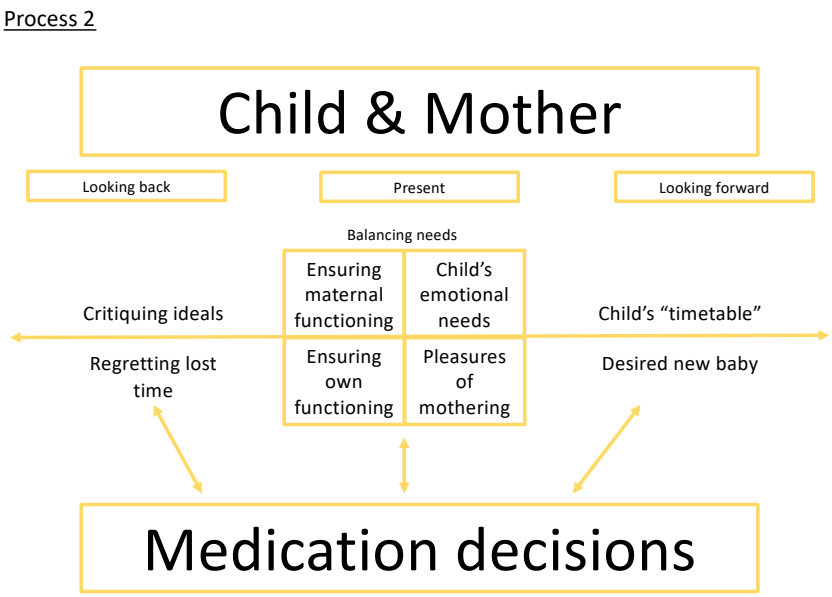

Figure 5 Process 2: 'Ensuring functioning'

3.2.1.1 'I can't just stop the world and fall apart': Ensuring maternal functioning

This first subcategory provides a bridge with process 1, retaining its sense of an idealised strong mother and its moral atmosphere, but here these inform medication decisions. The assumption among almost all of my participants was that as the mother they were the primary parent, and that a crucial task was therefore ensuring they could perform this role. Most participants justified medication use in order to function as mothers. Phrases such as 'needing to function' and 'keep going' recurred repeatedly, and there was a rather imperative almost Darwinian tone in the data, with terms such as 'fitness' and 'fit to practice' contrasted with the notions of 'indulging' or 'wallowing' in either emotional difficulties, or medication 'side effects'. There was talk of not being able to stay 'in bed' or 'on the sofa', and participants often mentioned the requirement of their physical presence and their ability to perform the practical tasks of parenting, such as nappies, the school run, and domestic tasks.

> I didn't have that indulgence of being able to spend the day in bed because there was this baby with nappies and stuff that needed dealing with.
>
> I: So where does the medication fit into that?
>
> P: It felt like it was something that I had to do to make sure that I was better, to be able to look after the baby. (Lucy)

The same applied to mothering older children:

> Even if you're not functioning in the other areas, you've always got to, somebody's got to get the child out of bed and get them picked up from school. (Vicky)

For some participants medication became an important part of the process of regaining their ability to mother at all. Mothers talked about how medication enabled them to 'be in the picture', or 'be on my game', in contrast to 'falling apart'.

Many participants conveyed how professionals encouraged this return to functioning as a mother via medication. Samantha, whose 'psychosis' and subsequent 'catatonic depression' had made her unable to look after her son, experienced antidepressants as enabling her to gradually build up her time with him at the insistence of her husband and professionals:

> I felt immediately better […] and they were very insistent that I spend more time with [son's name], even… I would do that even though it was quite painful for me to do it.

For some this link between maternal functioning and medication use appeared to feel more coerced:

> My ex-husband, husband at the time, saying basically, "Are you fit to be a mum?" It did scare me a bit in terms of – yeah, and then you've got the psychiatrist sort of saying, well, you got this diagnosis. You really should be taking this.

Even though most of the participants were working and had a fellow parent or – in the case of two of the three single parents – their own parent helping out, most conveyed their own and professionals' belief in the primacy of the maternal role and maternal strength:

> From my experience mum is always the backbone of the family. (Eleanor)

> I can't just stop the world and fall apart for a bit (Vicky)

This echoed mothers' strategy of keeping going in the Vicious Cycle subcategory; it is as if their experience was that having reached the point of almost coming to a stop, medication allowed them to start up again. The concern with functioning applied to all aspects of the medication decision-making process, from taking their medication in the evening in order not to feel 'drowsy' during the day to not taking medication at all, or stopping because of 'side effects':

> I was given lamotrigine and then sodium valproate, I think, and Abilify, and those antipsychotics, I had to stop them all because I had very strong side-reactions to the drugs. I couldn't function. (Naomi)

Several participants reflected on the fact that adjusting to medication might have been easier had they not been a mother and could have adjusted to the 'side effects' eventually:

> As a mother with a toddler running around the house you couldn't just sleep. […]I couldn't just wallow. (Anna)

For some 'wallowing' was connected to focusing on their own emotional state, even if they didn't end up taking medication:

> I couldn't just wallow in how I was feeling for myself, I couldn't and I didn't want to. I wanted to be showing up better em... For her […] So I'd just hold on to it [prescription] and I held onto it as a bit of an insurance policy. I thought if the things that I try myself don't help, then… then I might resort to it. (Aileen)

There were only a few exceptions amongst participants to this belief that resting and recovering whether to manage emotional difficulties, or the transition on to medication, was somehow immoral or lazy in a mother.

When participants lost this ability to function, it was presented by most of them as exceptional and temporary, and sometimes shameful:

> I felt helpless because I knew I wasn't really helping taking care of [son's name]. And I knew that that there are women who somehow did it without help. (Samantha)

And as with seeking support, not functioning temporarily was justified by participants with reference to others' advice. In this subcategory this was often that of medical authorities, with phrases such as their husbands 'being told' to help them recurring. Sometimes participants felt this permission came via medication itself:

> It felt like permission to not be a parent […] I just couldn't do anything and that I didn't care anymore. And the Diazepam, as I say, I think felt like confirmation that I didn't even have to try. (Alex)

Only the participant who did not regard herself as the primary parent felt able to take the space she needed to recover after going on antidepressants, but even here she showed a slightly self-critical awareness of the social norms around mothers' functioning:

> I knew the kids were in very good hands with [husband][…]so I almost could just be 'depressed Corinna'. It sounds very self-indulgent doesn't it? (Corinna)

3.2.1.2 'Put your oxygen mask on': ensuring own functioning

Process 2 captures mothers' constant balancing of needs, and in this second category, in contrast to the first, participants described how the scales tipped towards their own needs when there was a risk of not functioning per se. Participants who had had longstanding emotional difficulties or had experienced a

severe crisis placed more emphasis on taking medication in order to assure their own functioning and survival, before their parental functioning. However, this was still justified with reference to the child's needs:

> I don't really feel like I can support him unless I can look after myself. So...and I need to look after my needs to be able to look after his (Aayah).

Several participants use the analogy of an oxygen mask in an airline:

> The care I need to do for myself is more important than looking after my children in a way. I know people took that analogy of you know, you're in aircraft, your oxygen mask comes down and you sort yourself out then your kids. It's like I do have to prioritize myself. (Naomi)

Most mothers who were caught up in the *Vicious Spiral* retrospectively wished they had prioritised their own needs more, and felt this might have prevented the need for medication:

> [If] somebody had been talking to me and saying "actually, it's okay to try and have a bit of a routine" […] It's okay to take care of yourself so that you can look after your baby. (Lucy)

Having felt like she had 'lost' herself completely during her 'psychotic' breakdown, Samantha now recognised the importance of prioritising her own emotional needs:

> Now that I can kind of see, you know, how much you can really lose. […]I think I was just like, I gave him like everything. I was just… my whole life was centred around him. […] I wasn't thinking about myself. I was just thinking about him. […] And now I think a lot of myself and I think about him… I think about him in relation to me rather the other way around.

The majority of participants expressed the belief that children need their mothers to fulfil the imperative task of 'turning up' and functioning, often citing more practical tasks, but for some this needed to be balanced with the mother's own survival.

3.2.2 Meeting children's emotional needs

When making decisions about medication, participants also described taking into account their children's more nuanced emotional needs: protection from worry, a parent who is calm and stable amidst the child's own emotional storms and life transitions, and a good role model. The decision-making about medication of 13 out of 15 participants intersected with their desires to fulfil these maternal responsibilities, as captured in this category.

Sometimes social norms as conveyed in *Managing conflicting identities* were again evident here. At times participants' fluency suggested that talking about managing medication in a way that met their child's needs was comfortable because this process fits so well with mothering ideals; conversely participants who weren't influenced by this process seemed to feel ashamed. But often this sense of social norms receded, and the mothers' authentic love and concern for these children they are in relationship with came to the foreground in their accounts.

3.2.2.1 'Happy mum, happy baby': protecting the child

Many of the participants wanted to protect their children from worry about their mental state, including their sadness or anxiety. They were also concerned about the impact on their children of medication-related distress such as 'side effects' and withdrawal effects. Five out of the fifteen participants had experienced their own parent's emotional difficulties as a child and drew on this experience in their decision-making. They also took their child's specific developmental stage into account. Words such as 'worry', 'effect' and 'impact' run through the data. Actions such as 'act' and 'perform' also recur, as they did in *Managing Conflicting Identities*,

but rather than in the service of protecting mothers' social identity, or shielding them from judgement by professionals, here they are in the service of protecting their children from worry.

Several described not wanting to repeat their own childhood experience:

> I don't want to be down with him because I think my mom was quite depressed when I was growing up […] I try hard not to let him be impacted by anything that I feel, any sadness that I have […]And you know I'd always say you know 'happy mum makes a happy baby' .

Just as the oxygen mask metaphor recurred in *Ensuring Functioning*, here 'Happy mum, Happy baby' was a direct echo of the professional's words in *Vicious Spiral*, conveying the strong sense of a set of recurring shared cultural tropes around mothers' management of their distress.

The majority of participants justified taking medication in order to reduce the effect of their distress on their child:

> I mean, the antidepressants, when I did start them helped a lot with that because I just didn't cry and that was a great thing and I didn't think about death anymore, so…. […] I wasn't getting upset in front of her anymore. (Claire)

Some found the effects of withdrawal from medication potentially worrying for their children, and worked hard to protect their children from them:

> Just trying to…to play this…this hide and seek, em…kids are at school, I can…I can cry now, I can crawl in bed, I don't do…do anything, but by the time they come from school you have to act as if nothing's wrong. (Mila)

Several participants described a feeling of being more directly at risk to their children, because they had intrusive thoughts about harming their child, or about their child being harmed by others, and they attributed medication to reducing these, saying that it 'knocked them on the head', or 'helped'.

Several mothers expressed guilt about not being fully present with their child because of the effect of their anxiety and rumination, and felt medication helped:

> I would be doing stuff with her, but my mind would be on whatever worry, or obsession, or whatever was going on in my head.(Vicky)

Anxiety also removed their physical presence:

> I couldn't just sit. I'd be like ok I'm going to do the washing. Oh, I've just.... I'm going to go and do this [manic tone]. So they never got to enjoy mum. (Eleanor)

For some mothers this became a second vicious cycle, whereby they worried about the effect their worry had on their child, which exacerbated their anxiety:

> Rather than be thinking 'Oh my god, my anxiety, I'm not coping, I wasn't a good mum, what effect's it going to have on her?' […] I feel like the medication maybe can help me focus and stay in the moment with her. (Charlotte)

Whereas for these participants it was their distress that led them to be absent from their children, for other participants it was medication that stopped them from being present because it made them feel 'spaced out' or 'not myself'. Although she was one of two participants who did not take medication, Aileen was aware of the balancing act that mothers engage in, assessing the effects of distress versus medication and being aware of the tipping point between them:

> [I want] to be able to respond in a way that's alert and that's what she needs […]and I wonder if... I wonder if my senses were dulled if I'd be able to do that in the same way? Em, although […] flip side of that would be that, if I was continuing to feel constantly anxious and constantly, em, not with her because of that, then maybe the alternative [medication] would be better?

Four participants had negative experiences of their own parent's medication use and drew on this in their decision-making, describing seeing their parents as 'zoned out' or a like a 'zombie'. It led one to insist on regular monitoring, but another was reassured by medication having changed since her mother took it:

> Medication in those days were calming down and taking away emotions – were like suppressing them […] but now this medication does not do anything of that. […] I have the impression that as long as I take this I feel normal. (Mila)

Some participants became more aware of the effect of their moods on their children when they were older. Anna became more aware of the effect of her 'manic' moods on her daughter – described by her as 'flare ups' - once her daughter could articulate this:

> When she was younger she wouldn't vocalize and say "Look mom, I'm feeling really stressed because you're having a thing." Whereas now […] say if we went clothes shopping or whatever […] she'd say to me "You can't…don't be loud please don't be loud"

This led her to start taking medication.

At times the power of the discourse around ideal mothering was apparent when the small number of participants who did not make decisions for the sake of their children expressed self-criticism and retrospective worry about it: 'Selfishly I think I was thinking more about myself.' (Eleanor)

Participants also worried about the 'side effects' of medication, again linking it to their child's developmental stage:

> [She] might not understand that it was the tablets making me sick and might think there was something worse wrong with me because at that age, I think she would have been … five or six? And kids start to be aware of illness. (Claire)

Unlike their approach with peers, many of the participants were open with their children about their medication use, explaining it in a way that appeared to be to provide reassurance, especially to teenagers who understand the risks of mental health:

> I've gone to great lengths to explain to her that I've never been suicidal and that is not anything that's ever affected me. That is something I definitely don't want her worrying about that one day […] She knows I'm not going to be on antidepressants for ever' (Claire)

With younger children mothers often used the same simplistic terminology they had felt mocked by, such as 'my happy pills' and they sometimes gave reassuringly simple physical explanations:

> [I've told her] These tablets help me help my brain make the chemicals it needs in order to be happy about all the things that happen in my life. (Alex)

3.2.2.2 'To stop, to breathe': being calm and present

Some mothers spoke about discovering that medication helped them to tolerate the stresses of parenting, and to be stronger and more containing towards their child's own demands and emotions. These tended to be the same participants who

experienced being *Caught in a vicious circle*, in which the pressures of mothering increased their anxiety and distress. The words 'calm' and 'patient' were used repeatedly, and contrasted with terms such as 'irritable' and 'short fuse'.

> It's given me space just to be able to stop, to breathe…when [daughter's] being a bit you know three-year olds as they are, and pushing buttons as they do. (Brenna)

Several attributed their difficulties to something in their body – 'I need something in my body', 'I felt such a bodily response' – and attributed this to their inability to be calm:

> I want to be that patient person, but, as I say, I have the impression that my body… em, my body, my breathing, my heart[rate] – is sometimes against it so in order to be able to achieve that I take medication. (Mila)

Anna explained the cause as 'my brain wiring is a bit haywire', and spoke about a moment when she lost self-control with her daughter, before she started taking medication:

> She was probably about 6 and she had left all her toys out in the living room and I just snapped, and I said…and I got a washing basket and I started throwing everything in saying "Right! that's it! It's all going to donation, it's all going to charity" and she's just sort of looking at me […] like "My God what's going on…"

Many expressed a concern about the possibility of losing this calm if they stopped taking medication. Words such as 'reverting back' and 'relapsing' recur repeatedly:

> I mean I do find myself cross quite a lot of the time just through being a parent of a preteen [laughs]. It's not uncommon at all, but if I had sort of medication withdrawal issues going on.

I: At the same time.

P: It would be very easy just to sort of yell. (Claire)

As well as being calmer, mothers described feeling more able to be firm and decisive as a parent after taking medication:

> I felt very wishy washy, whereas now I'm like no actually…[…]No I'm definitely not going to stuff you up if I make you wear your wellington boots when it's pouring with rain.' (Brenna)

But others chose not to take medication, and to find a source of calm in their parenting – and in their life generally – by non-medical means:

> I actively went to yoga […], and went on a mindfulness based stress reduction training course for 8 weeks and did lots of stuff like that and a lot of that helped. (Aileen)

1.1.1.1 'They learn from what you do': being a role model

Many of the mothers spoke about the importance of being a good role model for their children and this influenced every facet of medication decision-making, including taking medication order to reduce behaviours they did not want their children to learn from:

> I don't want them to pick up on my coping strategies, which is to clean, to…everything's got to be perfect, em. It's not healthy, I know it's not healthy, em, and my worry and fear is that they... They will inherit that from me. So if I ... if I can be on medication and that can dampen it slightly and that they're then less aware of it, it won't affect their lives (Eleanor)

Conversely, some mothers were concerned about sleeping too much because of their medication 'side effects', and took that into account in their decision-making:

> I mean, they learn from what you do and you don't want to be setting an example that, you know, everyone needs to have a lie down in the afternoon because they feel so terrible. [laughs] (Claire)

This role-modelling extended to communication about medication itself for some mothers, especially when they were concerned about their child's own emotional state:

> I could draw from my own experience and say 'Well, you know, I'm not saying they will work for you, but they worked for me for a period of time. I went on them, I came off them.' (Corinna)

Many mothers wanted to provide a positive role model around medication use, because they worried that their child might inherit their difficulties genetically.

Others felt it was important to model a positive outlook and ways of managing stress without medication:

> And eh, role modelling as well? Just... She calls me a hippie [laughs] […] I do try to support her to have a…a positive outlook on the world and for herself, which she doesn't have a lot of the time [laughs] but I try. And em, I'm trying to do that with myself as well so that she sees it. (Aileen)

3.2.2.3 'She has her own sort of timetable of important things': providing stability

Mothers didn't just make medication decisions based on their current emotional state. They described their awareness that their children were going through constant changes and transitions of their own, and frequently mentioned transitions

to nursery, primary and secondary school, and biological changes such as puberty. They expressed a desire to be 'stable' themselves for these moments. In what was sometimes a two-way process, some felt that their child also kept them more stable than they would have been before mothering, by actively helping them to be more aware of their difficulties or giving them a reason to monitor their moods. Mothers' decisions included persisting with 'side effects' to enable moments of separation to go as smoothly as possible:

> I don't think it's a coincidence that it was the first year that my daughter started school […] I really wanted this start at school to be a good thing. And I think that that was a real factor in riding out the side effects. (Vicky)

They also included the resolution to go back on or come off medication depending on the stage a child was at, whether in a calm period or a time of upheaval and stress:

> She has her own sort of timetable of important things. So, like one of the things that I was nervous about, was she's just gone to secondary school this year, but that's gone quite smoothly, because I was quite stable. […] I could imagine if I was having a wobble, and she was doing her GCSEs, I'd be straight on the medication again. (Vicky)

For Megan impending adolescence was a reason *not* to take medication:

> She's 8 and her hormones are already kicking in and I need to be as stable as I can, I need to be…I need to keep it together.

And others did not feel medication helped with their own emotional responses to their child's transitions, and found talking therapy more helpful:

> I suppose now every stage throws up challenges […]so I suppose that's why I decided [on counselling]…cause I sort of had that tip over point when she

> was starting school and she was… her anxiety, my anxiety went up. So I felt like actually the medication I don't feel is actually doing a lot. (Charlotte)

Just as mothers in the *Ensuring Functioning* process contrasted their decision-making with that of non-parents – in that they were not willing to persist with a medication until the 'side effect' subsided because of the effect on their functioning as mothers – here too mothers contrasted their decision-making with decisions they might have made had they not been parents:

> I'm not working at the moment […][so] if I was not a parent, I might start tapering down now because I could just stay at home on my own all day […] But because my daughter is with me all the time, I mean, I've got to choose the right time to do it, that it's not going to have a bad effect on her. (Claire)

Several demonstrated careful, nuanced thinking around these issues, even to the point of dose increments:

> If I did start to feel like I was getting way too ratty with her or snapping or yelling when I should be more patient, then I'd […] go up to the previous dose and stay on that for a few more weeks, and then try again. (Claire)

A couple chose to manage their difficulties without medication, partly because they looked ahead to their relationship with their child in the future:

> Because of my feeling about medication, mental health medication, antidepressants being something that's not a long-term solution. Em... Knowing that I wanted, I needed to do something that was long term because I'm in it for the long term with her. (Aileen)

3.2.3 Taking the pleasures of mothering into account

This category captures the fact that mothering brought pleasure and desire for the participants, not just responsibility. Participants took this into account when making decisions about medication, and sometimes felt the happiness brought by mothering reduced their distress more effectively than medication.

3.2.3.1 'It's the best thing ever': child improving wellbeing

Some participants not only did not find that becoming a mother led to or exacerbated mental distress, but saw their identity as a mother as beneficial. Sometimes there was a rapturous feel in the data, with words like 'bliss'. The word 'love' recurs, and 'purpose' or 'reason for being'.

> I think generally being a mum, knowing you're a mum is... makes people happy I think, and that kind of helps me. I don't know what I'd be like if I didn't have a child, you know… cos we struggled to have [son] and if I didn't have him I wouldn't be, you know, as happy as I am now. […] something that kind of helps me stay well. (Aayah)

Participants expressed both pleasure and pride in their mothering:

> It's the best thing ever. And I tell her that quite frequently. I absolutely love being with her. (Alex)

Several reported feeling 'saved' by their children:

> My daughter absolutely saved me. And I don't think medication would have necessarily done that. (Megan)

And wanting to retain clarity in that relationship led two participants not to take medication:

She was kind of like the spot of light that allowed me- that gave me clarity in an otherwise horrible space, and I'd be buggered if I was gonna take any […] any drug that was going to take that away from me. (Megan)

3.2.3.2 'I should have just loved that and treasured that': Regretting lost pleasure

Participants often described their awareness of how their children were ever-evolving beings, whose stages of development were finite:

> You kind of realize that this is it [laugh]
> I: Yeah.
> P: So em, there's no other chance to enjoy him at this stage (Aayah)

But not all of the participants were able to enjoy their children. This and children's growing up fast brought a sub-category of regret for six mothers, who regretted the way their distress deprived them of the varied pleasures of motherhood. Words such as 'hindsight' and 'loss' and 'spoilt' recur. Several participants expressed regret about having no memories about whole periods of their child's life. They described their regret about not having had specific experiences of mothering. This included the pleasure in 'holding' or 'cuddling' or just being with a baby, which participants feel they should have 'treasured'. It also includes loss of the pleasure of playing with older children – terms such as 'playing' and 'fun' and 'enjoyment' recur:

> I can play with the kids, I can…I can enjoy them. Like last night we was upstairs we was, me and, just ... [miming having fun] and normally if there's any fun going on [my husband] is normally there, and he wasn't and I can't... That's... oh I'm getting upset [tearful] […] but that's like, like I haven't had that. (Eleanor)

Some found it hard to know whether to attribute loss of pleasure to the dampening effects of medication:

> I sometimes wondered if I might enjoy some of the more fun aspects more if I'd not been on it? But…see…I'm not sure. I suspect as well that if we'd had very active grandparents locally who'd want to take the baby for a couple of hours, that I would also have experienced more joy. (Lucy)

Some were sure that the medication played a role and regretted not taking it sooner:

> I feel like I lost about 18 months of what could've been really interesting time with my daughter. And I don't blame myself for it, other than that I regret it. (Alex)

3.2.3.3 'I wanted another baby': Looking ahead to a new child

Mothers did not think only about their existing child when making decisions about medication. Two thirds of the participants talked about how their thinking and behaviour around medication were influenced by their desire to have another baby, making this one of the subcategories most represented amongst participants. In the previous subcategory participants yearned for a lost past; in this one they projected themselves into a possible future.

Some chose not to take medication that might affect their fertility:

> The chances of my falling pregnant are remote to none. But I've always stressed that I would like to have more kids if the miracle occurred […] if the medication was gonna affect fertility or my ability…like…because a lot of the bipolar meds they kind of recommend that you don't fall pregnant and that you don't have a baby. […] And I think that's definitely played a role in what I allow them to recommend me to take. (Anna)

Some did not continue with medications they might have to come off if they became pregnant:

> A massive factor about not wanting to take the medication and the panic over it was because at that point, I wanted another baby and I hadn't quite figured that bit out about, 'well, if I go on this, how long will I be on it?' […] if I can get better with therapy, that would be better, because I won't be stuck on this medication that then I've got to come off. (Vicky)

Mothers described being torn between two subcategories in this process: functioning for their existing child, and thinking ahead to a new baby, conveying how complex decision-making for mothers can be:

> The mothering part of it probably pushed me towards wanting the medication to be functioning better. But, then the thought of having another baby then was a pull […] that sort of took me away from taking the medication. (Vicky)

Several participants feared 'relapsing' if they came off medication due to pregnancy, and again balanced this with their current child's needs, worrying it would be 'unfair':

> They always say there's a slight risk of heart…heart defect or something? Or do I come off it then at that point, and then have… revert back to the fear of: am I going to go completely, you know just become completely anxious again and tightly wound? (Brenna)

The *Balancing Needs* process conveys how parenting a dependent and still-forming child and balancing her needs with the parent's own needs intersected with and complicated the sequence of medication decision-making at every point. This set of concerns and other issues could lead to tensions between mothers and those who prescribed their medication, as explored in the third process.

3.3 Seeking integrated care

Where the first process captured the more discursive sphere of social identity, and the second the intimate work of parenting, and balancing the needs of the child with the mother's own needs, this third process takes us into the consulting rooms where the participants' mental state is assessed, and interventions offered. As conveyed in the processes above, all of the participants described interactions with a wide range of professionals. Mothering brought contact with midwives and health visitors and nurses; mental distress brought encounters with GPs, psychiatrists, psychologists and therapists. All of the participants appeared to remember vividly both the helpful things that professionals had said to them and the unhelpful comments, the latter often seeming to worsen their distress significantly. Because of my research question, this third process focuses mainly on the professionals my participants saw for mental health assessment and medication prescription, monitoring and advice.

As in the first process, there is a division in this process between the identity of mother and the identity of medication user, but this time for more clinical and organisational reasons. The diagram of this process can be seen in Figure 5, with the division between the mother and patient identities represented by the two separate circles, with the titles of the subcategories relating to each sitting within the circles. The overlap between the circles represents the final category, in which mothers described their appreciation for collaborative care which integrated the two identities.

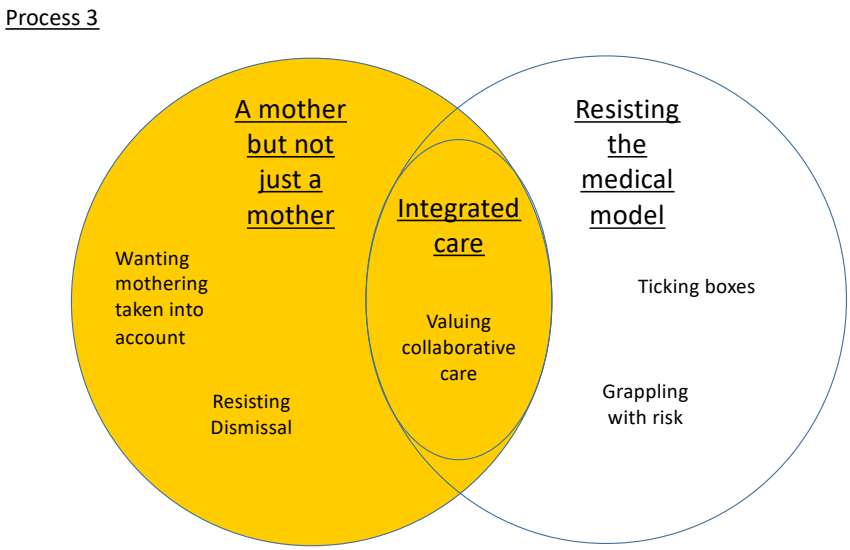

Figure 6 Process 3: 'Seeking Integrated Care'

3.3.1 Resisting the medical model

The first category in this process captures how participants encountered medical professionals whose assessment methods, and the treatment and advice they offered, often felt at odds with the complexity of their own lives and decision-making. Participants sometimes complied, but often overtly or quietly resisted, in order to ensure the right outcomes for themselves and their children, and meet the tasks of *Balancing needs*.

3.3.1.1 'They could be more enriched in what they ask you': Ticking boxes

Many participants expressed dissatisfaction with being seen through a narrowly clinical lens during consultations about their emotional distress. Most of the participants entered their meetings with doctors feeling distressed and caught in complex relational dilemmas. Yet many described being seen as a collection of 'symptoms', in brief consultations where they did not feel fully known as people, let alone mothers. Mothers often attributed the short consultations to an over-stretched health system. Many participants described quick and impersonal assessments, often using measures. Words such as 'brief', 'scale' or 'measure' recurred, as do phrases conveying not feeling 'known'

Megan described how jarring this could feel at a first primary care consultation:

> It was a guy doctor and I remember talking to him and we did that anxiety scale thing and he went right then – I mean it was literally in and out, he did the anxiety scale thing and it was like oh you're 7 out of 10 or something, here have some…have some drugs.

The brevity of the consultation, and the reliance on the scale, led her not to take the medication prescribed:

> It didn't cross my mind once to take that medication […] Partly maybe because we didn't even really have a conversation.

Finitude came up for some mothers in this process too, in their sense of impatience at waiting to get an appointment. One participant sought support for distress during pregnancy and was not contacted until her baby was well into her first year ('I was like well that's bloomin' hopeless!'). Some described having to wait to change

medication so that they could increase their dose or waiting to be called back by their doctor, all while their children were rapidly growing and changing.

When participants did take the medication prescribed, they often expressed frustration with the way the medication 'levels' and their 'symptoms' were monitored, rather than their wider wellbeing as mothers:

> It was like 'Do you feel the dose is right? Are you happy on that?' but it wasn't much more than that if I'm honest […] I can't remember any of them saying to me about the baby, about anything more than that. […] I don't know, I think that they could be more enriched in what they ask you. (Charlotte)

Several participants described how after a certain point even that basic monitoring of medication by their GP stopped:

> I've been on this for a year now and I had no GP ... I just put in for a repeat prescription and no one's ever contacted me […] I thought, I...well what I thought you should have been reviewed every six months on antidepressants (Eleanor)

3.3.1.2 'Potentially poisoning my baby': Grappling with risk

Mothers often discovered they had a different perspective from the professionals about medication, sometimes more risk averse, sometimes less. The professionals were presented by the mothers as taking a rather 'paternalistic' role towards the issue, with words such as 'permission' and 'necessary'. Sometimes the participants described feeling reassured by this and sometimes rebelling against it.

Samantha wanted to come off her medication partly because she now felt well, but also because she wanted to shed that phase of her life, but this was at odds with her doctor's view that she should stay on:

> [I'm] back to my former mood and capable of taking care of [son] and able to go to work and do all these things. And I kind of want to just be free of it. […] [but] every time I've sort of brought it up it's just been 'We really think you should stay on until May'. I think they're kind of looking at it from a statistical point of view rather than a case by case basis. And so it's a bit frustrating to be seen as a statistic [laughs]

Participants were not just managing their own recovery and their relationship with their child, but many were contemplating managing a body in symbiosis with another body during pregnancy or breastfeeding. Participants who became pregnant or planned pregnancy while on medication found themselves caught up in a balancing act between their emotional needs and the needs of their baby, while drawing on incomplete evidence. Words such as 'harm' and 'danger' and 'risk' recur in the data, as do 'ethics' and 'legal'.

One linked her doctor's caution about her trying to get pregnant on a particular medication to the drug companies' legal concerns:

> I think also they don't wanna be sued to kazoo so they'll be conservative with their recommendations. So even if there's the slightest chance that it might cause some elevated risk with pregnancy they'll say [stern voice] "No don't take while you're pregnant." […] so, then as an individual I'm not really basing my decision on the best outcome for me. (Anna)

Conversely several participants were more cautious than their doctors about medication during pregnancy:

> I did speak to my psychiatrist before we were planning on getting pregnant and she explained that on balance I should probably stay on the lithium. [But] I was still quite concerned about the effects on the baby. So I don't know exactly why but I just felt that I didn't want to be on lithium. (Aayah)

Several participants either did not take the medication prescribed to them or came off medication during pregnancy without consulting their doctors:

> It didn't feel to me there was any other option. That I would be potentially poisoning my baby if I carried on. (Alex)

Mothers who subsequently felt their mood worsen then became involved in further risk assessment, echoing the participants' balancing acts in *Balancing Need*:

> Towards the end of the first trimester I was just a bit concerned that I might be feeling high or you know not that well controlled in terms of my mood. So I went back on it […] I just didn't want to be in a situation where I was ill and I was at harm to myself or that.. he was in danger. (Aayah)

Some found the scientific perspective reassuring at this point, with echoes of the *Oxygen mask* subcategory:

> She was really pragmatic and said, "It's completely clear, you must go back on them." And she explained to me about how there's no clinical research because it wouldn't be ethical to do research on pregnant women […] One thing she said that stuck with me was on the balance of risks, that it was more important that my baby had a mum who was healthy than somebody who wasn't. (Alex)

This prioritising by mental health professionals of the patient suffering mental distress over the mother, could lead to more than frustration. Despite her decision not to take the medication during pregnancy being motivated by concern for her

child, one participant was almost reprimanded by the mental health team at the hospital when her mental health worsened after giving birth:

> The mental health team came to see me on the ward and met with me and [my husband], and then I was basically told you didn't take your medication, did you? We told you this was going to happen. (Eleanor)

This exacerbated her difficulties:

> I had guilt with [my partner] that I'd taken away, em, pleasure in having a child, because I was so bad, but then there was also my daughter? Em, she went home and said to my mum 'mummy doesn't want the baby near her', em, so I had that. I then had the guilt that I hadn't bonded with [son], or that I didn't want him near me like it was just there was just a whole heap of guilt […] and then being told well you could have avoided this by taking the medication was just the icing on the cake really. (Eleanor)

Some professionals appeared to see the participants through the clinical lens of mother and baby – such as the midwives and health visitors who found it hard to acknowledge their distress – and expected them to prioritise their baby's needs; whereas others appeared to see them through the lens of 'mental health patient', and were frustrated when – for relational reasons – they did not comply with treatment. There appeared to be a parallel here with the tension mothers felt between the two identities in *Managing conflicting Identities*.

Consistent with this, several mothers contrasted the stringent advice given to mothers *without* mental health difficulties during pregnancy and breastfeeding with the more flexible recommendations they themselves were given:

> It's also confusing, because when you're pregnant, you're basically told to avoid anything remotely useful, medication-wise, like, you know, even just cold remedies and things like that. And then to be breastfeeding and told it's

> absolutely fine to be taking these things – and it's like, well - really? And how much is going into my baby? (Lucy)

This again contrasts with health visitors' horror about formula in the first process, as if at that point professional are concerned with the ideal mother rather than the compliant patient.

Several mothers expressed concern about women and mothers' unique biology not being taken into account in general information and research around medication:

> I've heard that most drug safety studies in humans are based on male biology because it complicates things too much to take into account women's hormonal fluctuations. (Claire)

And most wanted information more targeted at their needs:

> For me it would be more, is there better medications [for mothers]? […] what are the right medications. Especially I suppose when you've got all your hormones [laughs] and all those things. It doesn't feel like there's a hell of a lot of information out there. (Charlotte)

3.3.2 A mother, but not just a mother

The second category in this process captures how participants complained that being a mother can be both over and under-emphasised by services. Whereas in *Managing conflicting identities* the two were separated by the almost magnetic repulsion of conflicting social identities – and that influence still persists at times in this process – here they appeared more often to be kept apart by the way professionals compartmentalised difficulties and client groups. Whereas in the first process mothers themselves worked to keep them apart, here they expressed a desire for them to be integrated. There was a sense in the data of coming up against

professional and institutional power, often amplified by gendered power. Again, the categories include mothers' overtly or quietly resistant responses to this, and to professionals' assumptions, in order to ensure the right outcomes for themselves and their children, and succeed in the task of *Balancing needs*.

3.3.2.1 'Just a mother who can't cope': Resisting dismissal

Several participants felt their distress was dismissed by others in general as just due to mothering. It was if beneath the idealisation of mothering, and the denial of mental health difficulties in the first process, there was an acceptance that actually mothering is so challenging that it could sometimes even be 'misinterpreted' as mental health difficulties:

> A lot of the stuff that I got told in the first year is 'It's knackering being a mother' and 'What do you expect?'. (Vicky)

Participants often talked about how others felt they should just 'get on with it'.

> [My mother in law] said 'Everyone goes through this, you just need to deal with it. (Samantha)

Participants themselves sometimes appeared to assume that 'normal' motherhood and 'mental health problems' were discreet, clearly delineated categories. Some participants themselves looked back after they felt better and wondered whether it was 'just' parenting that was difficult:

> I didn't have a sense of scale as to how much of it was parenthood and how much of it was mental illness (Alex)

This led to some confusion about the diagnosis of postnatal depression, expressed by five of the participants, questioning whether it's really just something biological and 'temporary'.

Two participants felt dismissed by their GP when they requested medication for their experiences of depression.

> They basically just said, "Oh, well, we're all tired, we are all stressed. I get it, you are a [trainee] and you're a single mum. No wonder you feel like this." Oh, well, that's life type thing, so I was kind of fobbed off. (Claire)

In an intersection with process 2, one participant attributed this dismissal of mothers partly to their commitment to 'functioning', which misleads doctors:

> They sort of see you're a person who is getting your child to school, whose child is perfectly healthy and happy. Your family isn't falling apart. Therefore, you can't be that bad. (Vicky)

Some mothers initially complied with the doctor's conclusions and tried to keep going, but when they reached crisis point, they returned and requested an intervention.

3.3.2.2 'I wasn't just at home taking medication': Wanting mothering taken into account

Many participants wanted their parenting responsibilities taken into account more by the professionals who managed their medication, rather than being seen purely as a 'patient'. The word 'whole person' was used by several. For some their mothering being taken into account meant being offered different support in addition to medication. They also wanted their network – whether the GP and health visitor, or professionals and family members – to 'link in', in order to support

them and help them manage their distress and their medication. The words 'support' and 'resources' recurred, and again for several participants the sense that mothers felt they were in a health system under strain.

> I think there was a big gap with the lack of the post-natal support group and the lack of the counselling, perinatal, that support. (Lucy)

Participants also complained that they were not warned about the potential challenges of managing medication 'side effects' as a mother:

> You know like people go why would you do that, you've got kids, why would you kill yourself, that's such a selfish thing to do…however, knowing the side effects that I had with those tablets it would have been very easy for me to have done it […] I was fortunate that I had support around me, but I do think there should be a lot more warnings, on these medications, or…or…women given... because there's a lot of single parents out there. (Eleanor)

And they complained that they were offered no extra support when these side effects were debilitating:

> I said to him I was really struggling with the side effects of it? […] I was saying I'm finding it too difficult, I can't sleep, I'm feeling sick, I've got to look after a baby. But again, where's the support around that? (Charlotte)

Mothers repeatedly conveyed that they were seen as isolated individuals, rather than whole people, which included their motherhood:

> He was very big on right try these different medications with all these different side effects. But I felt it was removed from the fact that I had got a life. I wasn't just at home taking medication, unable to – you know, just isolate myself. […] I felt that he didn't really see me as a whole person. (Naomi)

Several described how they were initially 'compliant', but then stopped taking their medication without consulting, saying things like 'I came off' or 'I took myself off', 'I just stopped'. Several just did not return to their GP after doing so.

The most extreme experience of neglect of her needs as a mother – and as an individual per se – was given by a participant who was separated from her son and admitted to a frightening psychiatric ward in the United States where her physical vulnerabilities as a mother were neglected:

> It was a co-ed ward so I just knew that there were all these like different people around me and they were all there for different reasons, and we were all just sort of existing in this strange drugged up state. [laughs] And I had been breastfeeding, so like I had like mastitis, and it was just like a mess. (Samantha)

She imagined mothers benefiting from a less medical, more specialist setting, tailored to their needs:

> I've heard that in the UK they…rather than give Haliperodol or medications they just sort of keep you in a ward, a mother and baby unit where you're with other mothers, not necessarily on medication, but for a prolonged period of time where you let the time pass
>
> I: Oh right.
>
> P: So… I don't know how true that is. That's just hearsay that I've…
>
> I: Yeah

> P: But I can see that as being, you know, maybe that would have been a more gentle way of…Letting it pass rather than just throwing a bunch of drugs at me. (Samantha)

Several other participants felt that as mothers they required more focused advice:

> A proper consultation regarding medication. Not just 'here's a prescription, go and get it'. […] It's not good enough. And I totally get it, all NHS services are overstretched, but look what ended up happening to me, look what I then had to get involved in. (Eleanor)

3.3.3 'I trust your judgement': valuing collaborative care

This fourth category captures mothers' appreciation for care around medication that takes all their needs into account. It conveys almost a mirror image of the interactions with professionals described above. Participants described a relationship with their GP or doctor in which they felt known, and treated as both an individual with a mind, and as a mother with responsibilities. Most participants saw a range of different professionals about their medication, whether different GPs at the same practice, or psychiatrists at different points in their story, and most had at least some positive experiences. For those who had consistently good experiences, what made the difference seemed to be consistency of care (although consistency did not always produce good care). Words such as 'comfortable', and 'known' and 'consistent' recur, and the third person is often used, conveying collaboration. In contrast to the participants in the first category, all participants within this process felt known and trusted at least at points in their interactions with professionals:

> I sort of staggered into the surgery feeling like death. [laughs] My GP said, "How can I help you, Lucy? I said, "I think I've got PND." [crying] And she was like, "Right, okay." And she basically said, "Well I know your history and I

> trust your judgment, so I think we'll go with that." She didn't even bother doing the – whatever that scale – Edinburgh Scale, is it?

It's striking here that the trust is such that Lucy's doctor dispenses with using the standard measure for 'postnatal depression', in contrast to the participants in *Ticking Boxes*.

Several participants described feeling empathised with by professionals who are sometimes women, and sometimes also mothers themselves, with the word 'empathy' recurring.

> She quite clearly um expresses kind of empathy with me as a woman about certain relationships and stuff. (Megan)

Participants appreciated their mothering being involved in the consultations:

> We always talked about our children, because I always told her how lovely my kids were, and how my, em, how my relationship with them was really great, and that I definitely… she knew that I would never never never want to jeopardise the situation my kids were in because of…because of some feelings I had. […] she said I feel as a mom that at least you're a good mum. (Mila)

Eleven of the participants had had some form of talking therapy since they became mothers, and nine of them found it helpful, partly because it gave them more time, and a space to reflect on their experiences as mothers, among other things:

> Trying to unpick and go, you know, over the journey so far and then actually working through different parts of the journey? […] Like from pregnancy. Also a bit before obviously because you're shaped before that aren't you? (Charlotte)

Most participants contrasted care in which they did not get clear information about medication or time, with care in which they did, whether in different countries, or with different individuals or in different care settings:

> I saw a different GP who did explain…em...She was just better at explaining things to me basically […] I felt that she had more time to kind of explain it (Eleanor)

These professionals helped participants to think ahead about transitions in their lives, when making decisions about their medication just as participants in *Providing Stability* thought ahead to their own children's transitions:

> We had a bit of a discussion about my plans for maternity leave and going back to work. She said it's a really bad idea to come off it when you're doing another big life change. So it's a sort of plan ahead type thing. (Lucy)

4 Discussion

This chapter summarises the results, and then relates them to the literature, including the results of the metasynthesis, the qualitative literature on taking medication, and the parental mental health literature. It includes findings in the metasynthesis papers not explicitly linked to medication or parenting and therefore not drawn on for the metasynthesis's analysis. Following this, it explores the study's contribution to some existing theories about mothering and medication. It then outlines the study's clinical implications and evaluates its quality and limitations. It concludes with suggestions for future research.

4.1 Summary of findings

My findings suggest that when mothers make decisions about medication for mental health they get caught up in multiple competing agendas clashing social identities as mother and medication user that are both freighted with social expectations and hard to integrate; attentiveness and adaptation to the child's emotional needs and stages of development alongside the mothers' own emotional needs; and clinical and organisational agendas that can neglect either their mothering or the severity of their distress.

As captured in the categories, and illustrated in the model diagram in Figure 2, these processes operate at different levels: the discursive, the institutional, the praxis of parenting, and the embodied. And as captured visually in the diagrams of the three processes in Figures 3-4, they involve multiple points of tension and splitting: the tension between a previous identity and new identities, the tensions that arise between a child's needs and a parent's; and the tension when someone with relational concerns encounters a medical model which treats services users as disconnected individuals. Sometimes this tension is not just uncomfortable, but threatening and potentially dangerous, with a threat to survival, and a risk of losing

the right to parent one's child. Participants in this study often appeared to want to bridge the divides and splits produced by these different processes.

It could be argued that the typical medication user that researchers and drug companies have in mind is a discrete individual focused on their own recovery, for whom time is linear, and for the whom the present is most important. By contrast, this study suggests that mothers engage in relational decision-making, and have a more complex relationship with time: they are aware of the finitude of their child's stages, and looking ahead to transitions in their child's life when making decisions about coming off or going back on medication; they also look ahead to the desired next child as well.

The findings suggest that the division between perinatal care and mainstream mental health care neglects the way mothers move in and out of pregnancy and childrearing over an extended period of time. Possibly one of this project's most important findings is that it suggests that mothers take the needs of potential future children into account in their medication decision-making. My research aimed to focused on parenting considerations rather than mothers' concerns about the risks posed to children during breastfeeding and pregnancy, but issues around potential future pregnancies kept being raised by participants, showing that these more physiological concerns persist in between children, with a hidden and unacknowledged impact on their medication decision-making.

4.2 Comparisons with the literature

4.2.1 Mothering ideals and mental distress

The literature on parental mental health echoes my findings in *Caught in a vicious cycle* that mothers feel a sense of failing to meet expectations – from both themselves and others – and conform to the 'good mother' ideal, and they enter a spiral of distress and guilt, and find it hard to be open about their distress. A metasynthesis of the literature on postnatal depression found an incongruity between expectations and reality (Beck, 2002; Bilszta et al, 2011). The parental

health literature finds mothers feeling their confidence reduced by scrutiny (Montgomery, Mossey, Bailey, & Forchuk, 2011), and the insensitive responses of healthcare professionals (Bilszta et al, 2011; Holopainen, 2001). Previous research also finds difficulties exacerbated by childhood trauma (Patel et al, 2013) and a need to juggle multiple responsibilities (Abrams & Curran, 2009). Other studies find similar feelings of guilt (Hine, Maybery, & Goodyear, 2019; Dolman, Jones, & Howard, 2013), and the fear of being seen not to be coping and the need to be seen as strong (Bilszta et al., 2011). Research has consistently found the keeping of difficulties from others and a reluctance to seek help (Halsa, 2018; Montgomery, Tompkins, Forchuk, & French, 2006; Montgomery et al, 2011; Dolman et al, 2013; Diaz-Caneja & Johnson, 2004).

Like my participants both in *Caught in a vicious cycle* and *Finding it hard to be open about medication use*, previous researchers have found a fear of custody loss (Dolman et al, 2013; Sword et al, 2008), although this might be culturally specific, as it was not found in a study of Chinese mothers (Chan et al, 2018). Previous studies have found a 'spiralling' (Beck 2002; Patel et al 2013, p.684) until mothers 'hit bottom' and seek help (Montgomery et al., 2011).

4.2.2 Identity

As outlined in the introduction, concerns about the effect of medication on the sense of self and about entering a stigmatised identity have been found to be concerns for those taking medication whatever their parental status (Higashi et al, 2013; Roe et al, 2013; Tranulis et al, 2011; Wade et al, 2017; Knudsen et al, 2002; Anderson et al, 2015; Beresford et al, 2010). Like many participants in my study, some have found the biomedical model of distress useful in reducing this stigma (Buus et al, 2012; Schreiber & Hartrick, 2002), although the medical model has been shown to be associated with more negative attitudes than psychosocial accounts of distress (Cromby, Harper & Reavey, 2013).

However, both the metasynthesis and the primary research results presented here strongly suggest that being a mother brings an added dimension to this concern. For mothers, taking medication does not just mean acquiring a stigmatised identity, but losing an idealised, strong identity, whose loss might risk the loss of mothering itself. Researchers have found a desire to be identified by others as a 'good mother', and enjoying feeling valued for this (Perera et al, 2014; Tjoflat & Ramvi, 2013), along with a fear of being seen as dangerous (Halsa, 2018,), or unpredictable (Patel et al, 2013). My participants' struggles to combine these clashing identities are consistent with the findings in the second metasynthesis dilemma, *The dilemma of stigma and shame versus functioning as a mother*. In this dilemma, medication use as a mother produced both personal shame at requiring medication (Patel et al,2013; Heron et al, 2012; Bilszta et al, 2011; Abrams & Curran, 2009; Holopainen, 2002) and a stigmatised social identity as a mother on medication (Bilszta et al, 2011; Chan et al, 2018; Turner et al, 2008; Patel et al, 2013, Martinez et al, 2013).

This finding about medication is echoed in relation to mental health in general in the qualitative literature on parental mental health, which finds a universal concern with stigma and identity management, and difficulty reconciling the 'dual identities' of someone with mental health difficulties and the 'good mother' (Dolman et al, 2013; Davies & Allen, 2007). Consistent with my findings, a difficulty integrating the identities was found to be particularly difficult for women whose first experience of a mental health issue came after having a child (Patel et al, 2013). Research has also found mothers more likely than fathers to perceive and internalise stigma associated with their mental distress (Lacey et al., 2015).

Previous research has also found selective disclosure of difficulties by mothers to their social contacts, but also a desire to speak out to reduce stigma (Hine et al., 2019); but unlike in my findings it is related more broadly to mental health, rather than use of medication per se. It has been argued that it would be clinically helpful for clinicians to see mothers who do not seek support as involved in a complex form of 'identity work' produced by these competing identities, rather than being in denial or reluctant to seek help per se (Halsa, 2018).

This study's findings on medication and identity are echoed in mothers' responses to mental health generally in previous research, as if medication is a concrete signifier of mental health difficulties. But medication is not just a proxy for mental health – my findings show that it brings specific challenges of its own for mothers in relation to identity: a heightened sense of risk, something concrete to be hidden for fear of custody loss, the element of cultural mockery of mothers on 'happy pills', and an exacerbation of feelings of weakness through dependency on a substance in order to perform one's mothering role. It is striking that the one paper included in the metasynthesis which directly investigates the issue of stigma for mothers with mental health difficulties contains several themes concerning medication in its analysis (Chan et al, 2018).

4.2.3 Functioning

Users of medication not specified as parents have reported taking medication in order to perform their roles and reduce the effect of their emotional states on their relationships and in order to participate in their relationships and the activities of daily life (Malpass et al, 2009; Salzmann-Erikson & Sjodin, 2018). Users of antidepressants described a reduction of anger and worry, which had a beneficial effect on personal relationships (Price et al, 2009), and female users of antidepressants – who might have been mothers[16] - described them as providing a 'breathing space' (Fullagar, 2009, p.398).

The parental mental health literature has found a similar imperative around functioning (Perera et al, 2014), and a need to 'get on with' being a mother (Patel et al., 2013, p.686). Like my participants, mothers in previous studies have expressed an appreciation of support from fathers and other family members when they were feeling distressed, but continued to view themselves as the primary parent (Halsa, 2018). They felt like a failure if they were no longer able to function in that role (Blegen, Eriksson, & Bondas, 2014). As in the *Put on your oxygen mask* subcategory,

16 Parenting status was unspecified by the researchers

some argued for prioritising their own needs in order to look after their children (Sheehan, Schmied, & Barclay, 2013), and this was encouraged by professionals using the same oxygen mask metaphor (Perera et al, 2014).

But the way the first dilemma in the metasynthesis, *Balancing difficulties and medication effects in order to function as a mother* echoes the *Ensuring Functioning* process in my study strongly suggests that making decisions about medication for their distress brings additional considerations for mothers. In both, participants took medication in order to function as mothers (Turner et al, 2008; Ho et al, 2017; Martinez et al, 2013; Chan et al 2018; Maxwell, 2005; Abrams & Curran 2009). And – as found the metasynthesis theme *Discontinuing because medication effects stop me mothering* – stopped taking medication because 'side effects' prevented them from functioning as mothers (McMullen & Herman, 2009; Rampou et al, 2015). My participants and those in the metasynthesis complained of side effects consistent with the literature on medication use summarised in the introduction, including nausea and lack of motivation (Haslam, Brown, Atkinson, & Haslam, 2004); and sedation (Angermeyer, Löffler, Müller, Schulze, & Priebe, 2001). And like my participants, mothers expressing the metasynthesis theme *Searching for a balance…*, sought a balance between distress and 'side effects' in order to mother (Rampou et al, 2015; Perera et al, 2014; Heron et al, 2012, Deegan, 2005, Chan et al, 2018). For my participants the choices were not so often conceived of as binary dilemmas; and they were also bound up with balancing their own needs with their children's. But the overlap in the findings suggests that mothers' decision-making around medication is bound up quite specifically with their desire to function as mothers.

It could be argued that the literature suggests medication users in general might follow Moncrieff's (2008) 'drug centred model' rather than the 'disease centred model', in that even though they might sometimes speak about medication effects and 'side effects' as separate, pragmatically they don't differentiate them, acting on the basis of their overall functioning, rather than taking medication in order to remove the 'symptoms' of a 'disorder'. It could be argued that for mothers the

simplicity of the individualistic disease model is disrupted still further when children's needs enter the picture.

4.2.4 Balancing needs

Although my study's *Conflicting identities* process and its *Ensuring Functioning* category from the *Balancing Needs* process (as well as the findings about professionals, explored below) were found in the metasynthesis, the categories in the *Balancing Needs* process in which mothers reflected in detail about their relationships with their children and their own experience of mothering in relation to medication use, appear to be unique to this study. The only directly relevant comparable findings were found in a study of fathers with psychosis, who reported that medication reduced their ability to emotionally engage with their children (Evenson et al, 2008). This absence might be partly due to the fact that the topic of mothers and medication was not being investigated directly in 18 out of 19 studies included in the metasynthesis, but emerged as a side concern when exploring a different research question. It might also be due to the research focus of 8 the studies in the metasynthesis being on attitudes to care, including four directly on reasons for non-adherence, a framing which might have led participants to focus on the imperative of functioning rather than exploring the more nuanced emotional needs of their children and themselves.

Despite its absence in the metasynthesis, there are findings in the parental mental health literature consistent with *Meeting Children's Emotional Needs*, though without reference to medication. Mothers report hiding distress (Halsa, 2018), and masking or censoring it (Montgomery, 2011), for the sake of protecting their children. They express concern about the effects of mental health on the child, and the way it increases their tendency to be impatient (Perera et al, 2014), and they express concern about not being available for their children (Rampou et al, 2015). They report balancing their own emotional needs and the needs of their children, struggling to 'be present' (Blegen, Hummelvoll, & Severinsson, 2012), and feeling the 'dual demands' of taking care of their children and of their own mental health (Ackerson, 2003). Mothers also described reaching a turning point where they

realised they had to reduce perfectionism and meet their own needs (Awram, Hancock, & Honey, 2017).

Mothers' own perceptions about the effect of their difficulties on their children have been echoed in research capturing the views of children themselves (Riebschleger, 2004). Children have reported feeling worried and noticing that parents are sometimes not present or are 'grumpy' on 'bad days' (p.27) and unable to perform parenting tasks. A glimpse into the issue of medication is found in children's complaints in the same study that medication made their parent tired (Riebschleger, 2004). But my findings of an explicit interaction between mothers' medication decision-making and their children's emotional needs appears to be new.

4.2.5 Mothers' needs

There is no other literature directly on the interaction between medication decisions and mothers' own pleasures in motherhood, captured in my subcategory *Taking the pleasures of Mothering into Account*. But the findings of my *Child improving wellbeing* subcategory are echoed in the literature on parental mental health, where mothers report motherhood as central and rewarding (Dolman et al., 2013) and as providing a sense of purpose (Krumm & Becker, 2006; Savvidou, 2003). They report feeling saved by their children (Tjoflåt & Ramvi, 2013), valuing and gaining strength from their identity as mothers (Shor & Moreh-Kremer, 2016), and gaining pleasure (Deegan, 2005) and fulfilment (Diaz-Caneja & Johnson, 2004) from the role. These and my findings fit with recent interest in the neglect of 'maternal desire' in our culture, and the importance of recognising the pleasure mothers find in mothering (De Marneffe, 2015).

Previous research finds a similar preoccupation with loss and regret, with mothers diagnosed with a range of forms of distress experiencing regret over loss of early parenting experiences (Hine et al., 2019), and mothers diagnosed with 'postnatal depression' looking back to time lost with their baby (Patel et al, 2013; Heron et al, 2012). My study added the insight that mothers' regret can encompass regret over their decisions about medication.

The way mothers think about time differently has been touched on in previous research. Studies have found a sense of urgency in relation to children's finitude and vulnerability (Tjoflat et al, 2013; Heron et al, 2012), and mothers looking ahead and fearing relapse when making decisions about having more children (Patel et al., 2013). But again, medication decision-making is not explicitly included in these studies. My research has therefore contributed original insights into the way mothers' emotional responses to their children and the balancing of these with their own emotional needs influence their decisions about medication, and it captures the way this engages them in temporal considerations perhaps not experienced by other users of medication.

4.2.6 Relationships with professionals

Like my participants, participants not specified as parents have complained of a lack of collaboration and communication around their medication with professionals (Harris et al, 2017; Byrne et al, 2006; Lorem et al, 2014). They have also criticised a lack of support (Higashi et al, 2013), and a lack of acknowledgment by professionals of the negative impact of medication (Morant et al, 2017). They have expressed a desire for more information (Salzmann-Erikson & Sjodin, 2018; Gibson et al, 2013; Anderson & Roy, 2013) particularly on 'side effects' (Garfield et al., 2004). They wanted better emotional support from professionals, more regular reviews (Leydon et al, 2007), and more stability in their relationships with them (Gibson et al, 2013).

In relation to mothers' concerns, research has found a desire for more personalised care, time and empathy from medical staff (Holopainen, 2002), and a resistance to being separated from their child and placed in a general psychiatric setting (Heron et al, 2012). Research has also found a desire for family dynamics to be taken into account, the family as a source of support to be engaged with and valued, and children's needs to be taken into account (Keogh et al, 2017). My findings are consistent with the lack of any focus on parents in mental health services mentioned in the introduction (SCIE, 2009).

Echoing the *Just a mother who can't cope* subcategory, mothers with a diagnosis of 'postnatal depression' have expressed confusion around what to attribute to adjustment to parenting and what to attribute to mental health difficulties (Patel et al, 2013; Bilszta et al, 2011). They also experienced professionals and others normalising their difficulties as part of motherhood (Bilszta et al, 2011; Sword et al, 2008), and described being faced with the view that they should 'pull themselves together'. (Blegen et al., 2012). Like my participants and their doctors, these mothers and the professionals they consult appear to see the distress produced by 'normal' motherhood and that produced by 'mental health problems' as distinct.

Like my participants in *Resisting the medical model*, mothers with mental health difficulties have complained about finding mental health care cold, impersonal and over-scientific (Abrams & Curran, 2009) and wanting more consistent care (Diaz-Caneja & Johnson, 2004). They find it difficult when there is not already an established relationship with a professional before mothering (Russell, 2006, cited in Sword et al 2008). They have also complained about professionals not asking about their experiences of parenting (Diaz-Caneja & Johnson, 2004), and expressed the view that health professionals should consider the needs of mothers and their children, while acknowledging a tension between their needs as mothers and their needs as 'psychiatric patients' (Heron et al, 2012). Again, mothers themselves appear to conceive of the two as being distinct. Participants in both my study and the metasynthesis (Cremers et al, 2014) described the experience of having professionals 'throw' medication at them, vividly capturing how their care seemed to feel somehow impatient and impersonal.

Echoing my *Valuing collaborative care* category, though with a more medical slant, researchers highlighting mothers' struggle with a conflicting dual identity recommended that skilled health professionals move between an 'interactional frame' that treats the woman as 'mother' and one that treats her as 'patient' (Davies & Allen, 2007, p.373). Others recommended 'walking alongside' mothers, taking

their life situation into account, and trusting their own expertise (Ottar, Marit, Randi, & Bengt, 2014).

However, none of the above critiques about mothers' interaction with professionals related specifically to their decision-making about medication. The metasynthesis and the findings of my research both filled this gap in the research, with the *Wanting mothering acknowledged in interventions* dilemma in the metasynthesis and the *Seeking integrated care* process in this study both producing strikingly similar findings about the specifics of care around medication desired by mothers.

The metasynthesis theme *Wanting mothering taken into account in medication consultations* matched strikingly closely with my subcategory *Wanting mothering taken into account*. The metasynthesis found the same complaints as my study about the impact of side-effects on parenting not being adequately taken into consideration by professionals (Bartsch et al, 2016; Diaz-Caneja & Johnson 2004; Heron et al, 2012), and about information about medication not being tailored to their needs as parents (Holopainen, 2012; Rampou et al, 2015; Heron et al, 2012).

Similarly, the metasynthesis theme *Feeling mothers need a space to talk* echoed the findings in my categories *Ticking boxes*, and *Valuing collaborative care*. In both the metasynthesis and this study there was a contrast between an impatient, coolly scientific care with a more empathic care. Participants felt not properly listened to, and that medication was prescribed in an unthinking way, without the provision of wider support (Abrams & Curran, 2009; Cremers et al, 2014; Turner et al, 2008; Heron et al, 2012). They expressed a desire for a space to talk (Sword, 2008; Turner et al, 2008; Heron et al, 2012), ideally to a trustworthy woman (Abrams & Curran, 2009), and appreciated being given more time (Holopainen, 2002); and they appreciated the way their concerns about their children could be included in talking therapy in contrast to medication consultations (Cremers et al, 2014).

The metasynthesis produced one finding about medication and professional care not included in my analysis: the theme *The difficulty for mothers of accessing*

interventions. Participants complained about not having childcare to enable them to attend medical appointments (Rampou et al, 2015), and opted for medication because of difficulties travelling to therapy appointments as a mother (Turner at al, 2008). They opted not to take medication to avoid an increase in medical appointments, which brought the need to wait (Turner et al, 2018), and led some to self-medicate with sedatives (Holopainen, 2002). This fits with findings that mothers on low incomes complain about practical constraints in accessing mental health treatment (DeCou & Vidair, 2017).

My study did not replicate these findings, perhaps partly because 13 out of 15 of my participants were getting support from a different (UK) health system[17] from participants of two of the studies above, and perhaps because my sample differed in relation to social support, economic situation and difficulties experienced. My participants were mainly middle class, employed and married (see Limitations). The participants mentioned work as a strain but also as a positive, and their husbands were quite present in the data, often giving support and advice. Whereas eight out of 10 of the participants in Rampou et al (2015) were single or divorced, and only one was employed, and in Turner et al's (2018) study fewer were in work and of those fewer in professional employment than my study. Logistical challenges might also have been presented by the fact that all eight participants in Rampou et al (2015) had been given 'diagnoses' that suggested severe difficulties, and the participants in the other two studies had been given a diagnosis of 'postnatal depression', and were therefore caring for young infants. This variation in findings highlights the need for future research to take into account how mothers' circumstances vary in ways that affect their medication decision-making (see Limitations and Future research).

4.2.7 Summary of comparisons with the metasynthesis

Despite differences in research focus, epistemological stances and participant characteristics, there are striking consistencies between the findings of my study and

17 A suburban area in Australia (Holopainen, 2002), and an urban area in South Africa (Rampou et al, 2015).

the metasynthesis, in both the details of their results and also in the overall feel of their analyses as containing tensions, splits and things that are hard to integrate. (See the Limitations section for a consideration of my own role in this similarity.) Both found the same concern with functioning, and the weighing up of the effect of difficulties and medication effects on parenting and on the child. Both convey the same sense that the concern with stigma found in the qualitative literature on medication has an added layer for mothers, in that it is at odds with a culturally constructed strong and selfless mothering identity. And both find the same unhappiness with professional care that is not supportive and collaborative, that has a narrowly medical view of difficulties and does not take mothering into account. This suggests that some genuine preliminary insights have been generated into the subject of mothers' decision-making around medication for mental health difficulties by this project as a whole.

Both this study and the metasynthesis suggest quite agonised decision-making at times, although the metasynthesis often conveys a more desperate, stuck response. This is captured in the organising principle of dilemmas, and theme titles in the literature such as 'the lesser of two evils', 'no-win', and the repetition of words such as 'struggle' and 'battle', 'ambivalence' and 'uncertainty'. This might be partly due to the inclusion of investigations into adherence and relationships with services contained in the metasynthesis, which might have selected participants struggling with decision-making, and might have put participants into a self-justifying position when defending a single point of decision-making. It might also reflect the higher number of participants experiencing social and economic stressors and more severe mental health difficulties in the metasynthesis studies than in my study.

My study's exclusive focus on mothers' decision-making about medication and its focus on the social processes that inform this, has enabled it to capture deeper and broader insights into the research question. They include how medication decision-making for mothers is informed by empathetic concerns about the child's emotional needs, and the mothers' awareness of their own needs as a mother, and the way it

catches them up in time, both in looking back with regret, and looking forward to new stages in their child's development, and to a desired new baby.

4.3 Theoretical implications

This section considers some theoretical links that can be made around each of the three processes. It focuses particularly on the way my findings in the second process map on to some recent ideas about both motherhood and medication, informed by feminist and psychoanalytic ideas and the growing literature on maternal ethics. I have focused on this literature partly because of my discovery of some striking parallels between my findings and the existing literature on maternal ethics; and also because the detailed relational findings around medication found in my second process are the most novel of my findings. If space had permitted, theoretical links might also have been made with systemic factors and the influence of the broader social context.

4.3.1 Ideologies

Both the 'mother' and the user of medication for mental health have been subject to recent scrutiny by cultural critics. Feminist scholarship has highlighted how mothering as a historical construction has served the political and economic needs of particular cultures, reaching a peak in recent decades with the ideology of 'intensive mothering' (Hays, 1996). This has brought an insistence on maternal perfection (Newman, 2014) just as more women also have work outside the home.

Being subject to cultural expectations of perfection while left with most of the burden of domestic work – as mentioned in the introduction as a source of unique stress for women generally – exacerbates mothers' vulnerability to mental distress and feelings of failure and entrapment (Johnstone & Boyle, 2018).[18]

[18] Much of this theorising focuses on middle class professional women. Research has found that age, class, ethnicity employment and economic status all influence mothering and perceptions of the mothering role (Koniak-Griffin, Logsdon, Hines-

At the same time, the disease model of mental health has been seen as producing a modern form of selfhood which regards distress as due to neurochemical deficiencies, making medication a 'technology of self-improvement' (Rose 2007, cited by Fullagar, 2009). A hermeneutic approach has argued that this enables unwanted parts of the self to be split off and attributed to biological processes (Stepnisksy, date, p.202) rather than being integrated, as in previous religious or psychoanalytic versions of the self.

It could be argued that these two modern strands of ideology come together in a way that affects women disproportionately. Research into women's antidepressant use has shown the way media representations promote Prozac's enhancement of the productivity of white, middle class women (Blue and Stracuzzi, 2004), and the way women justify using antidepressants in order to feel 'normal' and cope with all the competing demands on their time and emotional energies, with reference to the idea of 'the neurochemically deficient self' (Fullagar, 2009). Mothering is one of the roles mentioned in these studies, but my research provides more detail on the pressures of mothering in particular and how these might intersect with medication decisions. It also broadens the picture to include all the main groups of medication.

4.3.2 Maternal ethics

Recent philosophical and sociological scholarship on mothering differentiates the patriarchal ideology of motherhood described above from the day to day practices of mothering. It argues that the role creates particular capacities and ways of thinking which should be valued by society (Ruddick, 1995). Living in close proximity to 'a rapidly changing other' (Baraitser, 2008) has been held to produce a particular kind

Martin, & Turner, 2006), but more research is needed into how economic status or cultural background inflects mothering ideals and practice.

of subjectivity, including a less bounded sense of self, that is not necessarily gender specific (Ruddick, 1995, p. 61).[19]

One of the most influential of these theorists, Ruddick (1995), concluded that the child has needs for 'preservation, growth and social acceptability' and that meeting these needs generates three kinds of maternal work respectively: 'preservative love, nurturance, and training'. Rather than seeing mothering as mindless physical care, Ruddick argues that it therefore requires a particular form of complex ethical thinking from mothers, in order to carry out these responsibilities, and that key elements are cross-cultural.

Ruddick's forms of maternal thinking map strikingly closely onto my participants' desires in the *Balancing needs* category to protect, be calm and present, and be role models. My study suggests that mothers under pressure to perform this demanding form of thinking might sometimes turn to (or away from) medication in order to achieve it, especially if they are undertaking it while experiencing distress and social stressors[20].

Maternal thinking is generated partly because 'we think when we are disturbed and want to recover equilibrium' (Ruddick, 1995) and children disturb mothers' equilibrium. Mental distress, too, could be argued to bring a disturbance to our equilibrium and the sense of self, meaning that mothers with mental health difficulties are having to contend with two simultaneous disturbances to the self, and their medication decisions then have to 'balance' both.

Where maternal thinking may involve an unbounded self, women also specifically experience an unbounded body during childbearing and breastfeeding, which has been argued to produce a different, less unitary form of subjectivity (Marion Young,

19 For historical and biological reasons it is currently mainly found in women.

20 The relationship between and impact of mental distress on maternal subjectivity and thinking appears to be neglected in this literature.

1990). The literature on the phenomenology of pregnancy has not to my knowledge considered mental distress, and my study shows some of the complex balancing acts required when medication decisions need to be made while pregnant or planning to conceive.

More recent studies have argued that mothering produces a unique relationship with time, with interruption by the child breaking up our egoistic relation with ourselves (Baraitser, 2008). In contrast to what might be a more linear narrative of the boundaried individual taking medication in order to recover, it is striking that my participants 'interrupt' courses of medication, stopping or going back on for their children, bearing the child's own transitions and developmental shifts in mind in their decisions.

4.3.3 Psychoanalysis

Psychoanalytic theory too has emphasised the relational demands made on parents, who must act as a thinking container for the child's own undigested distress (Bion, 1963), and must provide a 'facilitating environment' for the child's development (Winnicott, 1963, chapter 7). It acknowledges what huge demands this makes on parents, who therefore themselves need support (Winnicott, 1963), and containment (Bion, 1963) in turn. At times in their talk of the 'calming' effects of medication it seems a possibility that medication provides a 'container' for some of my participants while they do the difficult work of parenting. A new approach to medication using object relations theory, acknowledges that medication can sometimes be treated as a person, or object, including a 'soothing object' (Tutter, 2006). At other times, my participants appeared to want this containment from professionals, and there are hints of parallel processing (Searles, 1955) in the similarities between the empathetic, calm, patient stance they seek from professionals and what they expect from themselves as mothers. Future investigations might explore these dynamics.

4.3.4 Concluding reflections on mothers in the current mental health system

My findings suggest that mothers want their 'maternal thinking' acknowledged in consultations. Whereas in Malpass's model of antidepressant use (2009) the 'self' that is taken into consideration in medication decisions is seen as private and individual, and not relevant to the medical consultation, for my participants the self and its concerns appear to be relational – being a mother influences their decision-making and they want that brought into the consultations.

All of the nuanced relational thinking and complex subjectivity described above takes place in a mental health system premised on a radically different idea of the self. The medical model ignores the social experience of the self (Davidson, Golan, Lawless, Sells & Tandora, 2006), and the way that distress only has meaning within social relationships (Broome & Bortolotti, 2010). The mental health system which employs this model subsequently ignores relationality, both in the causes of and interventions for mental distress (Pilgrim, Rogers, & Bentall, 2009). Part of my participants' dissatisfaction with the professional care they receive appears to be the way it is so at odds with their relational way of thinking. And many professionals and clinical guidelines in turn ignore the thinking that many mothers themselves are doing and the way it affects their attitude to interventions for their mental distress.

On the other hand, if fathers and others more often shared the work of maternal thinking, it might encourage mothers to prioritise their own needs, secure in knowing that their children's needs are being met. A societal shift that enabled this, reflected in policies, resources and support structures, could reduce the pressure on mothers to function. This might then lead to fewer mothers experiencing distress, and making decisions about medication.

4.4 Clinical implications

My findings suggest several recommendations for policy and practice. The NICE guidelines suggest clinicians should be aware of stigma associated with diagnoses (Shepherd & Parker, 2017). My findings suggest they could also highlight for clinicians the particular difficulties for mothers. Mothers might benefit from a greater

awareness among professionals, in both maternal and mental health services and primary care, of the pressure of mothering ideals and the difficult identity clash they therefore face when experiencing mental distress and taking medication, which makes it hard to be open about their distress.

At present the only specific clinical guidance regarding mothers experiencing distress is for those who are 'planning to have a baby, are pregnant, or have had a baby or been pregnant in the past year' (NCCMH, 2007). After that point parents become invisible in the mental health system and in all of the clinical guidelines about adult difficulties. For example, in the guidelines for depression, families are mentioned as sources of support for the person with depression, and sleep hygiene and a programme of regular exercise are recommended in the guidelines, perhaps implying the individual has no caring responsibilities of her own (Shepherd & Parker, 2017).

Clinical guidelines could include consideration of how the parenting role might impact decision-making. The findings suggest that mothers with children of all ages would benefit if professionals conducting medication consultations were more aware of mothers' drive to function and the relational nature of their decision-making. They could also take into account their desire for more empathic consultations which take their mothering into account. A review has concluded likewise that taking the subjective experiences of parents into consideration in services is crucial (Krumm, Becker, & Wiegand-Grefe, 2013). Parents would also benefit from clearer information, particularly around 'side effects' and length of course and how these might affect their parenting, and an awareness of their desire for wider support. The potential impact of regret on both mental health and decisions about future interventions could be sensitively explored with mothers.

At the moment the clinical and research agenda around mothers' decision-making about medication is limited to the perinatal period, which runs from conception until the baby is one. It would benefit mothers if professionals in primary care and mental health services were aware that mothers – and indeed women who are not yet mothers – might be considering having a future child or children over the course of

their child-bearing years, and that this possibility might affect their decision-making about medication. This is particularly important in a time when our health services have perhaps solidified the divide between perinatal mental health and other mental health services with the recent welcome expansion of perinatal services.

As well as all the splits described in this study, there tends to be a divide in services between the tasks of medical staff and psychologists and therapists, and the latter tend not to explore in detail their client's decision-making about medication. However critical we are, it is important for psychologists to understand medication and its effects, as one of the core treatments offered, and to provide clients a space to reflect on it, as recently recommended for psychotherapists.[21] (Guy et al, 2019) Doing this study has helped me feel more informed and engaged when clients raise the topic of their medication, and to feel more confidence when liaising about it with the MDT. Clinical psychologists could also be aware of the potential desire for more children and of 'maternal thinking' in their assessments, formulations and interventions for mothers and could share this awareness with the MDT.

4.5 Quality criteria

I strove as far as possible to fulfil the quality criteria for qualitative research (Elliott, et al 1999; Tracy, 2010), as shown in Table 11.

Table 11

Steps Taken to Ensure Research Quality

Quality criterion	Steps taken	Documentation for reader
Reflexivity and transparency	Reflective journal	Extracts of journal in Appendix R
	Supervision	Reflective section in Appendix Q
	Peer and service user consultation	

21 The same publication reported that 96.7% of therapists reported worked with a client currently taking medication, but only 7% felt trained to advise them on their concerns.

		Outline of interviewing and analytical processes in Methodology. Interview schedules from different stages and extracts of key stages of analysis included in Appendices S to Z
Rigour	Interviews all between 50-90 minutes long. Rich data produced. Confirmed via supervision.	Outlined in Methodology and in data extracts in Appendix T.
Ethical	Detailed risk assessment conducted. Service user consultation sought. Sensitive consent-soliciting process Sensitive preparation for and conduct of the interviews. Careful debrief, and follow up communication.	Considerations of risk outlined in Methodology; consent procedures, interview process and consultation outlined in Methodology and documentation included in Appendices G to J.
Clarity and coherence	Feedback sought from supervisors, peers and service user consultant.	Process and impact of consultation described in Methodology
New and valuable topic	Topic only investigated, on a more specific sample, in one previous study (Patel et al, 2013) The findings have clear clinical implications.	Original research question demonstrated in narrative literature summary and Metasynthesis. Clinical implications outlined in section 4.10.

4.6 Limitations

4.6.1 Sample

The sample was self-selecting, and therefore might have skewed towards those who saw a connection between medication and mothering and towards those who felt clear and confident enough about the topic to be interviewed – for example, more than half of my sample had taken medication before becoming a mother.

Perhaps because of recruitment through my own network and through social media, the sample was mainly white, middle class, and heterosexual. [22] They were also able bodied and in employment and seemingly stable housing, and had had children in their late twenties or early thirties. The twelve who were married described that they were generally well supported by their husbands. Only one of my participants did not regard herself as the primary parent. My participants' education level and class might have influenced my findings, for example, in enabling them to be more assertive with professionals about their medication and in influencing the assumptions professionals made about them. It also enabled a number of them to access private therapy. The decision-making about medication of participants who were also suffering poverty, domestic violence, racism or other forms of prejudice and unable to pay for interventions outside the health system would very probably have been different in important ways. Mothers on low incomes have reported that navigating the social service and welfare systems added to their feeling of having an overwhelming amount to juggle, and they attributed their difficulties to this and to lack of money and unsafe living conditions, believing they therefore did not require medication (Abrams & Curran, 2009). Studies have also found both effects on experiences of parenting and negative experience of mental health services in mothers experiencing homelessness and substance use problems (Barrow 2014), abuse (Perera, Short, & Fernbacher, 2014) and racism, as well as religious beliefs (Carpenter-Song, Holcombe, Torrey, Hipolito, & Peterson, 2014).

22 Despite some inaccuracy in the algorithms used to determine demographics of Twitter users, it appears that the middle class professionals and self-employed are over-represented on the platform (Sloan, L, Morgan, J, Burnap, P, Williams, 2015)

4.6.2 Methodology

Grounded Theory was appropriate for the research aim of getting a broad sense of the social processes involved in an area not previously researched; but the use of a discourse analysis might have enabled more sustained investigation into how participants responded to the ideologies they were caught up in, and a phenomenological methodology might have produced more in-depth insights into their emotional worlds as mothers and medication users.

4.6.3 Influence of the metasynthesis

The similarities between the results of my own research and the findings of other researchers as presented in the metasynthesis suggest that some genuine light has been shed on my research question by this project as a whole. However, although I conducted the analyses of both my own research and the metasynthesis methodically and separately, and did not consciously make any changes to either that were informed by the other, it should be borne in mind that I conducted both analyses in tandem within a short space of time, and that the influence of one on the other might be partly responsible for some of the striking similarities between the two.

Even if the analyses did not influence each other, the similarities between the two might also conceivably reflect my own pre-existing assumptions and analytic tendencies (for example, a tendency towards polarised thinking). Despite my regular use of supervision, further consultation on the analysis from peers and my service user consultant, and the fact that conflicts or dilemmas were also found in the secondary analysis of most of the papers analysed for the metasynthesis, other researchers might have generated quite a different analysis for both.

4.6.4 Epistemological limitations

As outlined in section 2.8 and explored further in Appendix Q, I was aware throughout the process of how the framing of the research question and my own epistemological stance might have influenced the research process and findings.

As explored further in Appendix Q, the research question and interview schedule might have prompted some participants to try hard to see connections between mothering and medication, especially given the context of a social system which expects mothers to see their role as primary. In the analysis, I was sometimes concerned that my research focus and questions had made certain codes more likely, and that I again risked perpetuating mothering ideals with categories which emphasised how much mothers took their parenting into account when making decisions about medication.

I was aware throughout the data gathering and analysis that my own critical stance on the medical model of distress might be affecting how I conducted and analysed the interviews. My own cultural and professional assumptions might also have influenced the conduct of the interviews, the lenses through which I viewed the data and the theoretical links made in the discussion – for example, my interest as a clinician in relational interventions, with their focus on early relationships, might have led to the more intrapsychic emphasis, particularly in the second process. Another researcher might have explored socio-political factors influencing the mothers' decision-making in more depth at interview stage, and been more alert to these factors in their analysis.

4.7 Suggestions for future research

Researchers could expand on my findings and address some of the limitations of this study by investigating the decision-making around medication of the broader samples of parents more generally, and of women, in order to compare the findings, and further establish what is unique to mothers' decision-making. Future researchers might also investigate the decision-making of more specific samples of mothers, and others, as shown in Table 12.

Table 12

Avenues for future research

Mothers with different experiences and backgrounds
With less social support
Experiencing financial and/or housing strain
From different cultural backgrounds and family formations.
Experiencing more severe difficulties and ongoing not represented in my sample, such as hearing voices.
Who have experienced crisis, and/or enforced medical treatment.
Who have experience the removal of their children.
With more children (only three of the participants for this study had more than one child).
Who have adopted or are fostering children
Who are parenting children with disabilities or other additional needs.
Those in extended or blended families or same sex relationships.
Research might also compare mothers' decision-making around medication to their decision-making around other types of intervention.
Other groups
Fathers
Grandparents
People making decision about medication while providing other forms of care, such as for older adults or adults with learning disabilities.
Professionals – for example a study focusing on awareness in professionals of the concerns raised by mothers in this study.

4.8 Conclusion

This study has contributed to the small body of literature on medication for mental health difficulties from a psychosocial perspective, and has shed light on an issue for mothers experiencing distress that has either been unaddressed in the literature on their experience to date, or included in a fragmented, accidental way. It suggests that decision-making about medication for mental health difficulties brings particular tensions and challenges for mothers, generating some important clinical implications, and areas for future research.

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Appendices

Appendix A Metasynthesis Search Terms

Mother	Child Parenting	Medication	Actions and Attitudes	Mental health	Qualitative research
Women	Baby	Treatment	Decision	Disorder	Qualitative
mother*	kids	Medication	Ambivalence	Mental health	Experience
parent*	son	Drugs	Adherence	Depression	Phenomenological
mum*	daughter	Psychotropic	Beliefs	Psychosis	Grounded theory
Maternal	family	Pills	Feelings	Anxiety	Them*
	child	Antidepressants	Perceptions	Mental illness	Voices
	dependent	Neuroleptics	Side effects	Mood disorder	Personal accounts
	taking care of	Prozac	Quitting	Schizophrenia	
	looking after	SSRIs	Effects – positive and negative	Bipolar	
		Antipsychotic		Depression	
		Mood stabilisers	Meaning		
		Pharm*			
		Tablet			
		Medication AND mental health			

*terms truncated during search

Appendix B Metasynthesis Literature Search Inclusion and Exclusion Criteria

The inclusion and exclusion criteria for the metasynthesis literature search can be found in the table below.

Inclusion criteria	Exclusion criteria
Qualitative research	Substance misuse
Peer reviewed journals	Forensic or inpatient populations
Women with dependants at the time of being prescribed medication	Participants whose children have been removed from their care.
Participants aged >18	Older adults
Medication could include all prescribed medications for mental health including anti-depressants, mood stabilisers, anti-psychotics/neuroleptics or minor tranquilisers, or any combination of these	Young people
	Effects on children
	Data from sources other than interview/focus groups (survey, online data etc)
Published post-2000	Pregnancy
	Non psychiatric medication
	Only male participants
	Participants not yet of childbearing age

I excluded research about pregnancy because my scoping had found the primary concern around medication in this body of literature to be harm to the foetus and the focus of this metasynthesis was on parenting rather than physiological concerns.

Because the social contexts of both mothering and psychiatric medication are quickly evolving, I decided to include only papers published since the year 2000, and to exclude those whose participants were older adults.

I excluded research studies whose participants engaged in substance misuse, because it might be hard to separate out its effects from the effects of prescribed medication, and because substance misuse might impact on parenting (Rampou et al., 2015). I decided that mothers whose children were in care would be engaged in a different decision-making process around medication.

I decided to focus on rich qualitative data gathered through individual interviews or focus groups. Studies using qualitative data found online in blogs or message boards, or through surveys and questionnaires were therefore excluded.

Appendix C Rationale For Final Selection of Papers for the Metasynthesis

Lack of raw data

In order to ensure that the meta-ethnograpy's conclusions were transparent and valid I decided to include only papers in which the analysis was illustrated by raw data, or by a clear and specific authorial summary of the raw data, such that the origins of the authors' analysis were transparent.

Lack of clarity of terms

Papers were excluded if there was any ambiguity or lack of clarity about mothering or medication being directly involved in the analysis, for example, even if 'treatment' appeared to imply medication but medication was not specified; or if caring responsibilities were mentioned, but mothering not specific.[23]

Lack of inductive analysis

In order to ensure the metasynthesis met its aims of translating findings into third level analysis, I excluded papers where analysis was not genuinely inductive – for example, where it was either structured around responses to the questions asked or clustered via pre-existing issues or models.

Clarity of procedure and write up

Sandelowski & Barroso (2006) recommend that papers should not be excluded by quality from a metasynthesis. However I felt clarity of analytic process and coherence of expression (Tracy, 2010) were crucial in order to interpret and

[23] I retained one paper (Tjoflåt & Ramvi, 2013) despite a lack of clarity about mothering and medication being definitely involved in its analysis. The paper in question did not specify whether the data on parenting and medication came from one of 5 female participants or 1 male participant, but I felt inclusion was justified because the tone of the raw data and statistical likelihood strongly suggested it concerned a mother.

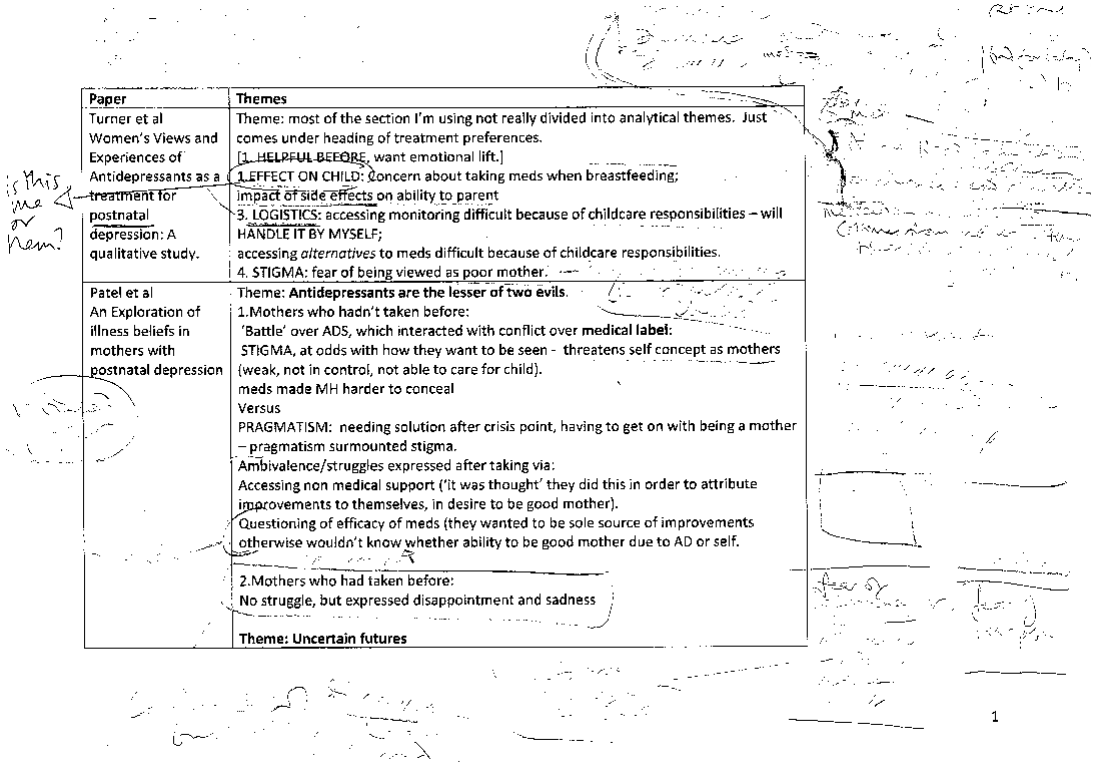
translate the findings. Papers were excluded where the conclusions were hard to understand because the expression was poor or the original badly translated, or the studies had a specific philosophical stance that was hard for me to follow. Several papers were excluded for this reason when I tried to summarise their findings about mothering and medication for the summary table and was unable to do so confidently.

Appendix D Extract from the Table of Raw Data for the Metasynthesis

Paper	Quotes from participants on medication. [Authors' words in brackets.]
Depression Symptoms Among Low-Income Ethnic Minority Mothers in the United States (Abrams & Curran, 2009)	[Take a pill theme] Marta: I went to the doctors and they gave me Xanax and I said, "I'm not gonna take it," and they say, "Just take when you feel like you can help things and just to relax but don't drink it all the time." And I got it but I threw them away in the toilet. Interviewer: You did? How come? Marta: Because as I say, I could handle it. You know I thought that I would handle it. I could handle all the stress and all these things. So and I went back to the doctor and he would say, "You drinking them pills?" and I would say, "Yeah, I'm drinking it." He said, "Do you feel better?" I would say, "Yeah I feel better." [this isn't really presented as a dilemma – except between being strong and conforming to doctors' advice.] [Medication first theme] 'Medication first' was interpreted by mothers as 'uncaring' or a substitute for really listening]. They evoked medicalised images of 'white coats', 'clipboards' and 'laboratory testing'. Whereas the preference is for 'talking it out' and the 'ideal' person to talk to is a trustworthy, noncritical woman who takes time to listen and express care and concern. 'I wouldn't like somebody all dressed up and looking like, you know what I'm saying? Just looking like they're doing an experiment you know, but just look like a regular person, just to listen'.
Women's Experience of Postnatal Depression - Beliefs and Attitudes as Barriers to Care	[When medication was offered as a treatment option, many women found it extremely difficult to weigh up the risks and/or benefits of medication in relation to the severity of their symptoms and the potential side effects to their infant.] A: 'that was another issue for me really to get over, was the fact that I did need help in the form of that medication. It was very hard for me to accept that, and I still feel very bad sometimes that I have to

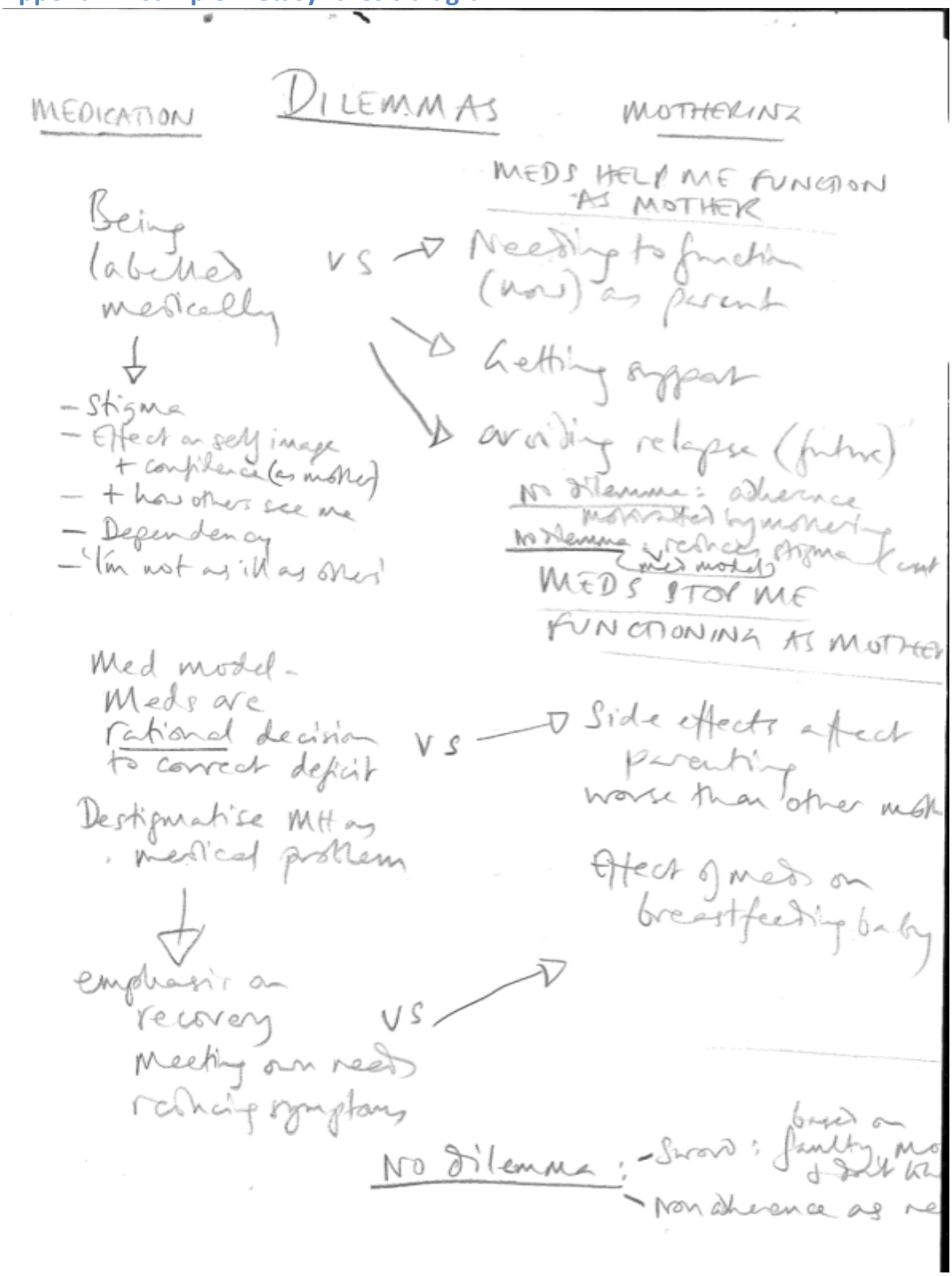
(Bilszta et al., 2011)	take it. There's been a couple of times over the last three years that I've just stopped taking it because it's made me feel so bad that I'm taking medication' (Community focus group). [Also stigma dilemma: Theme: Health professionals] – no raw data. See theme summary sheet.
Experiences of self-stigmatization and parenting in Chinese mothers with severe mental illness Chan, Ho & Bressington	L: She (sister-in law) had once scolding me in supermarket, in front of my husband, saying "just take your medication, you are mentally ill!"...Others in the streets would become scared of me, avoid me!..I felt like I wanted to avoid it (from happening) H: There was once I tried a medication regimen, I did not even know what I was doing after taking it... I did know I have something to do but I was unable to tell him what I needed to do.. .I was woolly then, he could only follow me around in the streets.. . I: I deciding on whether to take medication.. . he (father) suggested me not to take medication.. . He.. .he didn't want me to take it, he just told me to think more positively.. .I hesitated.. . B: Before taking medication, I would easily get into fights with my husband...it scared the kids. Then I fig- ured it cannot happen again, and I started medication. After I took medication, it was alright since... G: I would become drowsy after taking medication...they (other parents) would urge them (their children) to achieve more... if I could, I would have done the same... send them to competitions.. . they might learn slower than others I think. Now all children are racing with each other, but then they (her children) might ended up behind... A: I seldom take my medication now.. . unlike those who are seriously ill... I won't give up, so you don't have to worry about me. F: .. . it was too tiring. I told my doctor I didn't want to take that much (medication).. . He helped me to titrate it to half a tablet. But I am actually taking one whole tablet now, and have to take it daily (to keep my emotions stable to parent my child). If I missed it for 2-3 days, it would start to get worse...

Appendix E Annotated extract from the Table of Second Order Analysis for Metasynthesis



Paper	Themes
Turner et al Women's Views and Experiences of Antidepressants as a treatment for postnatal depression: A qualitative study.	Theme: most of the section I'm using not really divided into analytical themes. Just comes under heading of treatment preferences. [1. HELPFUL BEFORE, want emotional lift.] 1.EFFECT ON CHILD: Concern about taking meds when breastfeeding; impact of side effects on ability to parent 3. LOGISTICS: accessing monitoring difficult because of childcare responsibilities – will HANDLE IT BY MYSELF; accessing *alternatives* to meds difficult because of childcare responsibilities. 4. STIGMA: fear of being viewed as poor mother.
Patel et al An Exploration of illness beliefs in mothers with postnatal depression	Theme: **Antidepressants are the lesser of two evils**. 1.Mothers who hadn't taken before: 'Battle' over ADS, which interacted with conflict over **medical label**: STIGMA, at odds with how they want to be seen - threatens self concept as mothers (weak, not in control, not able to care for child). meds made MH harder to conceal Versus PRAGMATISM: needing solution after crisis point, having to get on with being a mother – pragmatism surmounted stigma. Ambivalence/struggles expressed after taking via: Accessing non medical support ('it was thought' they did this in order to attribute improvements to themselves, in desire to be good mother). Questioning of efficacy of meds (they wanted to be sole source of improvements otherwise wouldn't know whether ability to be good mother due to AD or self. 2.Mothers who had taken before: No struggle, but expressed disappointment and sadness **Theme: Uncertain futures**

Appendix F Sample metasynthesis diagram



Appendix G Participant information sheet

PARTICIPANT INFORMATION SHEET

Mothers' decision making around medication for mental health difficulties

This sheet is to provide you with the information that you need to consider whether to participate in a research study being conducted as part of my Clinical Psychology Doctorate at the University of Hertfordshire. Please take the time to read the following information carefully and discuss it with others if you wish. Don't hesitate to ask about anything that is not clear or for any further information you would like to help you make your decision. The University's regulations governing the conduct of studies involving human participants can be accessed via this link: http://sitem.herts.ac.uk/secreg/upr/RE01.htm

What is the purpose of the study?

Those experiencing mental health difficulties are often prescribed medication by professionals. Previous bodies of research have shown both that making decisions about taking these sorts of medications can be a complex process, and that parenting while experiencing mental health difficulties can be challenging at times. We are interested in talking to mothers about their decision making around and experiences of taking (or not taking) medication, and their sense of the relationship of this to their mothering.

Who is doing the research?

The research is being conducted at the University of Hertfordshire as part of a doctoral training qualification in Clinical Psychology. It is being supervised by Dr Lizette Nolte, a member of the Herts teaching staff with a special interest in parental mental health. The research will be submitted in June 2019.

Please note that I am conducting this research in my role as a researcher and cannot give advice on clinical issues.

The project has received ethical approval from the University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee. If you have any concerns about this project they can be contacted at:

Secretary and Registrar, University of Hertfordshire, College Lane, Hatfield, Herts AL10 9AB

Who can take part?

You are eligible to participate if you meet the following criteria:

- You are aged 18+
- You are currently or have previously been prescribed medication by professionals such as a GP or psychiatrist for a mental health difficulty. This might have been a short period of low mood or anxiety, or it might have been a longer standing or more severe difficulty that might have led to your being under the care of mental health services. The medications prescribed might be anti-depressants, mood stabilisers, anti-psychotics/neuroleptics or minor tranquilisers, or any combination of these or other psychoactive medications. You might have taken the medication concerned or you might have decided not to take it.
- You are the parent of a child or children who was/were below the age of 18 when you were prescribed the medication.
- You are not currently undergoing social care proceedings.
- You are not currently in mental health crisis. For example, you are not currently in need of acute mental health care, such as hospitalisation or support from a crisis team, and you feel able to participate in an interview

If you are unsure whether you are eligible, please get in touch and we can talk it through.

What will happen to me if I take part in the study?

If you decide to take part, you will participate in an interview, which will last no longer than an hour. This will be conducted in a convenient location, and somewhere private where you can talk freely. We can also do a Skype interview if needed. Participation is on a voluntary basis. You are free to withdraw at any time up to the point of analysis of the material.

During the interview you will be asked to talk about your experiences of and decision making around medication, in relation to your parenting. The interview will be informal and you can decide what you feel comfortable sharing.

Participating will give you the opportunity to reflect on your experiences. It is possible that this might be upsetting. You can let the researcher know if this happens and you may choose at any time to stop the interview if you do not want to proceed, or you can choose not to answer specific questions. Other than these potential emotional effects, there are no risks of taking part.

If you decide to participate in the study, you will be one of a number of participants.

How will my participation be kept confidential?

Any information that is collected from you during the interview is completely confidential. The only time confidentiality would be broken is if the researcher was worried that you or someone else was at risk, based on what you have said. In that case, the researcher might have to break your confidentiality to seek further help and support.

Once data is collected, and prior to being stored, your name will be replaced with an identifying number. No details identifying you will be released to anyone else other than the Principle Researcher (Trainee Clinical Psychologist) and Supervisory team. Your data will be fully anonymised for the purposes of writing up the results of the present study for publication. The data collected will be stored electronically, in a password-protected environment until the study has been accepted for publication, after which time it will be destroyed under secure conditions.

What will happen to the results of the study?

When the research is finished, a summary of the findings will be shared with you if you would like to see them. The results will be published in journals and a doctoral thesis. Your data might also be used in a future piece of research. Wherever it appears, your data will always be anonymised, and all identifying details changed or removed, so it will not be possible to identify you.

If you are interested in participating, or would like to ask more questions about the study before deciding whether to participate please get in touch with me by email:

Sara Holloway
Trainee Clinical Psychologist
Email: xxxxxxx

Please also feel free to contact my supervisor by phone, email or writing: Dr Lizette Nolte, xxxxx, Tel: xxxx. Address: xxxx.

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix H Participant consent form

Consent form

Study title: Mothers' decision making around medication for mental health difficulties

Please put your initials in the boxes

1. I confirm that I have read and understood the information sheet for this study and have been given a copy to keep, and that I have been able to ask any questions I have had about the study. ☐
2. I understand what is being proposed and the procedures in which I will be involved have been explained to me. ☐
3. I understand that my participation is voluntary and I am free to change my mind and withdraw at any time prior to the analysis of the data, without having to give a reason why. I know that I have the right not to answer questions or to end the interview early. ☐
4. I understand that I will be told about any major change to the aims or design of the study, and I will be asked to give my consent to participate again. ☐
5. I understand that any recordings and written notes made by the researcher will be made anonymous to protect my confidentiality. I agree for anonymous quotes to be used in the write-up and any publications of the research. I understand that it will not be possible to identify me. ☐
6. I agree to the interview being audio-recorded. ☐
7. I understand that all my personal information will be kept secure, and that only the researchers will have access to it. ☐
8. I understand that I may be contacted again in the future in connection with this study or another study, and I agree to this. ☐

_____ _____

SIGNATURE OF PARTICIPANT DATE

_____ _____

S HOLLOWAY, TRAINEE CLINICAL PSYCHOLOGIST DATE
PRINCIPAL INVESTIGATOR SIGNATURE

Appendix I Participant debrief sheet

Debrief sheet

Mothers' decision making around medication for mental health difficulties

Thank you for taking part in this study. We really appreciate you taking the time to help us.

The aim of the study is to further understand mothers' decision making around medication for mental health difficulties. Your interview will be compared with others to see if there are any similar themes or patterns. We hope that this information will help us to learn more about mothers' experiences in order to help support them better in their decision making.

Please be assured that the information that we have gathered will be kept anonymous and confidential within the limits already explained to you. You have the right to withdraw from the study at any time. You are entitled to have a research findings summary, and this will be made available upon your request to the researcher when the study is complete.

If taking part in this research has caused you to feel upset, you may wish to seek support to talk about this. You may choose to do this with a trusted family member or friend. You can also contact your GP or mental health team (if relevant). Alternatively, the contact details of organisations that can provide support are provided below.

Samaritans

The Samaritans provides support for people who are experiencing feelings of distress or despair. 08457 90 90 90
24 hours a day, 365 days a year
Minicom/textphone: 08457 90 91 92

Email: jo@samaritans.org www.samaritans.org.uk

Mind Infoline

Leading mental health charity in England and Wales offering callers confidential help on a range of mental health issues.
Call 0300 123 3393 or text 86463
Weekdays 9am - 6pm

www.mind.org.uk

NHS Direct

NHS Direct delivers information and advice about health, day and night, direct to the public. Telephone 111
www.nhsdirect.nhs.uk

Researcher contact details

If you would like any further information about the study, or you would like to know about the results of the study, please contact us on:

Sara Holloway (lead researcher) Trainee Clinical Psychologist

Email XXX

Lizette Nolte (supervisor) Clinical Psychologist email XXXX

University of Hertfordshire
Health Research Building | College Lane | Hatfield | AL10 9AB

Thank you for participating in this study

Appendix J Ethics Clearance Form

University of Hertfordshire UH

HEALTH SCIENCE ENGINEERING & TECHNOLOGY ECDA

ETHICS APPROVAL NOTIFICATION

TO	Sara Holloway
CC	Dr Lizette Nolte
FROM	Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair.
DATE	06/08/2018

Protocol number: **LMS/PGT/UH/003404**

Title of study: Mothers' decision making around medication for mental health difficulties.

Your application for ethics approval has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

This approval is valid:

From: 06/08/2018

To: 30/09/2018

Additional workers: **No additional workers named.**

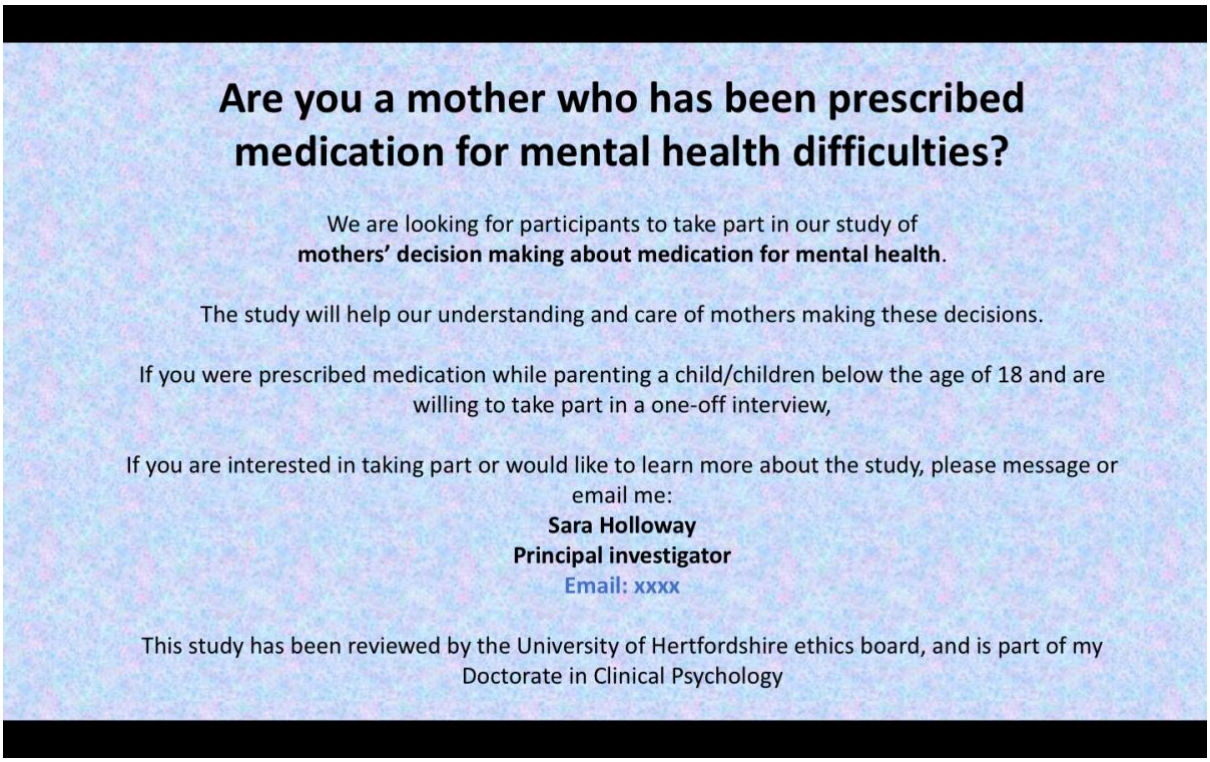
Please note:

If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and your completed consent paperwork to this ECDA once your study is complete. You are also required to complete and submit an EC7 Protocol Monitoring Form if you are a member of staff. This form is available via the Ethics Approval StudyNet Site via the 'Application Forms' page http://www.studynet1.herts.ac.uk/ptl/common/ethics.nsf/Teaching+Documents?Openview&count=9999&restricttocategory=Application+Forms

Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1A. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval (if you are a student) and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1A may need to be completed prior to the study being undertaken.

Appendix K Twitter post



Appendix L Mumsnet advertisement

Research into mothers' decision making about medication for mental health

Dear Mumsnet members

I'm looking for participants for my doctoral research into mothers and their decision making around medication for mental health difficulties.

Are you, or anyone you know, willing to take part in a one-off face to face interview?

The purpose of the study
Previous bodies of research have shown both that making decisions about taking medication for mental health can be a complex process, and that parenting while experiencing mental health difficulties can be challenging at times. We are interested in talking to mothers about their decision making around taking medication, or deciding not to take it, and their sense of the relationship of this to their mothering. We hope to improve professionals' understanding and care of mothers making these decisions.

Who can take part?

You are eligible to participate if:

- You are aged 18+
- You are currently or have previously been prescribed psychoactive medication by professionals. This can include medication such as antidepressants prescribed by a GP for a short episode of low mood or anxiety, or medication such as anti-psychotics prescribed for more long term or severe mental health difficulties, for which the person perhaps required care from mental health services.
- You might have taken the medication concerned or you might have decided to stop taking it, or decided not to take it at all.
- You are the parent of a child or children who was/were below the age of 18 when you were prescribed the medication.
- You are not currently in mental health crisis or undergoing social care proceedings.
- You are able to participate in an hour long interview, conducted in a convenient location or over Skype.

If you are unsure whether you are eligible, please get in touch and we can talk it through.

The interview will be informal and participants can decide what they feel comfortable sharing. Any information that is collected during the interview is completely confidential. When the research is finished, a summary of the findings will be shared with participants if they would like to see them.

If you are interested in participating, or would like to ask more questions about the study please get in touch:

Sara Holloway
Trainee Clinical Psychologist
sh16aef@herts.ac.uk.

Many thanks for your interest

Appendix M Recruitment email to contacts

Dear friends

I'm in the process of recruiting participants for my doctoral research on mothers and their decision making around medication for mental health difficulties, and I'd be very grateful if you could spread the word.

I'm looking for mothers who have been prescribed medication for mental health difficulties by a professional. This can include a wide spectrum of experience, from medication prescribed by a GP for a short episode of low mood or anxiety, to that prescribed for more severe mental health difficulties, for which the person perhaps required care from mental health services.

Participation would involve being interviewed by me for approximately an hour in a safe and confidential space, wherever would be convenient for the interviewee. For anyone outside London, I would be willing to travel or conduct the interview via Skype.

For obvious reasons I can't interview people I know socially. The interview transcripts would be anonymised and the contents kept strictly confidential. I haven't sought ethical clearance to recruit from the NHS, so I'm not expecting those of you who are NHS employees to support recruitment in your professional capacity, but just from your personal network.

The research is qualitative and quite exploratory, starting with no particular hypothesis. It joins a growing body of research into the decision making around psychoactive medication, and its relational aspects. I hope the experience of being interviewed might be interesting for the participants, and that the findings might be valuable for clinicians and mothers themselves.

As well as sharing this with your contacts via email and social media, if you have any suggestions for organisations or groups that might be good sources of recruitment, I'd be very grateful if you could let me know.

I'm attaching a participant information sheet. Please email or phone me if you have any questions.

Please ask any potential participants to email me on my university email: sh16aef@herts.ac.uk

Many thanks in advance,

Sara

Appendix N Initial interview schedule

Outline interview schedule

Initial interviews

The initial interviews will use broad open-ended questions, as recommended in Grounded Theory research. For example:

I'd like to find out about mothers and medication for mental health difficulties. What do you think it would be useful/important for me to know about this?

Can you please tell me about your experience of this subject?

What do you think would help me understand the topic?

Follow up questions would be used in order to solicit more detail, such as:

I'm really interested in what you said about….can you tell me more about this?
Can you remember anything more about…?
Can you walk me through/can you trace back for me…?

The interview would close with questions such as:

Is there anything important we haven't covered that you think it's important for me to know?

Is there anything you personally would be interested in finding out about the topic from other mothers who have been prescribed medication?

Subsequent interviews

Depending on the model that develops, we envisage exploring the following more specific domains: decision making about taking/not taking medication, alternative treatment options, family relationships, political context, stigma, service provision, embodied experience – what taking medication feels like. Below are the kinds of questions we might ask to illuminate the process of decision making.

Being prescribed medication

When were you first prescribed medication?

What kind? What was the experience like?

What information were you given about your medication and possible side effects? Were you a mother at the time?

Who prescribed the medication? What did they say about it?

Did you ask them any questions?

Have any other professionals been involved with your medication?

Who? What has communication been like with them?

(If non-adherent) Did you tell them you were coming off the medication?

Did you ever communicate with professionals about your parenting role?

Did the professionals ever mention your children?

Wider context: What support did you have with your mental health? (Primary/Secondary/3rd Sector/Community and Faith groups etc?)

Experience of taking medication

How would you describe your relationship with your medication?

How would you describe the experience of taking medication?

Did you experience any side effects?

Alternatives to medication*:*

What other options were being used in addition to medication/instead of medication - therapy/counselling etc?

(If received alongside medication) How did these interact with the medication? (Follow up: did they help you access eg therapy, or hinder it?)

Do you use any alternatives - complementary/vitamin supplements etc

Medication and parenting

Do you feel the medication had an effect on your parenting? (If it did have an effect did you feel medication had a positive affect on your parenting? Or did you feel medication had a negative affect on your parenting?)

Did you ever talk with your children about your medication?

Did you and your partner [if relevant] discuss your medication in relation to the children?

Did you talk about the medication in relation to your children/mothering with anyone else [family members, friends, professionals]?

If you became a mother subsequently, did the fact that you were taking medication play any role in your decision to have children?

Did you have any side effects? If you did have side effects, did these impact on other areas of your life, relationships, work etc?

What support did you have as a parent? (Friends/family/community/groups/schools etc?)

Was any of your decision making around medication connected to your parenting?

Did you ever decide to stop taking medication?

Were your children part of your decision making in relation to taking/continuing to take/stopping your medication?

Were other factors more important than your mothering role? What were they?

Appendix O Example of additional new interview questions

Participant 7 interview – additional areas to ask questions around based on theorising to date

Influence of own parents' experiences

The hit or miss/trial and error nature of medication consultations.
Professionals not explaining side effects.
Professionals not recommending support for transitional period
Professionals not taking mothering into account in medication consultations.
The relationship between therapy and medication
Waiting lists for other treatment – medication as something to hold you while you wait.
Medication being monitored. Medication as somehow containing. Medication as a symbol of MH difficulties and therefore source of shame.

Children exacerbating pre-existing difficulties – bringing need for meds (via internal mechanism of guilt re not being good enough, and external pressures; and via fact that concern re being judged delays openness re difficulties and leads to breakdown.

Meds helping me be present/calm as a mother.
Concerns re meds affecting my ability to be present for child) – Ask her about this, because it sounded as though she kept trying to come off them. Was it related to being a mother? To what extent were her children part of her decision making?

The difficulty of knowing what's due to meds and what's due to child's stage and other treatment
Do her children know about her depression and the meds?
What has her husband's involvement been? Her friends? Her father/siblings?
What are her thoughts about the medication?
Cultural issues – where is she from originally?
Views about the future?
Strengths gained?
What advice she would give other mothers in her situation re meds?

Other not directly med-related themes
Children bringing happiness – being part of well being
Guilt about not being able to enjoy children
Guilt at not being good enough mother
Unhelpful professionals vs helpful professionals.
Med themes not related to mothering:
Stigma re meds, Prozac etc.
Ask her why she felt she should come off the medication previously.
Ask how things might have been different in terms of treatment if she hadn't become a mother.

Appendix P Transcription confidentiality agreement

University of Hertfordshire

Doctorate in Clinical Psychology

University of Hertfordshire

Transcription confidentiality/ non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

Sara Holloway ('the discloser')

And

('the recipient')

The recipient agrees to not divulge any information to a third party with regards to the transcription of audio recordings, as recorded by the discloser. The information shared will therefore remain confidential.

The recipient agrees to stop transcription immediately if they recognise any parties mentioned on the audio recording, and to return the recording to the discloser.

The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.

The recipient agrees to return and or destroy any copies of the recordings they were able to access provided by the discloser.

Signed:……

Name:……

Date:……

Appendix Q Reflections on researching mothers and medication

Despite my stance on the medical model and mothering explained in the introduction, I was aware that I was influenced by the dominant discourses on both during the research process. For example, I was surprised despite my critical stance towards the medical model how often I slipped into medicalised terminology in my writing at the conception and recruitment stages, and in my use of terms such as 'symptoms', in my write up. My internal supervisor had to alert me to this quite frequently, which showed me how dominant and deeply engrained this way of thinking is.

On the other hand, I was concerned about how my stance on the medical model might affect the interviews. I was able to develop a good rapport with my participants, but sometimes felt inauthentic not revealing my own perspective when they talked about their views on diagnosis and medication, such as the chemical imbalance theory. Sometimes mothers with a biochemical view of their difficulties talked about their concern that their children would inherit them, with some anxiety. As a clinician it was also hard sometimes not to reassure them, and not to reflect privately on alternative reasons for their difficulties, such as social pressures or difficult experiences. Because of this, I wondered at times whether I might subtly be influencing participants towards certain ways of conceptualising their difficulties and medication use, through my tone and body language and the slant of my questions.

The research also influenced me: I was aware of becoming slightly less critical of medication and aware of its benefits (though still under the 'drug centred' model (Moncrieff, 2014)). Perhaps being immersed in the fine detail of medication use also normalised it for me.

In relation to mothering, the research focus on mothers rather than parents also raised dilemmas for me at times. The research question might imply a connection between mothers' parenting and their medication use, and in fact, several potential participants were unsure whether they qualified because they did not feel their

mothering informed their decision making about medication[24]. I myself felt an anxiety about straying from my research focus when the two topics of mothering and medication use remained separate during some interviews. But in trying to keep the focus on the research question I felt there was a risk of making the participants feel pressurised to find a connection and worried about being complicit in a social system which expects mothers to see that role as primary and all-encompassing. I was also aware at times of my own assumptions about mothering influencing my responses, and reflected on how that might be picked up on by my participants. During the interviews I felt I was sometimes the representative of cultural norms, and the participants would appear to be anxious to reassure me that they were good mothers.[25]

Even participants who felt their mothering had a bearing on their medication decisions had often not thought about the connection – or their thoughts about medication per se - in detail. I was aware that this requirement for thought might indicate moments when something new could emerge. I felt the tension between my clinical role and my research role here. It is ethical practice in therapy for new insights to be produced, whereas this might be unethical in research (Kvale, 1999, cited by Rizq, 2008).

I also worried about unsettling the participants in asking them to think about the topic in depth, an example of what Guillemin & Gillam (2004) have called 'ethically important moments' in qualitative research. On the other hand, sometimes the interview seemed to provide a space for participants to reflect on their experience of mothering and distress, with one explicitly saying she regarded the interview as part

[24] I reassured them that they were eligible.

[25] After reflection, I started to explain to my participants that there did not need to be a connection, even though it was common for mothers to feel guilt about decision making that did not involve their children because of powerful social discourses around mothering. This appeared to be a relief to some participants.

of a therapeutic process. My sympathy about this made it hard for me to interrupt their narratives and refocus interviews on the research question at times.

I was also made aware of my own class and cultural assumptions, assumptions regularly flagged up by my internal supervisor, and sometimes participants themselves. [26]

The analysis of the data raised similar dilemmas to those encountered at the interview stage. I was sometimes concerned that my research focus and questions had made certain codes more likely, and that I again risked perpetuating mothering ideals with categories which emphasised how much mothers took their parenting into account when making decisions about medication. And I was aware of there being participants who were more in the minority in that regard in my sample, and that the main structure of the analysis might obscure their perspective, and they might feel misrepresented, or even shamed by their difference.

At times the discomfort and gaps in the interviews provided analytic insights. I memoed around the fact that perhaps it felt uncomfortable for mothers to talk about both in conjunction, and for my analysis to bring the two together precisely because it was hard to bring together the two strongly culturally organised identities of mother and medication user, and this insight was key to my final model.

In research and thinking around socially determined roles there is always a tension between the risk of universalism, essentialism or sentimentality, and the value in validating and understanding lived experience. Despite my concerns about perpetuating mothering ideals, I was often moved by the interviews, and there were moments during them when participants appeared to come to realisations about the way their experiences as mothers had been unrecognised by the health system and

[26] For example, one participant commented apologetically that her experience didn't 'fit' with my line of questioning because she made decisions with reference to her whole family rather than the mother-child relationship.

other social structures, which suggested that a ‘hermeneutic injustice’ (Fricker, 2007) had been righted.

Appendix R Extracts from Reflective Journal

I have my first two interviews this week. I feel grateful to my participants. I want to be quite open to what they bring. At the same time I am concerned about keeping the focus on the research question (they could talk a lot about medication in a way that's not relevant to their mothering, for example.), and also about asking leading questions, about steering them in relation to my own interests and concerns. Some people might be mothers and taking medication, but might never have thought about the two together. At the same time, I come with a clearly defined position about medication. So I'm aware that I'm bringing a lot to the table – the topic itself makes certain assumptions; and I'm bringing my own stance. What if they don't really see it as an issue? How can I justify it to them? What if they feel judged? (Before first interview)

Her experiences still felt raw. I found it difficult to probe at times because of this. It made me realise there can be a fine line in this sort of research – you want rich and true data, but you don't want to unsettle the participant too much or make them think about things they might not have considered before, especially about something as emotionally raw as mothering. I'm seeing the limitations of research into mothering and mental health here. (After interview 2)

[Participant] seemed so keen reassure <u>me</u> about being a good mother: – 'of course I would never have harmed the baby', 'of course I loved her'. That social discourse is so powerful, that I was caught up in it and felt an urge to reassure her. (After interview 3)

I felt worried at times that so much of the interview was not about mothering and medication,. I felt it was slipping into parental mental health often, or into medication experience, and it was hard to stay at the intersection of the two. I felt a

drifting away from the research question, but also that bringing it back to the point might be forcing her into a connection. (After interview 4)

The trauma of pregnancy and birth and early days were really what she wanted to talk about – there seemed a strong urge to narrative around that. It was hard to get the focus back on medication – it feels like a drier, less natural subject to take about for some mothers. (After interview 12)

Both participants said they'd never told anyone else the things they told me, which made me realise the privilege of this research and also the important of anonymity. The feeling they convey of being in a safe, confessional space highlighted for me the shame and secrecy mothers feel. (After interview 13)

I'm struck by how much more positive the participants are about medication than I perhaps expected, maybe because in the literature I had read people were reflecting on heavier medications. Some of them really love their medication, and don't want to give it up. I've found that my attitude to medication is shifting slightly. (24th March)

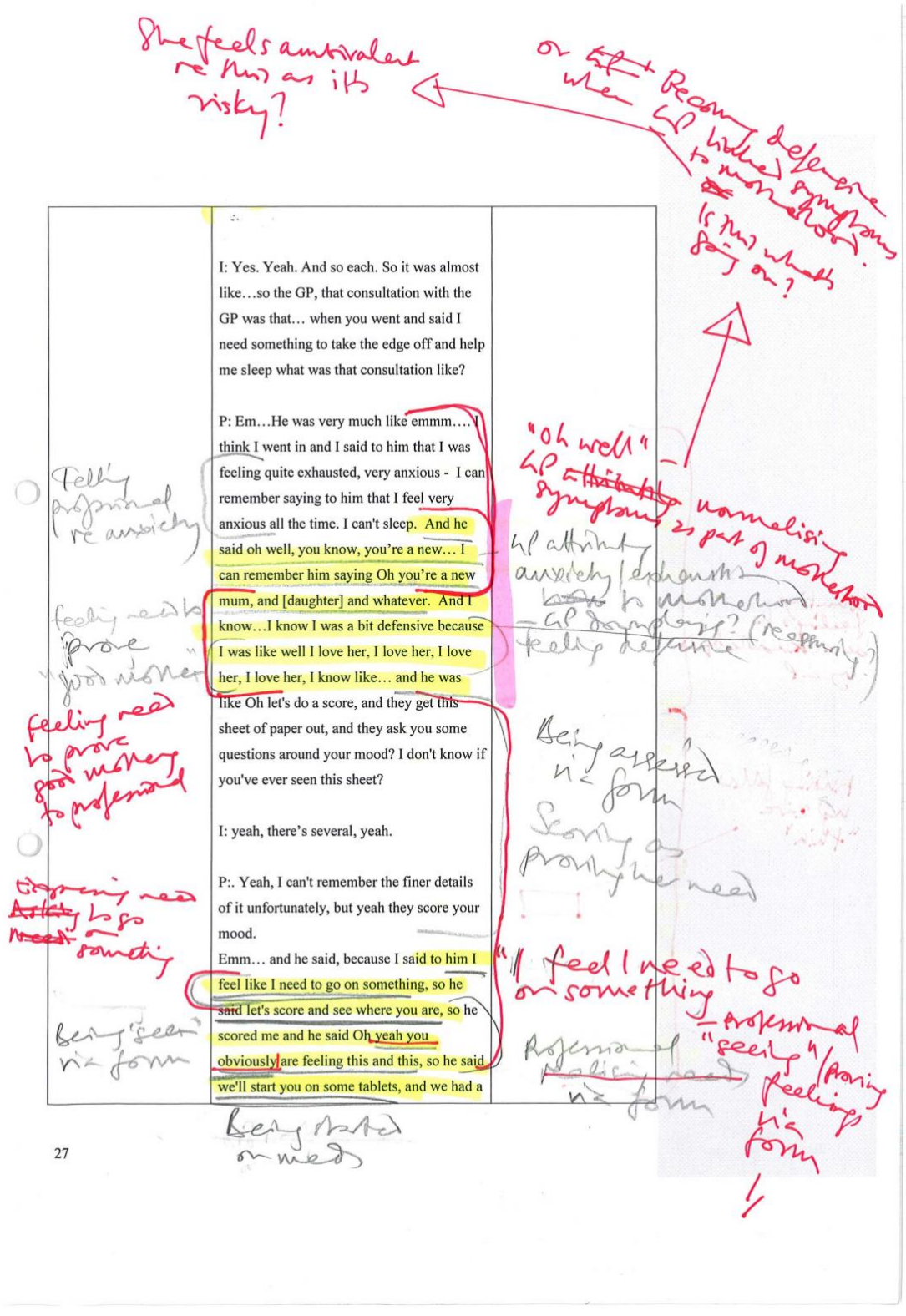
Appendix S Sample Initial Codes from NVIVO coding

Themes for P1

Name	Description	Files	References
A test on relationship with husband		1	1
Accepting ignorance about medical matters		1	1
Acknowledging cultural stereotypes re medication		1	1
Adjusting to new female roles		1	1
Advising other mothers not be scared of medication		1	1
Advising other mothers to be kind to themselves		1	1
Advising other mothers to seek help sooner		1	2
Advising other mothers to seek suitable support		1	1
Advising other mothers to trust their instincts		1	1
Advocating for a particular medication		1	1
Anticipating lack of understanding about medication from family		1	1
Anxiety building up over first few months of motherhood		1	1
Appreciating having a safety net		1	1
Arguing own case about		1	1

1

Appendix T Extract from transcript, with initial codes and focused codes



I: Yes. Yeah. And so each. So it was almost like…so the GP, that consultation with the GP was that… when you went and said I need something to take the edge off and help me sleep what was that consultation like?

P: Em…He was very much like emmm…. I think I went in and I said to him that I was feeling quite exhausted, very anxious - I can remember saying to him that I feel very anxious all the time. I can't sleep. And he said oh well, you know, you're a new… I can remember him saying Oh you're a new mum, and [daughter] and whatever. And I know…I know I was a bit defensive because I was like well I love her, I love her, I love her, I love her, I know like… and he was like Oh let's do a score, and they get this sheet of paper out, and they ask you some questions around your mood? I don't know if you've ever seen this sheet?

I: yeah, there's several, yeah.

P:. Yeah, I can't remember the finer details of it unfortunately, but yeah they score your mood.

Emm… and he said, because I said to him I feel like I need to go on something, so he said let's score and see where you are, so he scored me and he said Oh yeah you obviously are feeling this and this, so he said we'll start you on some tablets, and we had a

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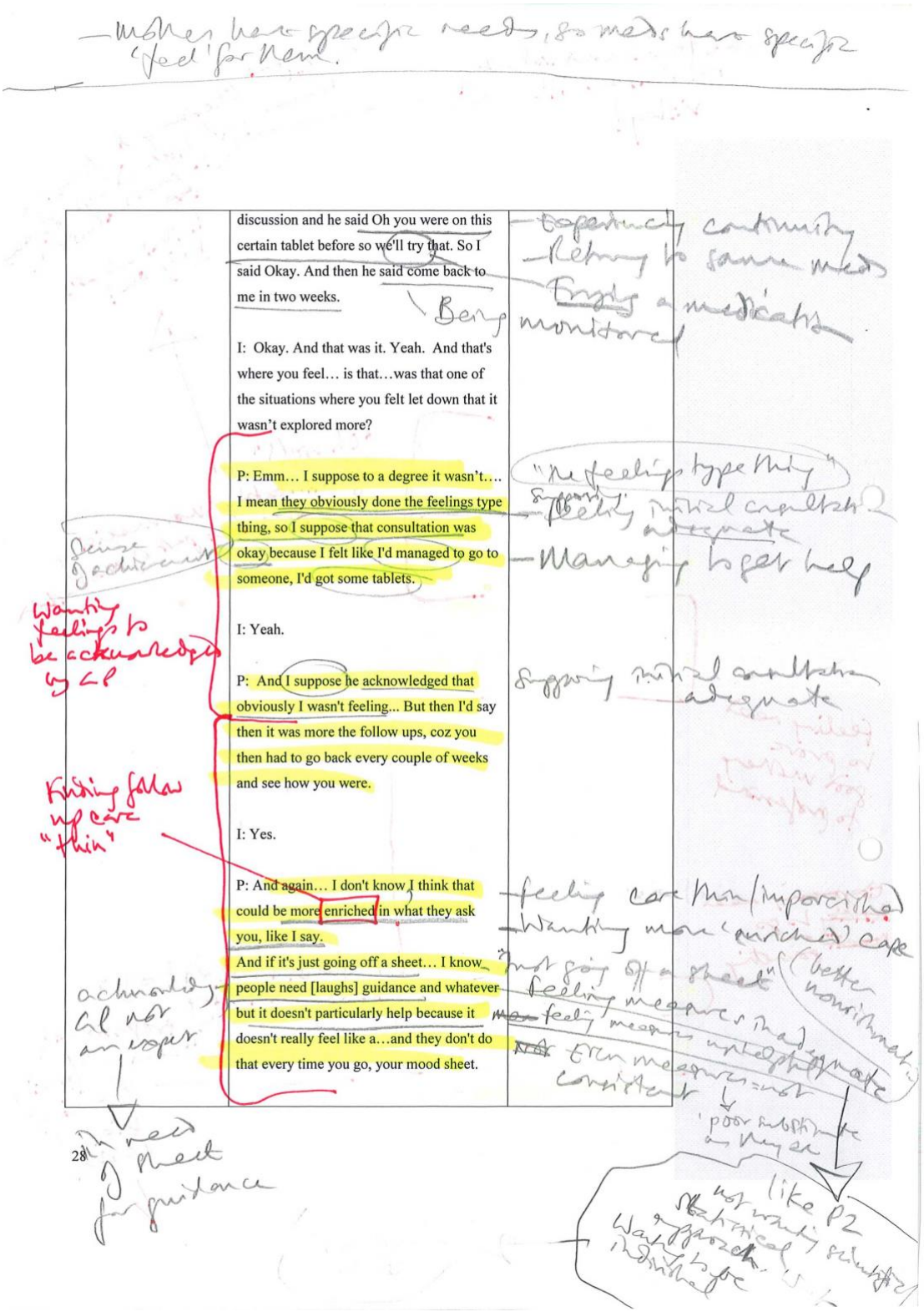
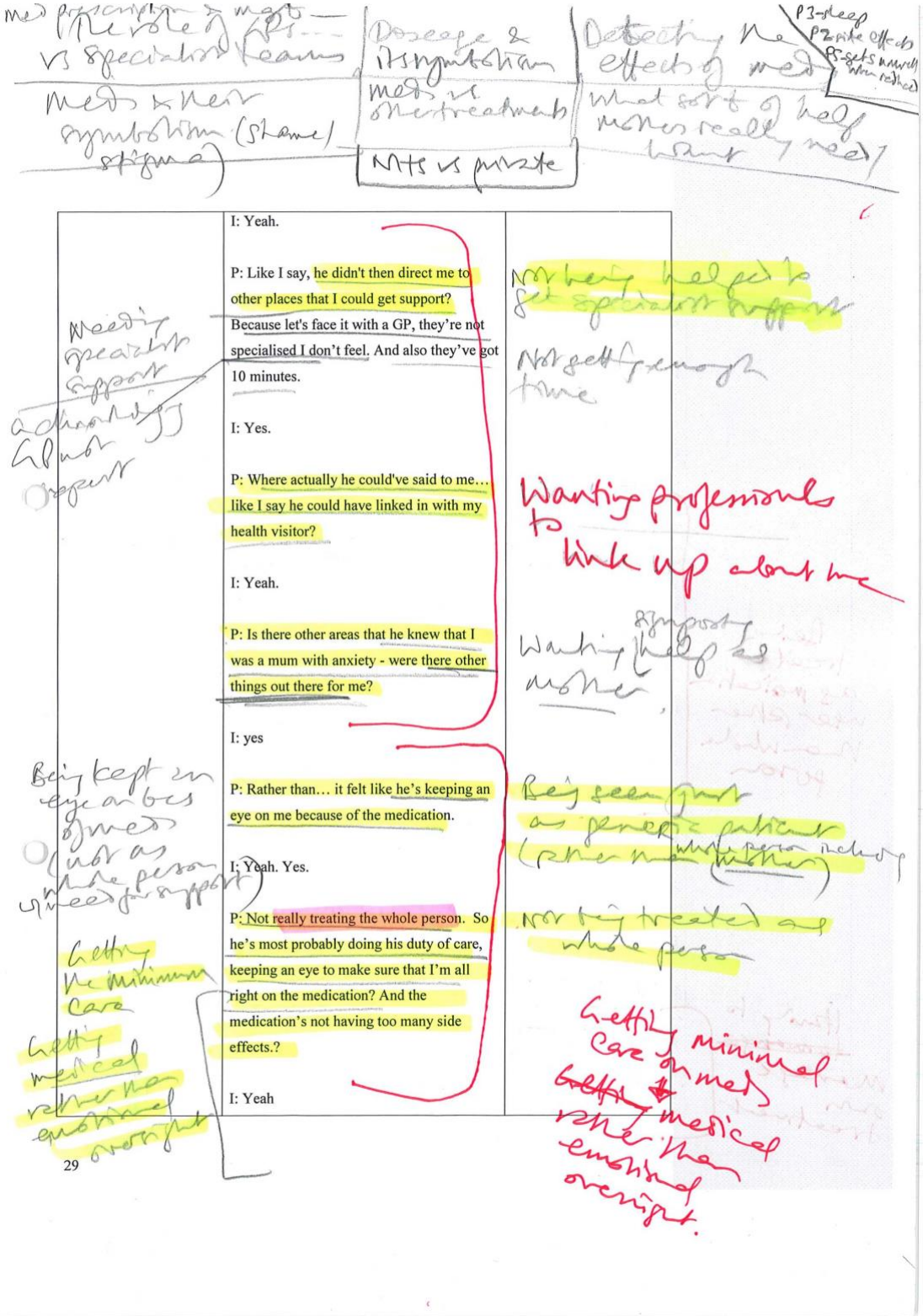

discussion and he said Oh you were on this certain tablet before so we'll try that. So I said Okay. And then he said come back to me in two weeks.
I: Okay. And that was it. Yeah. And that's where you feel… is that…was that one of the situations where you felt let down that it wasn't explored more?
P: Emm… I suppose to a degree it wasn't…. I mean they obviously done the feelings type thing, so I suppose that consultation was okay because I felt like I'd managed to go to someone, I'd got some tablets.
I: Yeah.
P: And I suppose he acknowledged that obviously I wasn't feeling... But then I'd say then it was more the follow ups, coz you then had to go back every couple of weeks and see how you were.
I: Yes.
P: And again… I don't know I think that could be more enriched in what they ask you, like I say.
And if it's just going off a sheet… I know people need [laughs] guidance and whatever but it doesn't particularly help because it doesn't really feel like a…and they don't do that every time you go, your mood sheet.
28



I: Yeah.

P: Like I say, he didn't then direct me to other places that I could get support? Because let's face it with a GP, they're not specialised I don't feel. And also they've got 10 minutes.

I: Yes.

P: Where actually he could've said to me… like I say he could have linked in with my health visitor?

I: Yeah.

P: Is there other areas that he knew that I was a mum with anxiety - were there other things out there for me?

I: yes

P: Rather than… it felt like he's keeping an eye on me because of the medication.

I: Yeah. Yes.

P: Not really treating the whole person. So he's most probably doing his duty of care, keeping an eye to make sure that I'm all right on the medication? And the medication's not having too many side effects.?

I: Yeah

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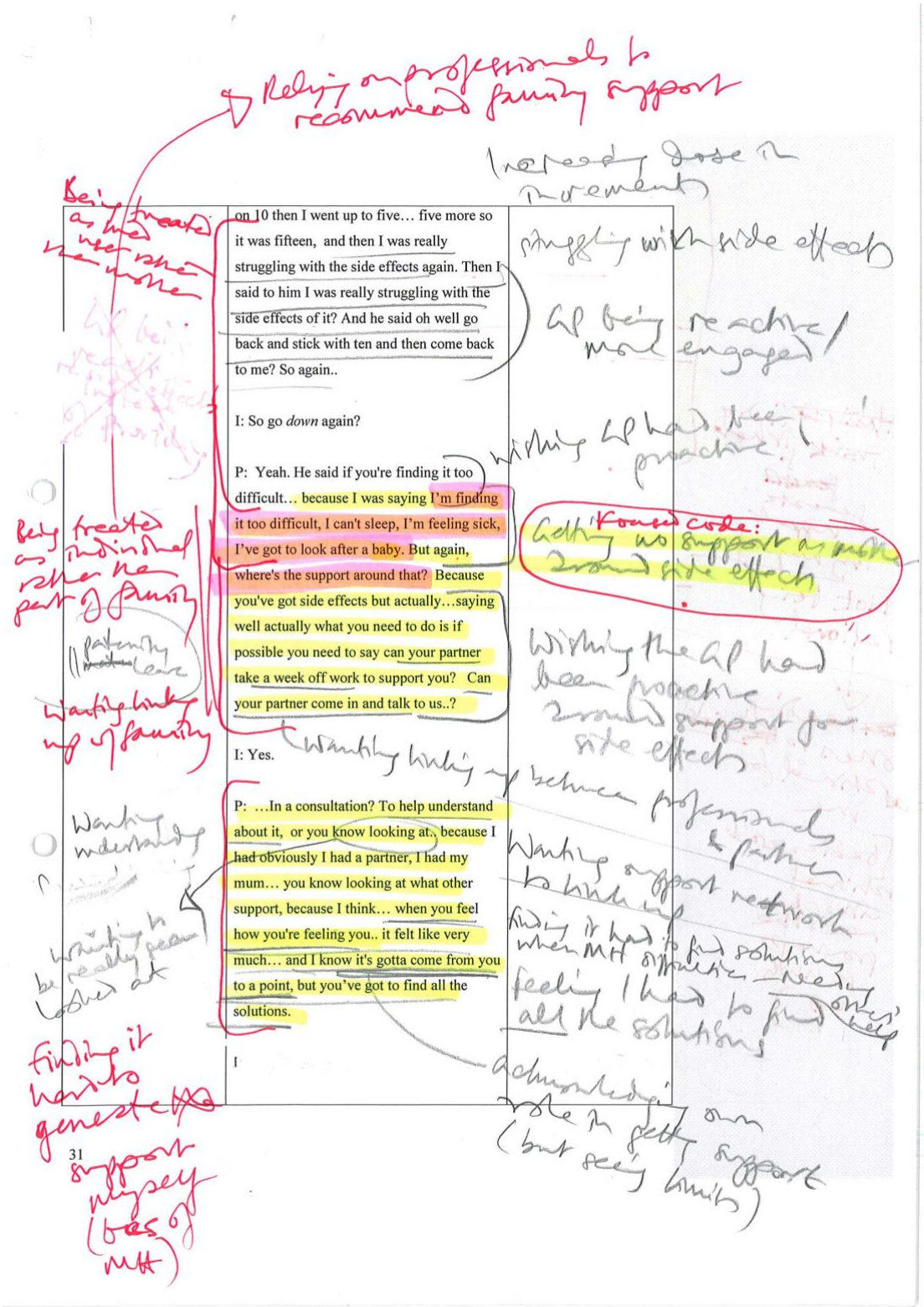
on 10 then I went up to five… five more so it was fifteen, and then I was really struggling with the side effects again. Then I said to him I was really struggling with the side effects of it? And he said oh well go back and stick with ten and then come back to me? So again..
I: So go *down* again?
P: Yeah. He said if you're finding it too difficult… because I was saying I'm finding it too difficult, I can't sleep, I'm feeling sick, I've got to look after a baby. But again, where's the support around that? Because you've got side effects but actually…saying well actually what you need to do is if possible you need to say can your partner take a week off work to support you? Can your partner come in and talk to us..?
I: Yes.
P: …In a consultation? To help understand about it, or you know looking at., because I had obviously I had a partner, I had my mum… you know looking at what other support, because I think… when you feel how you're feeling you.. it felt like very much… and I know it's gotta come from you to a point, but you've got to find all the solutions.
I
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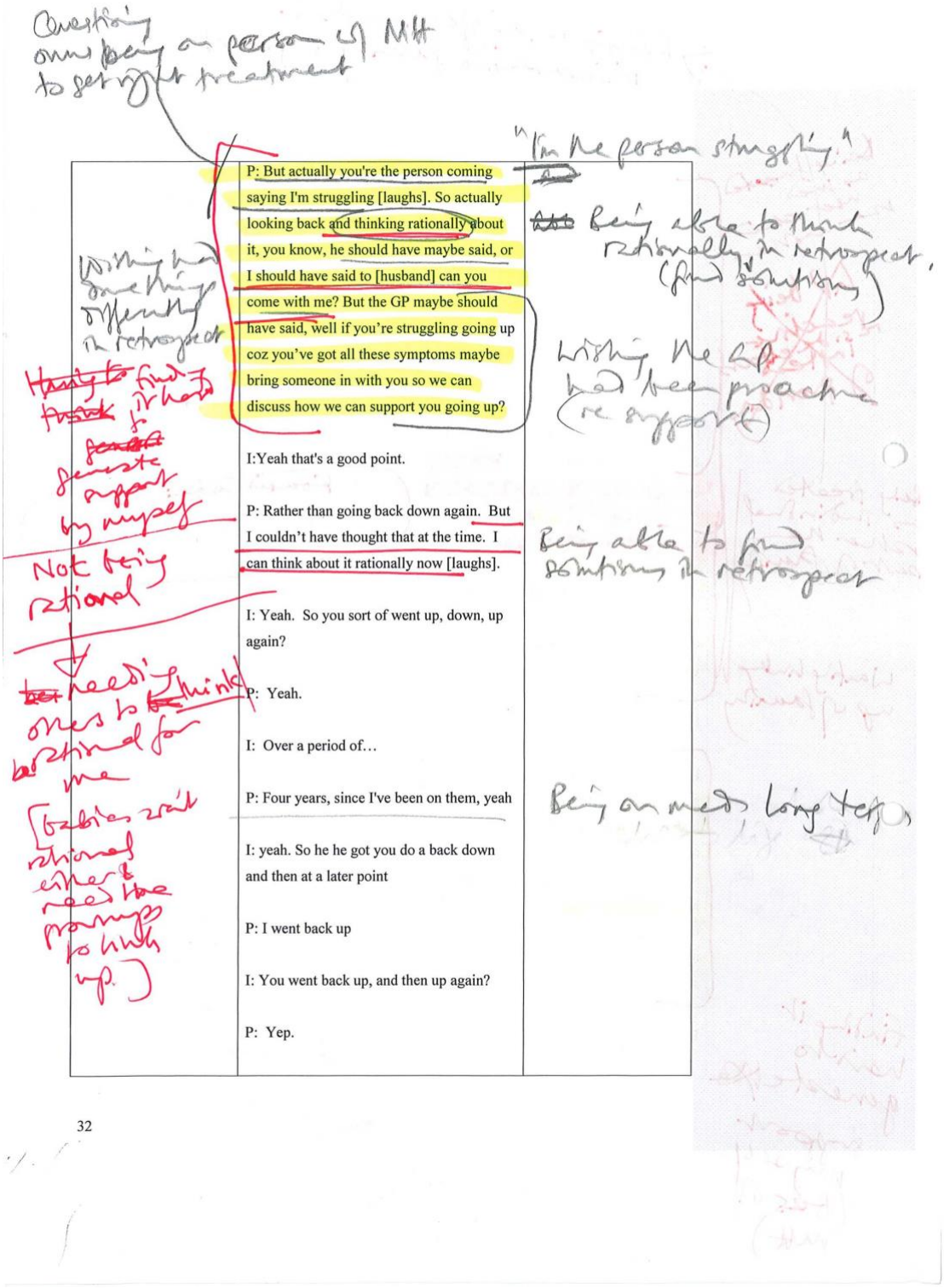

P: But actually you're the person coming saying I'm struggling [laughs]. So actually looking back and thinking rationally about it, you know, he should have maybe said, or I should have said to [husband] can you come with me? But the GP maybe should have said, well if you're struggling going up coz you've got all these symptoms maybe bring someone in with you so we can discuss how we can support you going up?

I:Yeah that's a good point.

P: Rather than going back down again. But I couldn't have thought that at the time. I can think about it rationally now [laughs].

I: Yeah. So you sort of went up, down, up again?

P: Yeah.

I: Over a period of…

P: Four years, since I've been on them, yeah

I: yeah. So he he got you do a back down and then at a later point

P: I went back up

I: You went back up, and then up again?

P: Yep.

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Appendix U Sample Extract from Initial Clustering of Focused Codes

'CRACKING ON'
Fearing the view that mothers with mh can't cope
Seeing the perfect mum as coping
Not coping is not being a good mum.
Trying to keep going
Feeling pressure to 'just get on with it'
Anticipating both mother and baby will get on with it
Good mums get on with it
Feeling pressure to just crack on as mother
Getting on with it after crisis bcs of mothering duties
'Getting on with it'
Pulling myself together and keeping going
Seeing through child's eyes = good mother
Feeling all responsibilities lie with mother
Taking responsibility for everything
Trying to care for son while own needs unmet
BEING UNABLE TO BE OPEN ABOUT FEELINGS
Fearing a distressed mother is a bad mother
Good mums have perfect babies: happy mum, happy baby
Feeling need to prove good mothering to professional
Being told to put child's needs first by professionals: 'Happy mum, happy baby'.
Prioritising children over own feelings
Feeling the strain of putting on act for children
Feeling moral imperative to separate mh self from mothering role
Prioritising children's needs over own coping strategies
Being an actress with children (when unhappy)
Believing negative emotions should be hidden from children
Believing mothers must be strong
Feeling shame at needing support as mother
Seeing good parenting as requiring clear mind (whether from meds or anxiety)
Not wanting to repeat own childhood experience (depressed mother)
Working to avoid own feelings impacting child
Feeling loved ones don't want me to have negative feelings
Being upset = imperfect mother
Hiding difficulties from professionals for fear of being seen as not coping. Hiding feelings for fear of being seen as not coping
'Swallowing back' difficulties as mother
Feeling I shouldn't speak about mothering difficulties
Hiding feelings for fear of child being removed
Keeping feelings hidden because of age/expectation of failure
Keeping feelings hidden because of fear of baby's removal
Hiding intrusive thoughts even from partner
Hiding unsafe thoughts meant waiting for treatment
Keeping illness private/hidden

Seeing not an illness but a private story of overcoming
Fearing prejudice through ignorance
Seeing illness as separate from everyday life
Saying it out loud opened something
Feeling outside and inside clearly match (inner distress visible)
Hiding illness from son unless helpful
Hiding family history of mh
Motherhood as performance
FEELING UNSEEN
Distress unseen by professionals beneath coping 'mother'
Professionals 'pretending' to assess mental health
Playing a game of hide and seek with professionals
Criticising professionals for not 'seeing' me;
Feeling 'unseen' by professionals
Having own emotional needs ignored by professionals
Having anxiety heightened by professionals
STOPPING
Wanting to stop coping & go to hospital
Feeling unable to cope
Recognising something wrong because of physical symptoms
Breaking down
Spiral ending in total breakdown
Losing everything
Experiencing total loss of control of mind and body
Experiencing mismatch between reality and my brain
Losing son
Mother and baby both falling apart
Feeling profound anxiety/disintegration of self
Coming to a complete stop – body, mothering
Going through the motions (mind/feelings not present)
Not being able to function normally
Seeing that time as a blur
Hiding total collapse of mothering
Feeling suicidal
Experiencing total loss of confidence as mother
Hospitalisation – a form of stopping?
Eg : Wanting to stop coping and go to hospital
Losing ability to mother via depression/breakdown [ie mother and mh patient can't coexist?]
Losing all confidence in mothering
Forgetting how to be a mother
Requiring proxy mothers (husband, carer, own mother)
Retreating from world thru depression
Requiring replacement mother(s) (family, husband)
Finally being honest about inability to mother
LOOKING FORWARD
Hoping to explain meds to children in future

Hoping this understanding will prevent repetition with next baby.
Worrying about the risks in having another child
Feeling broodiness competing with anxiety
Blaming self for not having second child
Feeling concerned about effect on foetus of medication
'Everything was for the baby' – stopping meds during pregnancy
Feeling concerned re effect on own mental health of not being on meds during pregnancy
Feeling a huge amount at stake for self, baby, work if came off medication
Consulting professionals before conceiving
Being advised to stay on meds during pregnancy
Trusting own hunches in decision making about meds during pregnancy
Weighing up of own needs and foetus's needs (after starting to feel unwell during pregnancy)
Fearing a second pregnancy will make it necessary to come off meds
Rebelling against instructions re meds during pregnancy because of concerns for baby
Trusting in GP re decision making around meds and next pregnancy despite anxiety
Deferring decision re meds and pregnancy until necessary (crossing that bridge)
Never getting clarity re length of course [maybe doesn't belong here

Appendix V Examples of Grounded Theory diagrams

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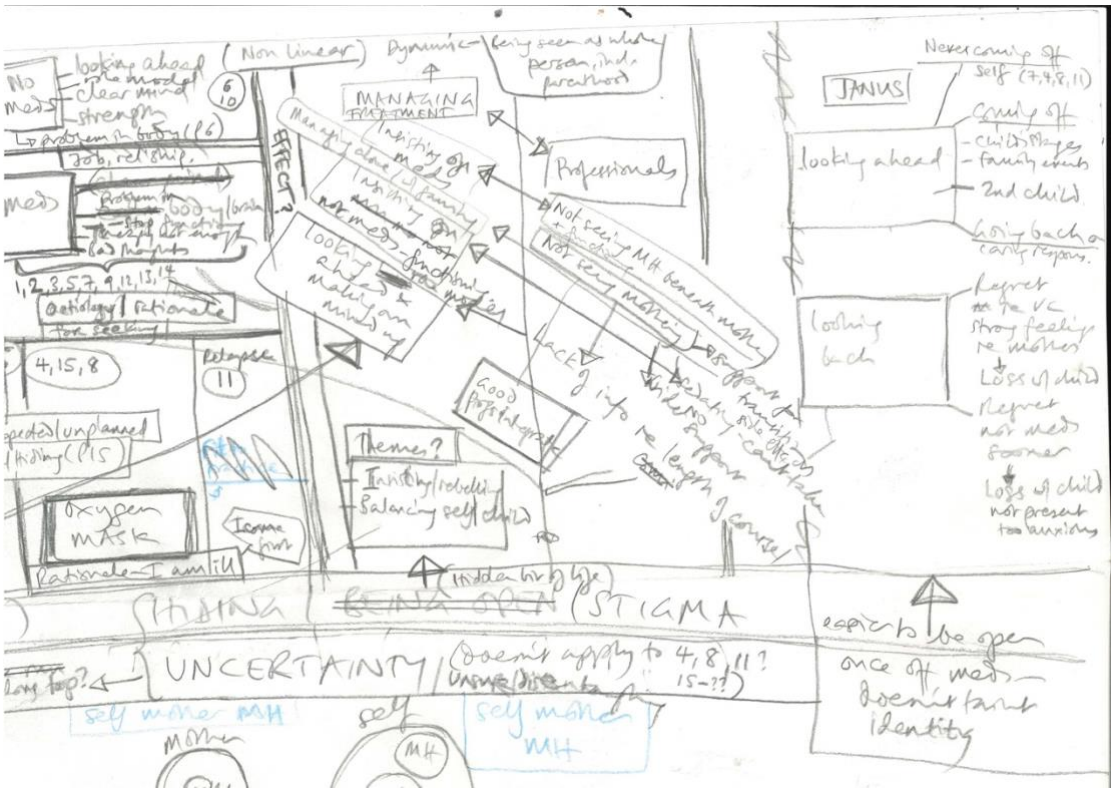

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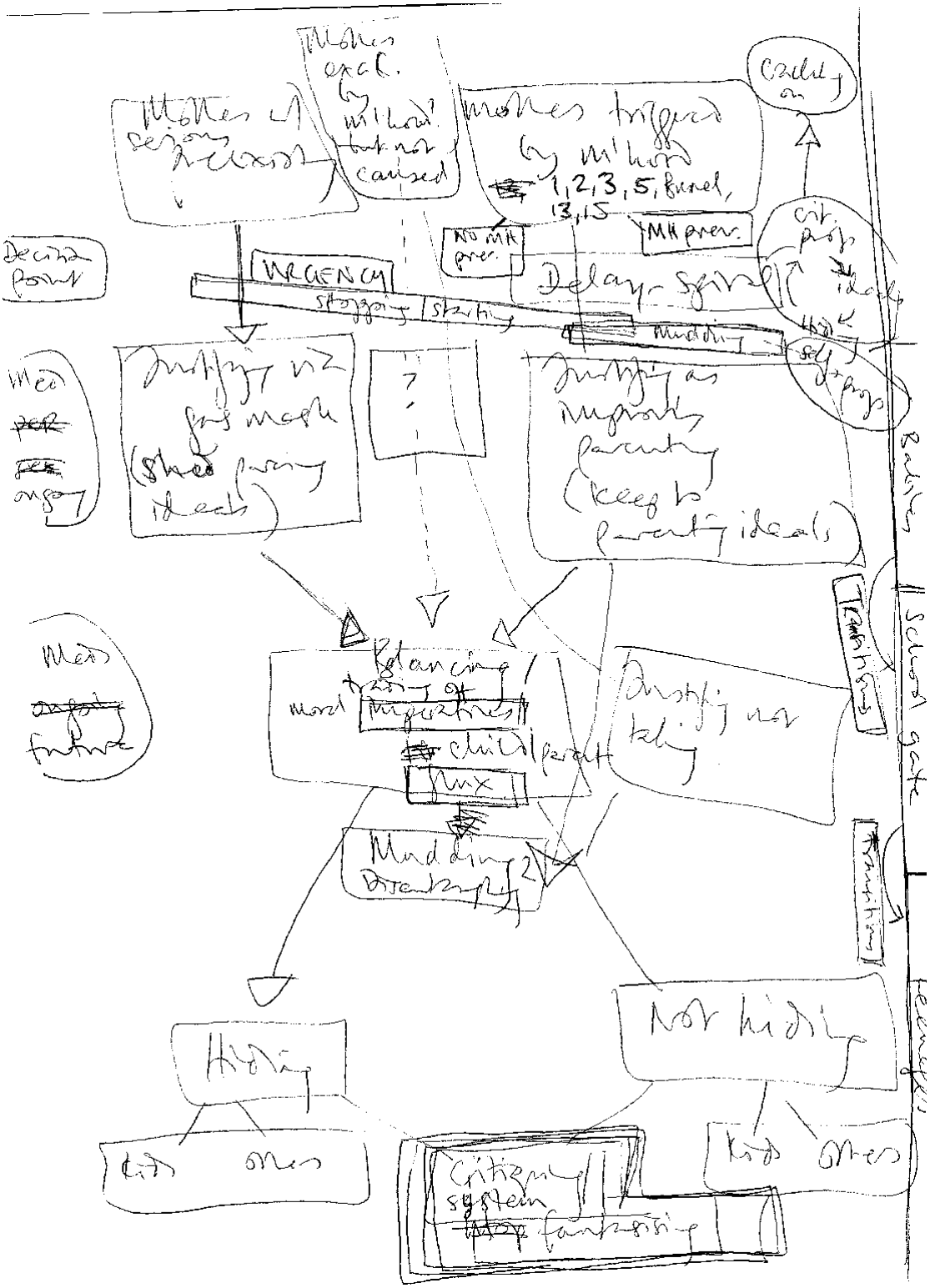

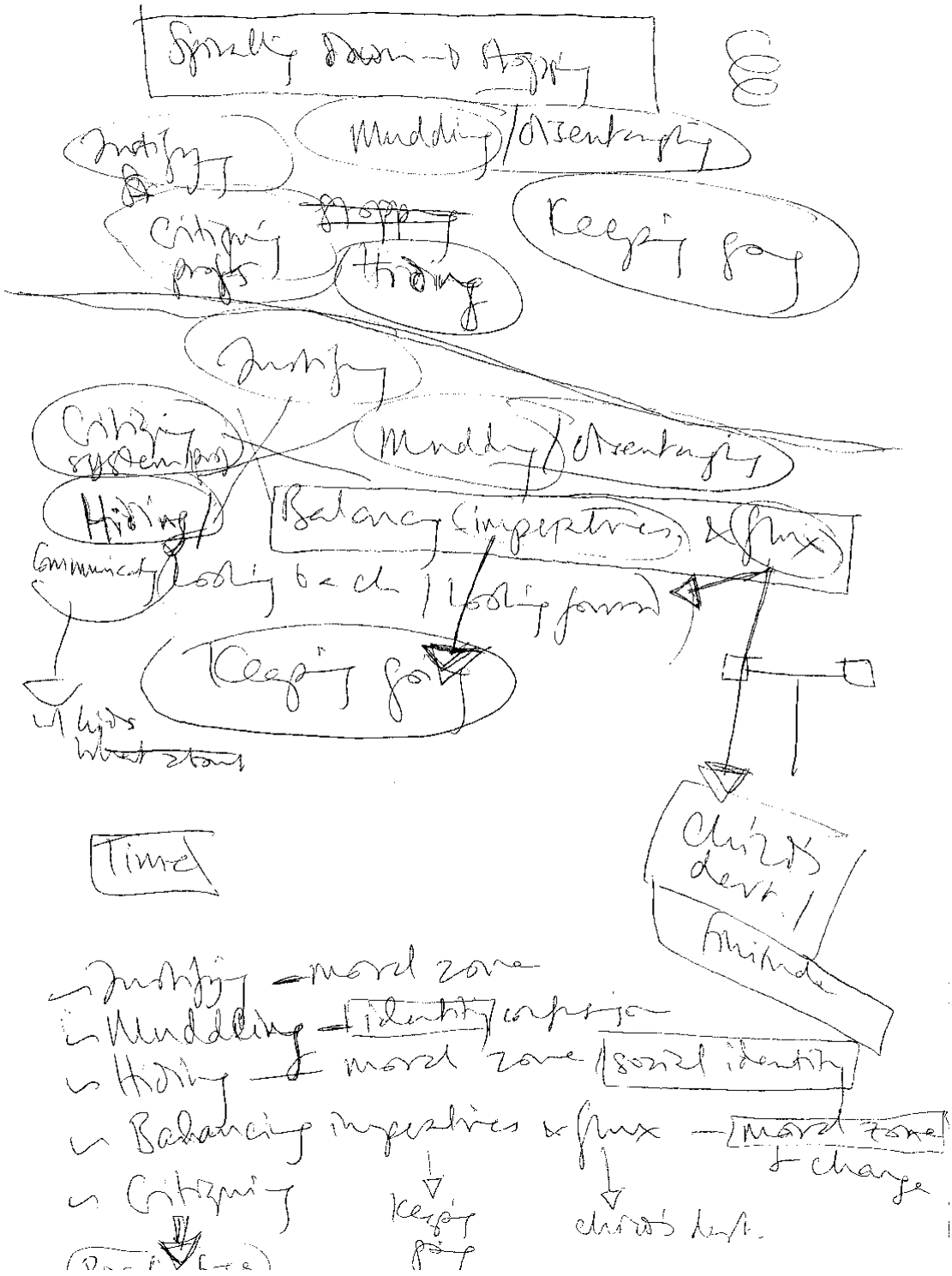
Spiralling down → stopping
Mudding/Disentangling
Justifying
Citizen profs
Stopping
Hiding
Keeping going
Justifying
Citizen system (proj)
Mudding/Disentangling
Hiding
Balancing (imperatives & flux)
Communicating
Looking back / looking forward
Keeping going
Time
Child's dev't / finitude
Justifying — moral zone
Muddling — identity confusion
Hiding — moral zone / social identity
Balancing imperatives & flux — moral zone + change
Citizen
Keeping going
child's dev't

T

Appendix W Sample Extracts from memos

This appendix contains memos from different stages of the research process, to show the development of my thinking, and some avenues I explored but that didn't make it into the final analysis.

After interview 5:

There was so much overlap with other interviews. It suddenly feels as though a lot of what is being said is familiar. Repeat themes are coming thick and fast. The themes of guilt as mother, of not being open about difficulties, of the professionals giving medication prescriptions without really explaining things, of medication helping one be more present and playful with one's children, but of medication also representing mental illness and stigma. (She said it was embarrassing to be on medication.) Also the theme of things moving so quickly with small children that it's hard to know what to attribute to the medication and what to changes around you.

After interview 13:

I liked her point about GPs seeing mothers functioning and therefore thinking they don't need medication, when actually mothers will push themselves to function. Ie the measure of functioning/not functioning is different with mothers.

A couple of participants have been fobbed off at first with the response 'oh well, mothering is difficult'. So there's this (linked) idea that mothering is just seen as difficult and symptoms of mental health are just seen as typical mothering difficulties rather than mental health. And: when mothers are functioning well, their difficulties are underplayed as well, because it masks what's really going on.

So mothers coping and not coping both mask mental health difficulties

This is linked to the theme of just getting on with it/just cracking on: something that has come up in most interviews.

Another repeated theme in this interview which has come up repeatedly was the idea of not being present for their child, and missing out on pleasure. It seems often to be anxious rumination that makes them not present.

She was very positive about meds and really saw the effects clearly. The participants seem to divide into those who find it hard to feel the effects and those who feel them v clearly.

24.3.19

I'm aware of a lot of doubleness and hiddenness and part/whole imagery in the data:

Playing hide and seek with professionals
Acting a part with professionals and child
Hiding sadness from child as it's not good for it, it needs a strong mother
Hiding mental health difficulties and med use from peers because sign of weakness, not good mother
Weak and strong
Divided self
Being a statistic
Encountering cold and warm professionals
Wanting emotional monitoring rather than medical. Seeing that as cold.
Some professionals seeing whole person vs some just seeing symptoms [mothers don't show their whole selves to their children, but want the professionals to see their whole selves]
Whole self, part of self.
Good care/bad care
Parallel processing

Bright, jolly, rosy denial – denial of the difficulties of being a mother
Denial of being a patient – wanting to control the image others have of me
Wanting to control the image my child has of me

26.3.19 – after P14 interview

It's really interesting the way P14 shed light on things by being at the opposite end of the spectrum – eg able to concentrate on own recovery because parenting being done by someone else. Not feeling stigma. Not being part of the mothering community, with its pressures and its stigma. Being free of that school gate culture.

I felt the same way at times that I did with P4 – Where is my research question here? With some mothers the link with meds is just there– they are absolutely bound up together. Maybe that's the case with mothers for whom their mothering identity is primary? (eg p 7)

With her and P4 it felt like they were separate. They allowed them to be separate. Why was that? What does that tell me?

1.They were not so worried about mothering myths.
2. Their career was a key identity for them.
3.Their mothering was only positive for their mental health (at least it was for P14 earlier on) – it didn't worsen their mental health/cause their mental health difficulties.

4.They were taking the meds for themselves and their own recovery not for their parenting.
5.P4 was more private about her difficulties than P14. She feared misunderstanding. Maybe that's a function of the type of difficulty they had?

She's the only mother among my participants who is not the primary carer. The way she has been able to manage her mental health and mothering is perhaps a function of that.

Why are some people's difficulties triggered by mothering and some not? And is there any link between those who think the meds help their mothering?

13/4/19

Is a trade off a useful concept? (eg trade off between accepting flattening and avoiding depression) – that's part of rational decision making theory perhaps.

There are cultural imperatives – you should, you shouldn't as a mother
There are mental health imperatives
There are intimate personal imperatives

The topic of mothering and meds taps one into strong cultural imperatives.

15.4.19

<u>Languages</u>

There's legalistic/moralistic language around mothering. Getting caught up in that risk of being accused, being measured up, found wanting.

Then there's cold, statistical language around medication. Being a statistic, being a measure.

And my mothers try to resist both (they try to conform at first)

Very powerful constructions of human roles.
The first misses out fallibility, human flaws
The second misses out thickness, richness, complexity

They are rebellious about both. But they suffer from both.

Sleep permeates the data to such an extent that I wonder if it should be part of the analysis:

Lack of sleep as mother is a creator of mental health difficulties

Mothering prevents the coping strategy of getting enough sleep
Mothering anxiety robs one of sleep
And one can't stay on meds or take them at times that make one sleepy

Sleep is almost the antithesis of mothering, the keeping on going of mothering.
It's the definition of stopping.

24.4.19

I'm not sure putting stigma/hiding in with imperative to function is right.

It's not moral, the stigma issue. It's social pressure – bad/good mother.

Whereas functioning for my child is different.

Framing the whole functioning/not functioning, keeping going/stopping themes around the moral imperative doesn't feel quite right. I wonder if I made too much of a conceptual leap. I want to go back to the data.

There's something about time and urgency, vs waiting and sticking it out.

I'd also like to include hiding, performing, roles vs being me/struggling to be seen and understood in there.

I'm not sure entangling/disentangling is the right overall process.

And maybe looking back actually doesn't belong under a theme of time, but more under a theme of urgency – the urgency of children being finite.

Appendix X Elements of situational analysis

This appendix shows lists I made of discursive elements in the data

Related discourses (historical, narrative and/or visual – eg normative expectations of actors, moral/ethical elements, mass media and other popular cultural discourses

Good mother discourse
Natural/unnatural mother
Happy mum happy baby
Female guilt
Good wife
Happy pills discourse
Medication as crutch
Natural vs unnatural/extreme/chemical

Pop culture:
America/LA/Wacky/Good housewives/crazy discourse
Prozac discourse

Mental health:
Brain deficiency discourse
Anti stigma/just like physical illness discourse
Mental health stigma discourse

Psychological discourses:
Stress discourse
Coping mechanisms
Therapy discourses (unpacking, unpicking, unravelling, solving, processing, tools, opening things up, rougher ride, like learning, working through yourself)

Self care discourse
Recovery discourse
Coping strategies discourse

Developmental/parenting discourses:
Attachment
Bonding
Separation
Child picking up on mother's anxiety