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Review Article

Mothers' Experiences of Recovery from Postnatal Mental Illness: A Systematic Review of the Qualitative Literature and Metasynthesis

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Abstract

Mothers are most vulnerable to mental illness during the perinatal period. The aim of this metasynthesis was to understand mothers' experiences of recovery from postnatal mental illness. Four databases were systematically searched using key words and index terms to identify the qualitative literature exploring mothers' experiences of recovery from postnatal mental illness. Fourteenstudies met the inclusion criteria and were critically appraised in accordance with the Critical Appraisal Skills Programme Criteria and guidelines developed by Walsh and Downe.The review used the metasynthesis approach informed by Noblit and Hare. Five core themes emerged from the synthesis to describe a four stage model of recovery: *stage 1: recognising the problem involves crisis and relational distress; stage 2: seeking help consists of subthemes of accepting help and help to access help. Stage 3: achieving recovery includes subthemes of sharing with others like me, coping strategies and noticing recovery. Finally, Stage 4: Maintaining recovery includes; incorporating coping strategies into daily life; acquiring a different model of motherhood and processing the experience.* The role of the family was interwoven through each stage of recovery. Mothers valued support from their family throughout recovery. Future research synthesising the support needs of families would inform systemic interventions to facilitate recovery. These findings have implications for services and professionals who are often the first point of contact with this group of mothers and their families. The findings and limitations are discussed in detail with reference to implications for research and professionals.

INTRODUCTION

Childbirth is associated with increased vulnerability to mental health: a woman is more at risk of developing a serious mental illness in the postnatal period than at any other point in her life [1-5]. Postnatal depression (PND) and postpartum psychosis (sometimes referred to as puerperal psychosis) respectively are the most common and the most severe forms of perinatal mental health difficulties; the onset of symptoms ranges from days to months [6]. Thirty women in 1000 live births will develop severe PND in the weeks following childbirth [4,7] and one to two women in 1000 live births will develop postpartum psychosis [8].While each illness may present with slightly different difficulties and symptomatology, they can both lead to inpatient admissions, at a time when separation may have implications for the attachment relationship between the mother and her baby [4]. The National Institute for Clinical Excellence [9] recommends that first contact with services in both the antenatal and the postnatal periods should routinely assess current and previous maternal mental health. Thus, a range of services should be accessible to mothers who are at risk of severe PND and postpartum psychosis at the earliest opportunity.

Although PND and postpartum psychosis have been viewed as distinct forms of illness based on biomedical models of evidence [10], mothers prefer more psychosocial explanations about the cause of these illnesses [11, 12].There is now a growing body of disparate strands of literature exploring both illnesses

from an experiential viewpoint. Common themes, such as guilt and loss of self, were identified in a review of studies exploring perinatal mental illness (including depression, anxiety or psychosis) [13]. Similarly themes of guilt, coping, dual identities, stigma and the centrality of motherhood were highlighted in a review [14],which focussed on the experiences of motherhood from preconception to parenting in mothers with severe mental illness including postpartum psychosis and PND. However, these previous reviews did not consider the experience of recovery from perinatal mental health difficulties.

Although there is no one singular definition of recovery within the perinatal literature, the experience has been construed elsewhere as a complex and ongoing process for individuals with mental health problems [15]; it is not simply the absence or reduction of psychiatric symptoms. Individuals may consider themselves to be in the process of recovery by drawing on a variety of strategies unique to their personal experience [16]. In her metasynthesis exploring mothers' experience of PND, Beck [17] described recovery as examples of behaviour or insight that involved mothers being able to recognise and meet their own needs. To date, there has been no metasynthesis of the qualitative literature on the experiences of recovery of mothers with postpartum psychosis and PND. Hence, the aim of this review was to synthesise the experiences of recovery in mothers with postpartum psychosis and PND to provide a comprehensive account of common experiences and to highlight factors that facilitate this process.

METHOD

The metasynthesis approach, informed by Noblit and Hare [3], was chosen because it is the most widely used synthesis technique in healthcare research [18] and preserves the interpretive properties of the qualitative data [2]. The key themes and concepts identified in the qualitative literature were synthesised to identify broader themes across the studies. The current review included three stages: 1) a systematic literature search of qualitative studies reporting on mothers' experiences of recovery from PND and postpartum psychosis 2) a critical appraisal of studies identified, and 3) the metasynthesis of these studies [19].

Systematic search

For this review a broad definition of 'recovery' in terms of support, coping, psychosocial adjustment, rehabilitation etc. was used. Published articles exploring the experiences of recovery from PND and postpartum psychosis in mothers using qualitative methodologies were identified through searches of the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), MEDLINE, PsychInfo and Web of Science (WOS). This search strategy was informed by the SPIDER [Sample, Phenomenon of Interest, Design, Evaluation and Research Type] [20] search tool, designed specifically for identifying qualitative and mixed research designs. Search strategies were tailored to each database using a combination of terms used in the database indexes; keyword terms were entered manually by the first author. Three strings of search terms were entered into each database and combined using the Boolean operators OR and AND.

Inclusion and exclusion criteria

Studies were included in the review if they satisfied the following criteria: 1) were published in English, 2) were published in peer reviewed journals, 3) reported on primary data collected via focus groups, face-to-face interviews, ethnographic data collection or expert panel that involved mothers who experienced PND or postpartum psychosis, 4) used a predominantly qualitative approach to analysis5) reported data relating to mothers' experiences of recovery from PND or postpartum psychosis, 6) reported on the experience of mothers over the age of 18 years old, with one or more children, 7) included mothers as the primary informants. As it is good practice to be as inclusive as possible in a metasynthesis [21], studies describing mothers' experiences of recovery in the broader context of social support or coping behaviour linked to becoming well or keeping well and/or describing the experience of psycho-social adjustment or rehabilitation following PND or postpartum psychosis were included, even if this was the only construct of relevance.

The exclusion criteria were: studies that were not published in a peer review journal, studies with no participants who experienced PND or postpartum psychosis and studies that used quantitative methodology.

Screening

The combined search strategy yielded 1513 studies, whose titles and/or abstracts were scrutinised against the selection criteria. The process of searching and screening was based on the PRISMA guidelines [21]. Initial abstract/title screening identified 43 duplicates and 1446 studies did not explore mothers' experiences of recovery in the context of postpartum psychosis or PND Figure (1).The remaining 24 full texts were screened against the inclusion criteria. A second reviewer (SP) independently screened the 24 identified studies. Discrepancies in the criteria were discussed by referring back to the inclusion criteria, until agreement was achieved regarding studies to be included in the synthesis. Agreement between studies to be included and excluded was high at 75%. Twelve studies were excluded: four did not contain qualitative data, two did not report primary data, two were not peer reviewed and two studies did not report mothers' experiences of recovery. Two additional studies were identified through manual searching of other sources (e.g., reference lists). Hence, 14 studies were included in the synthesis.

Critical appraisal

The quality of studies was appraised in accordance with the Critical Appraisal Skills Programme Criteria [1] and guidelines developed by Walsh and Downe [2] in order to assess different aspects of methodological and increase interpretive rigour. Studies were rated in the following areas: appropriate participants, clear statement of aims, appropriate research design, sampling methodology, data collection, evidence of reflexivity, ethical issues, thorough description of the analysis and clear statement of findings. Each element was then totalled out of a maximum of 20 to give each study an overall score in the following categories: Category A (high) for studies with a score of 17 or above; Category B (medium) for studies with a score between 11 and 16; Category C (low) for studies with a score

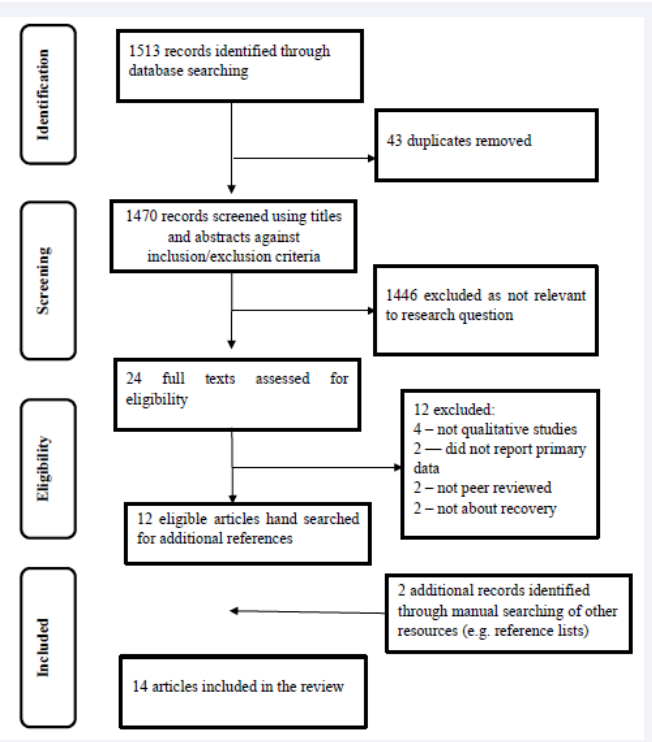

Figure 1 Flow diagram of search process.

of less than 11. An independent rater (NS) used this checklist to rate 40% of the included studies to ensure reliability. Minor discrepancies in ratings were discussed according to each appraisal criterion; however, this did not lead to revision in the studies' category assignment. Overall inter-rater agreement was high at 80%.

Metasynthesis procedure

The main stages outlined by Noblit and Hare [2] were followed: 1) deciding on a phenomenon (i.e., mothers' experiences of recovery from PND and postpartum psychosis), 2) developing rigorous inclusion and exclusion criteria to select qualitative studies relevant to the area being researched, 3) familiarity with data; reading selected studies several times and carrying out detailed data extraction in terms of demographic, methodological and thematic data, 4) reciprocal translation; comparing data between studies, 5) refutational translation; contrasting data between studies, and 6) synthesis translation; creating overarching themes to explain the phenomena in studies, while preserving the integrity of the original data.

RESULTS

Study characteristics

Of the 14 included studies, ten were on mothers' experience of recovery from PND and four described recovery from postpartum psychosis. The 14 papers included in the review reported the views of 395 women's experiences of recovery from mental health difficulties in the perinatal period. Eight of the studies were categorised as high quality (CategoryA) and six as medium (Category B). Generally these studies gained lower scores due to limited details regarding reflexivity and ethical issues. Included studies were conducted across eight countries including the United Kingdom (UK) and reported the views of mothers from at least eight different ethnic groups. Study characteristics and demographic details of studies are presented in Tables (1,2).

Synthesis

The findings of the synthesis identify recovery as a process along a continuum ranging from severe to mild symptoms Figure (2). Four distinct stages of recovery were identified across studies. Within each stage of recovery key themes emerged from the synthesis. **Stage 1: Recognising the problem** consists of one subtheme of *crisis and relational distress* and **Stage 2: Seeking help** is conceptualised as *Accepting help* and *Help to access help*. **Stage 3: Achieving recovery** includes *Sharing with others like me*, *Coping strategies* and *Noticing recovery*. **Stage 4: Maintaining recovery** includes *incorporating coping strategies into daily life*, *Acquiring a different model of motherhood* and *processing the experience*. A key theme of **the role of the family** that is embedded within each stage of recovery also emerged from the synthesis. A diagram illustrating the relationships between themes within each stage of recovery is provided in Figure (2). Similarly to Dolman et al.'s review [14], themes in this metasynthesis were not ranked according to importance or the number of times mentioned across the studies. Hence, each theme represents a process experienced by the mothers across time and at overlapping points in each stage of their recovery experience. Table (3) summarises the themes identified across studies.

The role of the family

The family had a key role throughout each stage of recovery, which ranged from helping mothers to recognise that there is a problem to maintaining recovery. Family members aided mothers to access and accept help from professionals. Emotional support from family was pivotal to recovery: *"The support of my family helped more than anything"* (p.161) [23]. However, the family members and could be a source anxiety and sometimes were limited in the support they offered to mothers because they didn't know how to help. *"He fully supported me. I think the only reason he couldn't have helped me more is he wasn't sure how to"* (p.444) [24]. Participants stated that fathers needed help to understand their partner's experiences, which provide emotional support as well as practical support during their wife's recovery. *"If my husband had a support group for new fathers to deal with a psychotic wife, it would have changed everything. He would have been far more compassionate had he known about my illness. He needed the tools to deal with a mentally ill wife"* (p.241) [25]. When mothers moved toward the latter stages of recovery; families understood what they had gone through and were in a position to help: *"I found they were totally different. My family seemed to have understood what I had done for them. They all knew that. They talked differently, not taking everything I did for granted anymore"* (p.454) [26].

Stage 1: Recognising of the problem: The first stage in recovery involved recognising that there is a problem. For the mothers this consisted of crisis and relational distress triggered in response to the presence of severe illness.

Table 1: Overview of studies in chronological order with quality ratings.

Author	Country	Sample Characteristics	N	Data Collection	Data Analysis	Themes	Quality rating
1. Lara-Cinisomo (2014)	USA	Twenty-two prenatal and postpartum Latina mothers participated in the study. The mean age was 24.12 years (*SD* = 4.46).	22	Each focus group took approximately 90 minutes to complete. Focus group discussions were audiotaped with the participants' consent. Spanish, English, and bilingual (Spanish and English) focus groups were conducted based on participant preference. One prenatal and two postpartum focus groups were formed.	Qualitative data analysis using procedures recommended by Miles and Huberman (1984).	Coping strategies - planful problem-focused, cognitive coping, and emotional disengagement. Treatment preferences (a hierarchy of care: the women's coping strategy; formal social support – health visitor; formal clinical support - less preferred than health visitor; pharmacology – last resort)	B: Medium
2. Williams, P. (2013)	USA	Women who perceived themselves to recover from postpartum depression. The ages of the participants ranged from 29 to 54 years.	9	In-depth interviews	Constant Comparison Method	Themes identified by women as crucial to recovery were: prelude to recovery igniting recovery, recounting recovery as a victory and realising recovery has been achieved.	A: High
3. Haga, S., Lynne, A.; Slinning, K & Kraft, P. (2012)	Norway	First-time mothers (aged 25 to 44 years) self-selected to participate in the study. Three women described themselves as depressed. One woman described crying and hopelessness that lasted several weeks. Five of the women described themselves as slightly depressed with fewer symptoms with lower intensity and shorter duration.	12	Semi-structured interviews	Thematic analysis	Themes identified: Personal approach – 'controlled' vs. 'relaxed'; Social support; Managing breastfeeding and well-being	B: Medium
4. Montgomery, P., Mossey, S., Adams, S. & Bailey, P.H. (2012)	Canada	Seven women living with PND accessing peer support. Five of the women attended all sessions and two women attended the last group session only. The women were aged 18 to 30 years.	7	Ethnography/participatory action research – written, visual and spoken stories. Invited researcher sat in on support groups over a 6 month period. The women were also equipped with disposal cameras and blank diaries to record their recovery experience in the manner of their choice.	Structural Narrative Analysis	Three groups of recovery stories were revealed. These were labelled as illness, mothering wisdom and mobilising.	A: High
5. Slade, P., Morrell, J.C., Rigby, A., Ricci, K, Spittlehouse, J. &Brugha, T.S (2010)	UK	Thirty women who took part in the PONDER trial with a score on Edinburgh Postnatal Depression scale (EDPS) indicating the likelihood of depressive symptoms participated in this research. The women ranged ages from 18 to 45 years.	30	'Template' approach to data analysis	Semi-structured interviews	Three broad themes: seeking help; roles and relationship and experiences of intervention or support	B: Medium

6. Di Masciio, V., Kent., A, fiander, M. & Lawrence, J. (2008)	UK	Two panels of women who had recovered from PND. Panel 1: 10 mothers recruited by Health Visitors who had recovered from PND. Panel 2: 158 women recovered from PND and part of national support group	168	Interviews and questionnaire	Delphi Technique	The eight recovery factors rated as 'essential' for recovery were: emotional support from partner; sleep; improved communication with partner; diagnosis; practical support from partner; emotional support from friends; time to bond with the new baby and prompt assessment by a health visitor.	A: High
7. McCarthy, M. and McMahon, C. (2008)	New Zealand	Fifteen women (aged 27 years to 41 years) treated by community mental health service for PND took part in the study.	15	Interview questions were open-ended, with prompts to encourage women to expand on their perceptions, experiences, and needs. The interview was audiotaped and later transcribed.	Modified Analytic Induction Method	Five core themes: an initial concern that something is wrong; reaching a crisis point and obtaining help; accepting the diagnosis; the gradual breaking down of the stigma through disclosure and the discovery that a wide range of women suffered the same problem; and subsequent recovery.	A: High
8. Letourneau, N., Duffet-Leger, L., Stewart, M., Hegadoran, K., Dennis, C.L., Rinaldi, C.M. and Stoppard J. (2007)	Canada	Fifty two women with average age of 31.2 years who had experienced postpartum depression. The participants' education level ranged from partial high school to university or graduate degree.	52	Data was collected using semi-structured interviews followed up by focus groups to elaborate on interview findings.	Thematic content analysis	One-on-one support preferred initially. Group support should be available once the mothers start to feel better and are able to comfortably interact with other mothers in a group format.	B: Medium
9. Chen, C.H., Wang, s.Y., Chung, U.L., Tseng, Y.F., Chou, F. (2006)	Taiwain	Participants were 23 Taiwainese women screened with BDI 6 weeks after birth for postpartum depression. Women ranged in age from 19 to 38 years old. Only two out of the 23 were being treated for depression at the time.	23	The initial interviews were arranged at 10–12 weeks after childbirth, and the BDI was carried out before each interview. The participants were considered recovered from PPD when their BDI score had dropped below the cut-off point of 10 at the time of interview. Follow-up interviews were conducted every month until the point of recovery. Each participant was interviewed on one to three occasions. The length of each interview was 1.5–2 hours.	Grounded Theory	Four stages of coping: shattered role identity; feeling trapped and breaking down; struggling for self-integrity and regaining vitality.	B: Medium
10. Amankwaa, L.C. (2003)	USA	Twelve African-American women interviewed after their last episode of PND	12	Interviews	Constant Comparative Method	Six key themes identified: stressing out; feeling down; losing it; seeking help; feeling better, and dealing with it.	B: Medium
Subsample of puerperal psychosis studies							

11. McGrath, L., Peters, S., Wieck, A..& Wittkowski, A. (2013)	UK	.All women were White British, living in England or Wales.	12	Semi-structured interviews	Grounded theory	A theory of four superordinate themes was developed from the data, including: the process of recovery; evolving an understanding; strategies for recovery; and sociocultural context.	A: High
12. Heron, J., Gilbert, N. & Dolman, C. et al. (2012)	UK	Five women who were members of Action Postpartum Psychosis and who had considered themselves recovered from their episode of postpartum Psychosis. The time length since their PP episode varied from 3 years to 20 years.	5	Service users trained at qualitative research workshop conducted 45 minute interviews with each other.	Grounded analytic induction approach	Themes identified: unmet expectations; ruminating and rationalising; social recovery; medical support; information needs, family functioning and giving recovery time.	A: High
13. Doucet, S., Letourneau, N. & Blackmore, E.R. (2012)	Canada and USA	Nine mothers who experienced PPP, 8 fathers/partners of the above woman. All mothers were hospitalized and treated in general adult psychiatric units.	17	The interview took place over the telephone (n = 9) or in person (n = 8) in a mutually agreed-upon setting. The interviews ranged from 45 to 120 minutes, with most lasting approximately one hour.	Inductive Thematic analysis	All mothers reported the need for instrumental, informational, emotional, and affirmational support. The mothers' support needs crossed two themes: generic parenting needs and serious mental illness needs.	A: High
14. Robertson, E. & Lyons, A. (2003)	UK	Women diagnosed and treated with PPP. Participants range in age between 28 and 44 years of age (M = 34 years). Duration of postpartum psychosis ranged from 1 month to 1 year and 10 months. Recovery time ranged from 1 - 10 yrs.	10	Interviews	Grounded theory principles.	The women felt; if health professionals explained the nature of the illness & symptoms to family, would alleviate some of the stress. Written information about symptoms and understanding illness may have improved the speed of recovery.	A: High

Table 2: Demographic characteristics of studies.

No.	Age yrs	Ethnicity	Recruitment	Marital status	Ed[1]. & employment	No. of children	1st baby?	Time: recovery - interview	Birth/pregnancy complications	Symptom onset	Child's age during episode	Mental health history
1.	M = 24.12	13/22: Puerto Rican 5/22: Dominican 2/22: Mexican 2/22: Other	Faith based research & Latina mothers support group.	12/22: Married 10/22: Cohabiting	10/22: high school education. 2/22: college Ed 1/22: Uni degree 2/22: NS[2]	NS	NS	NS	NS	8/22:2nd to 3rd trimester 15/22: perinatal period	NS	22/22:identified as stressed during the perinatal period
2.	29 - 54	NS	Obstetrician and Snowballing	Married or cohabiting	8: Ed beyond the high school 3: employed	NS	NS	Less than 1 year to 24 years.	8/9 participants: preterm labour; infection; hypertension, placenta previa& prolonged labour.	1st month postpartum	NS	6: depression unrelated to childbirth

3.	25 - 44	NS	Well baby clinics	Cohabiting with partners	All: higher education from Uni or college	All: 1st baby.	All 1st baby	NS	NS	NS	8 wks - 8 months	NS
4.	18 - 30	NS	Convenience sample/Peer support groups	Cohabiting with partner	All min. high school.	At least 1 child.	NS	NS	NS	NS	NS	NS
5.	18 - 45	NS	Health visitors.	3: singles parents. 10: cohabiting	NS	NS	21: 1st Baby	NS	NS	NS	NS	18: GP prescribed antidepressants
6.	N.S.	NS	Association for Postnatal Illness. & Health Visitors	NS	NS	NS	NS	NS	NS	NS	NS	74/158: previous depression
7.	27 - 41	NS	Community Mental Health Nurses	All in relationship with father of children.	6: 6 years of high school 4: polytechnic school 5: Uni degree	7: 2nd child 1: 3rd child 1: 4th child	6	18 months.	NS	NS	NS	NS
8.	M: 31.2	42/52 White :5/52 Aboriginal/Native 5/52: other	Advertisements in : newspapers, T.V., radio, psychiatrists' and psychologists' offices, mental health clinics, public health clinics, and health care facilities including maternity wards, emergency rooms, and mother-baby clinics.	46/52: married; 6/52:single; 3/52 cohabiting	3/52:partial high school; 9/52 completed grade 12; 9/52: partial community college/ technical school; 18/52;14/52 Uni. degree	NS	NS	Within last 2 yrs	NS	Within 12 weeks of delivery	NS	NS
9.	19 - 38	Taiwainese	Teaching Hospitals	All married.	23/23: more than 12 years of schooling; 7/23: Ft work; 3/23: Pt work; 13/23: unemployed; 11/23: SES; 8/23: low SES; 4/23: middle SES	11: second or subsequent child	12	10 to 12 weeks after childbirth and considered recovered by BDI score.	11/23: vaginal deliveries 12/23: caesarean delivery	6 weeks postpartum	NS	NS
10.	22 - 40	African -American	Professional/ Personal colleagues		High school to doctoral level. All middle class.	NS	NS	NS	NS	NS	NS	NS

11.	26 -45	White British	MBU & Web forums	1: single 9: married 1: divorced 1: cohabiting	1: Mat. leave 1: volunteer 2: house wife 3: Ft work 5: Pt work	2:later births	NS	4 months - 23 yrs	NS	NS	6: 1 - 4 yrs 2: under 1 yrs 2: 5 - 9 yrs 1: over 20 yr 1: 15 - 19 yrs	1: previous admission for severe depression 3: common mental health problems (anxiety & depression)
12.	NS	4: White British 1: White European	Web forum	All married.	3: Ft work. 2: self employed	NS	NS	3 - 20 yrs.	NS	NS	NS	1:Bipolar disorder
13.	NS	NS	Community and hospital agencies providing services during the postpartum period	6: married 2: cohabiting 1: divorced	1: partial Uni 8: Un./college 2: Ft workt 3: Pt work 2: Mat leave 1: house wife 1: unemployed	NS	6: 1st baby	3: fewer than 6 months 3: 1 year 2: 2 years 1: 6 years	NS	NS	NS	2: previous diagnosis of Bipolar disorder 2: previous diagnosis of depression
14.	NS.	NS	Research newsletter	NS	NS	3: 1 later birth	NS	1: 6 months 3: 2 years 2: 3 years 2: 5 years 1: 7 years 1: 10 years	NS	6 weeks postpartum	NS	NS

(Footnotes)
1 Ed. = Education
2 NS = Not stated

Crisis and relational distress

Recovery commenced with recognising illness. Without this initial stage later phases of recovery cannot occur. It was during the crisis that mothers acknowledged that they recognised the presence of symptoms: "*I had to walk-I'd try to get a mental grip. Okay. Go over and pick up the soap, you know, the routine. It is like we have a routine of doing things, and I couldn't really remember what the routine was. It was like, well, wow, I must really be, you know out of it. I can't even wash my face*" (p.304) [27]. When in crisis many mothers accepted that they were ill with the help of family members. Mothers were unable to recognise and actively draw on strategies that facilitate the acceptance of illness: "*My friend said you have got to see C (psychiatrist .... By this stage it was quite obvious that I needed hospitalization. I couldn't make a decision to save myself. But that night dad said, 'This is just getting bloody ridiculous. You need help'. And mum said, 'Get on the phone and ring' and I rang an 0800 number that night at the mental health unit*" (p.626) [28]. During this phase many mothers described their families as taking control, making decisions and accessing support.

Many mothers reported relational distress during the initial stages of recovery: "*I was being really weird and telling him I wanted to kill myself. He was trying to be supportive but he just looked scared, I put a lot of pressure on him*" (p.421) [5]. Relational distress with partners and infants was intrinsic to family members recognising that the mothers were in crisis. Many mothers talked about turning to other family members when they felt they could no longer care for their baby: "*...I said to my mother, this is after-I was just like totally overwhelmed, and overwhelmed feeling. I said you are probably going to have to the baby, so-I don't think I can take care of this baby*" (p.304) [27].

Stage 2: Seeking help: Seeking help involved accepting professional help that was often mediated through the family. Mothers needed help to access formal and informal help.

Accepting help

Formal support and contact with health professionals was a necessary component in recovery. The perception of the health visitor role and the relationship with the health visitor was influential in accessing professional support. Some mothers described their perceptions "*She wasn't as person-centred and she didn't really have the people skills to manage*" (p.443) [29] as a barrier to accessing support from the health visitor. In contrast "*prompt support from a health visitor*" that "*validates*" their experiences (p.256) [30] were examples of effective professional support. Many mothers with postnatal depression feared being judged as 'not coping' which limited their ability to access support from professionals. Some mothers sought support from health care professionals, in the guise of seeking care for their baby: "*... so I called him [GP] out ... I called him for [my infant] but I did want to talk to him at the same time ... but I used the excuse of him coming*

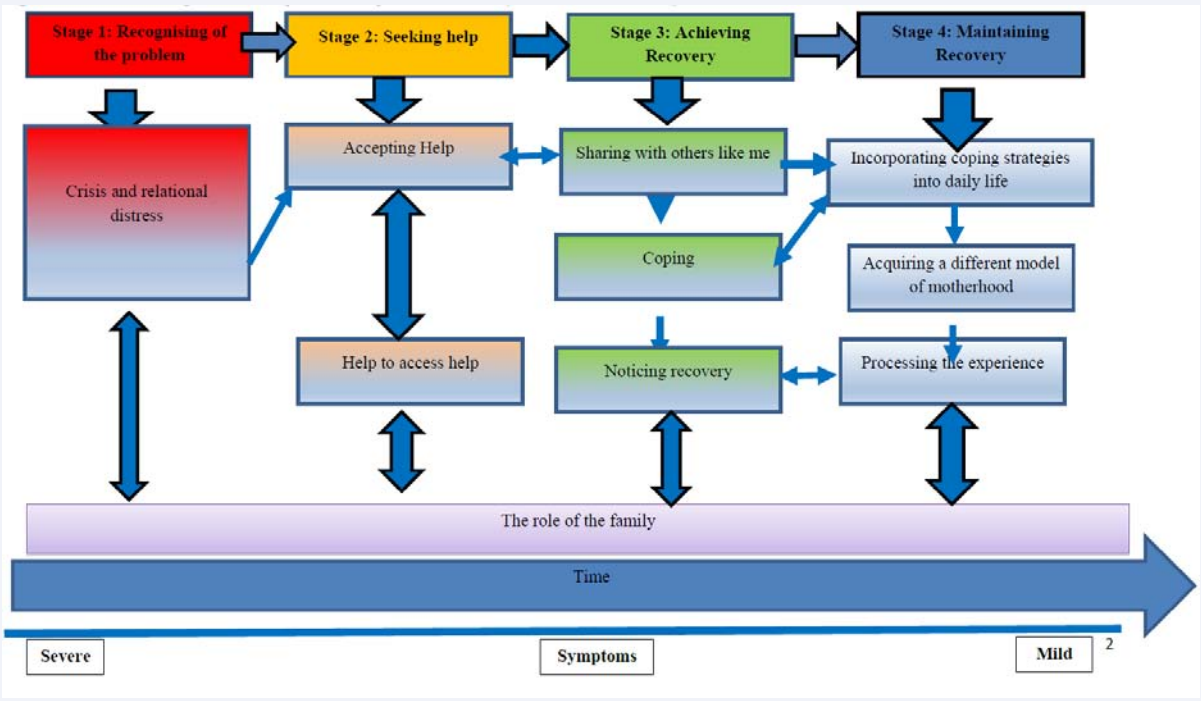

Figure 2 Model illustrating the relationships between experiences of recovery and the role of the family.

to see [my infant]" (Slade et al. 2010, p. 443). Overall mothers responded well to strong advice from family and partners that they needed help: "*It was sort of my partner saying to me 'Right if you don't go I'm basically making you an appointment, you are going, don't sweep it under the carpet, you know you can't just keep feeling like this'*" (p.443) [29].

When symptoms decreased, mothers needed contact with professionals that allowed them to reflect on and understand their experiences: "*Once you've got your [child care and household] routines down and you are on top of that game. Then you need the mental working-out, then you need the counselling*" (p.445) [24]. When the mothers moved out of crisis, this was the best time to access professional support that was psychologically informed: "*When you're beginning to feel a bit better and you're not really seeing health professionals that much I think then, if you had-five or six sessions or something, with a counsellor and just went through how you felt about it. And you know, got a little bit of advice about how to cope with it*" (p.158) [23].

Help to access help

Many mothers reported the need for more information and public awareness of symptoms and support needs of PND and postpartum psychosis, because often mothers' families facilitated access to professional support during crisis. "*I think people in general need to be more aware. Some people might not see it until their partner or their friend or their sister or somebody says, 'You're not yourself'. Other people around need to know, 'Okay, this is a possibility and these are the things you look for and this is what you can do'*" (p.446) [24]. Therefore, information and education for all the family about PND and postpartum psychosis is essential to recognise symptoms and help mothers to access professional help. "*I think it helped my husband first to be able to put a label on what was happening. Secondly, to realise that this is what happens in postpartum psychosis ... It was important to him in just seeing the process through ... to stick by me, to know that there was a treatment that could work ...*" (p.162) [23]. This helped the family, especially partners, to understand the mothers' symptoms and utilise strategies that supported them getting better through each stage of recovery.

Stage 3: Achieving recovery: Mothers shared their experiences with others as they progressed towards recovery. At this stage mothers developed coping strategies and insight that helped them to notice that they have moved into recovery.

Sharing with others like me

When symptoms decreased the opportunity to talk with other mothers who have had similar experiences was an important factor in getting better. Sharing with others normalised and reduced feelings of stigma: "*It is amazing once you open up ... and a few other people sort of said, 'Oh, I had that,' and it was amazing. I have actually since found out that quite a few other people around me that are friends and I didn't even know that they are on medication*" (p.650) [28]. Mothers valued support groups and a space where they discussed their feelings without being judged as a parent. "*Groups are a safe place to say 'This isn't the greatest time of my life'*" (p.445) [24]. Meeting other mothers in latter stages of recovery provided reassurance and hopefulness about personal recovery: "*So other people ... kind of saying 'I've done it too, I know how you feel' and also you know, just to encourage you from the years ahead of you that they are, is really, really valuable*" (p.159) [23]. Sharing with others increased mothers' confidence for their future wellbeing and the wellbeing of their children. "*The turning point was when I talked to some-one who had gone through the exact same thing as me. The fact that she turned out okay and*

Table 3: Overview of the themes identified across studies in the metasynthesis.

	Study Number													
Themes	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**
Role of the family	-	-	-	yes	yes	-	yes	yes	-	-	-	yes	yes	-
Stage 1: Recognition of the problem														
Crisis and relational distress	-	-	-	-	yes	-	yes	-	-	yes	yes	yes	-	yes
Stage 2: Seeking help														
Accepting help	yes	-	yes	yes	yes	yes	yes	yes	-	-	-	-	-	yes
Help to access help	yes	-	yes	yes	yes	-	yes	yes	-	-	yes	yes	yes	-
Stage 3: Recovery														
Sharing with others like me	-	yes	-	yes	-	-	yes	yes	-	-	yes	yes	yes	yes
Coping strategies	-	yes	-	yes	-	yes	-	yes	yes	yes	yes	-	-	-
Noticing recovery	-	yes	-	yes	-	-	-	-	-	yes	-	-	-	yes
Stage 4: Maintaining recovery														
Incorporating coping strategies into daily life	-	yes	-	yes	-	-	-	yes	-	-	-	yes	-	-
Acquiring a different model of motherhood	-	-	-	-	-	-	-	yes	yes	yes	yes	-	-	yes
Processing the experience	-	*yes*	-	-	*yes*	-	-	*yes*	*yes*	-	*yes*	*yes*	*yes*	*yes*

went on to have a happy good life with other kids was reassurance that I could get through this" (p.238) [25]. Many mothers felt that it was an important to share their experience to help others. Empathising and supporting others was described as a marker that mothers had moved forward in recovery. "*I suppose you can sympathize, well empathize with people more because you've been there yourself. I think that has made me a better person, I would never have done this before I was ill but now I feel I have something to offer them, and I want to give something back*" (p.424) [13]. Sharing with others o helped the mothers to reflect and develop a narrative of their experiences of illness and recovery: "*...I felt that I was almost making sense of the experience that had happened to me by educating others*" (p.158) [23].

Coping strategies

When symptoms reduced mothers developed coping strategies. For many mothers simple goals were the first coping strategies for getting better: "*I had to eat something, get out of bed, and take a shower. That was my job for the day*" (p.279) [31]. Many mothers found that simple pragmatic strategies, such as "*sleep*", were "*essential recovery factors*" (p.256) [30]. When mothers began to feel better, they were more involved in caring for their babies, this was also noted as an effective coping strategy at this stage: "*... like when I started weaning her and stuff, just seeing that she was developing normally helped*" (p.163) [23].

Noticing recovery

There were key moments when mothers recognised that they were recovering. Some mothers noted that the absence of symptoms was the first stage in noticing that they had taken their first steps on the path to recovery: "*No depression, no anxiety or panic attacks. Um, no snippy or snappiness to my husband or kids*" (p.279) [31]. Many mothers noticed small steps on a daily basis that were markers of recovery. For example, looking forward to activities planned later that day. "*I wake up and I'm pretty much thinking, what am I going to take on today*" (p.279) [31]. Many mothers gradually noticed increased confidence with day-to-day routines, caring for their infants and reconnecting with friends. This helped mothers to believe in their ability to take future steps towards recovery. "*I did actually think for the first time I thought, Maybe I can do this*" (p.344) [32].

Stage 4: Maintaining recovery: In the final stages of recovery mothers integrated coping strategies developed at earlier stages to maintain their progress. Mothers adopted new models of motherhood that maintained recovery. Accessible information such as leaflets or simple advice (formal or informal) helped mothers to process and make sense of their overall experience.

Incorporating coping strategies into daily life

As mothers started to get better, earlier coping strategies remained integral to staying recovered. Similarly, Heron et al. [23] illustrated how these initial concrete steps evolved into long-term coping strategies to maintain progress throughout their experience of recovery: " *... but it was little bits at a time, piece by piece, building yourself back together again. And I kept setting myself goals to achieve and I found that helped tremendously*" (p.162). Incorporating these early coping strategies with daily life seemed to aid recovery. One example of this is returning to work. Mothers took small steps with this area of day-to-day life: "*I went back-it's been almost a month and half now. I went back part-time and I am not doing what I used to do. I am doing something that is pretty easy, but yeah, I guess it is pretty easy compared to what I used to do*" (p.308) [27]. Mothers returned to activities that they enjoyed on a daily basis; this was described as a hallmark of recovery: "*... and started to do things that I enjoyed doing. That's when I felt I was gaining more control of myself ... more control over myself and also I feel, like um, like I think I was a little bit happier*" (p.279) [31].

Acquiring a different model of motherhood

In the final stage of recovery mothers developed a new model of motherhood. Mothers cared for themselves and acknowledged

their limitations: "*I know I don't have as much strength or energy right now*" (p.528) [24]. Chen et al. [26] described a move away from high standards held by many mothers as they strived to juggle the multiple demands of motherhood: "*It's much better. I am not as busy as I used to be. I was too busy in the beginning to finish all those things that I wanted to do, for I had to take care of my baby and do all the housework. One thing is different though. In the past, I tended to do the household chores like cleaning up without being interrupted. Suppose I was in the middle of the work and my child started crying, I would feel upset. But now it's different. I think of it this way, 'Well, let it be. Anyway, I can do the rest tomorrow*" (p.454).

Staying recovered involved acknowledging a change in identity and that pre-motherhood goal might not be pertinent to the mother who has recovered from mental health difficulties: "*… So I am back … I don't feel like my old self, but at this point I am – I am wondering if that's even realistic, because I am not the same … I am mommy now*" (p.308) [27]. Mothers altered their orientation towards personal and societal expectations as a means of coping and staying recovered: "*I … possessions and things…I used to be really career orientated. I wanted to do well, I wanted to be [top of profession]. Now I don't have…you know, maybe I will when he's older. I don't have any inclination to do that now*" (p.346) [32].

Processing the experience

As mothers became less symptomatic, they valued appropriate and credible information that facilitated their understanding of their experience. "*Even though it was the thing you'd not heard of, it was a relief to know… it does exist, other people have had it before me and there are things that can be done*" (p.347) [32]. Appropriate information from a credible source inspired mothers to stay recovered: "*I read it and just cried my eyes out. It was somebody suffering what I was suffering. And that was the best thing in the world because I thought, gosh somebody else had had this-it's exactly the same as what I'm having … so then I thought, well actually, they do know what it is and they're sorting me out…*"(p.161) [23].

Information and time provided mothers with the reflective space to process their experiences; this processing period was pertinent to maintaining recovery. Many mothers explained that: "*Time is a wonderful thing if you have it. Because I think it helps you to evolve and then you can look back and get perspective from the view of the future, so to speak*" (p.280) [31]. Similarly, mothers described a process of looking back and looking forward with hopefulness for the future and their ability to stay recovered and cope with future adversity. "*I can stand back and look at myself in the past when I was ill and that isn't me. I went from being a confident woman to … now I've regained my confidence and I feel better than I did before because I've been through this and come out stronger. Nothing as bad can ever happen to me again*" (p.424) [5].

DISCUSSION

This is the first metasynthesis to explore mothers' experiences of recovery from the most common and severe postnatal illnesses namely PND and postpartum psychosis: 14 studies were systematically reviewed and their methodological quality was assessed. Four core stages of recovery emerged from the synthesis and each stage consisted of key themes describing mothers' recovery experiences.

A key finding of this review is the integral role of the family across all stages of recovery. The family were involved in helping the mothers to recognise illness, access help, achieve and maintain recovery. This parallels the psychosis literature that states that recovery is achieved through relationships with family and friends [33]. Recovery begins with recognising the problem through the experiences of crisis and relational distress. Beck's [17] metasynthesis of mothers' experiences of coping with PND states that mothers had to accept that they needed to help before they could commence recovery. For the mothers in the current review, crisis involved relational distress with partners, friends and with their babies. This mobilised the mothers' support network to facilitate access to and accept of professional help, which helped the mothers move into the next stage of recovery. Similarly, previous research suggests that when mothers accept illness by experiencing crisis, they disclose the need for help to family members [12]. Research reviews of psychosis independent of childbirth have highlighted identifying and responding to illness as elements within recovery [33,34].

Previous research indicates that mothers rely on professional support for the alleviation of symptoms [13]. Our findings showed that mothers valued prompt support from professionals as it validated their experiences. However, theirfear of failing to cope in the eyes of professionals emerged as barriers to accessing professional help. This is similar to an earlier metasynthesis, which reported that the stigma of mental illness prevented mothers from accessing help [14]. However, Dolman and colleagues [14] looked at the motherhood experiences of women who had pre-existing mental illness, whereas our review considers the recovery experiences specific to mothers with perinatal mental health difficulties. An interesting finding of our review was that in some instances mothers accessed support indirectly via guidance on childcare. For mothers who had insight into their symptoms, this approach was a more legitimate means of accepting help. When symptoms decreased, mothers moved into the second stage of seeking help.At this stage in recovery there was a desire for psychologically informed professional support. As mothers' symptoms reduced, their insight increased, which allowed them to reflect on their experiences. This reflection helped the mother develop narratives about illness, coping strategies and overall recovery.

Many mothers expressed concern for partners and felt that professional support for partners would have facilitated their recovery. Earlier studies into PND and postpartum psychosis have found that mothers often rely on support from families, but this support doesnot meet their needs [13,35]. Other reviews within the general psychosis literature highlight the need for supportive relationships with friends and family [33,34,36]. A novel finding of the current review was the centrality of family members throughout recovery, with a theme of supporting families emerging from the synthesis. Hence, it seems essential to educate and support families to help them to support the mothers in recovery.

The opportunity to share with mothers who have had similar

experiences was important for recovery. Similarly to earlier research into PND and postpartum psychosis, talking about experiences and sharing with others has been identified as an important coping mechanism [13,25], comparable with the wider psychosis literature [33,34].Many mothers talked about changing their attitude towards routines, setting small practical goals, acknowledging their limitations and using practical strategies such as regular sleep as important steps in recovery. Achieving recovery comprised of noticing recovery; this was identified as an important factor across studies [31,32,37].When mothers noticed that they had recovered, they were hopeful about the future and were motivated to continue with their progress.

Maintaining recovery involved a move away from high standards and unrealistic expectations that mothers imposed on themselves. This was conceptualised as a subtheme of developing a new model of motherhood and is unique to recovery from postnatal mental illness. Interestingly, the changing of expectations around motherhood has been reported elsewhere [17,35] and it is comparable to research around adaptations to motherhood [38]. Thus, the latter phase of recovery is characterised by naturally occurring reactions to motherhood following childbirth.

Strength and limitations

As the metasynthesis approach inherently involves a degree of subjectivity, all studies in the review were screened independently. To enhance the rigour of synthesis the methodological quality of each included study was also independently rated (by NS), a high rate of agreement was reached. Steps were taken to maximise transparency in the search strategy, screening studies, appraising studies and the synthesis of themes. Detailed tables of the included studies and relevant themes are supplied Table (2,3).The search strategy was informed by the SPIDER search tool, designed specifically for identifying qualitative and mixed research designs [20]. This search strategy drew on the sample, phenomenon of interest and evaluation elements of this tool to preserve sensitivity and specificity. The search strategy was inclusive, using broader terms that were sensitive enough to capture studies specific to the aim of the review. Hence, there was no need to search on narrow terms relating to methodology.

As is common with qualitative research, this review included studies of heterogenous samples, methodologies and context. All included studies were of high or medium methodological quality, notably there were no studies assigned to category C. Whilstall synthesised studies where of good methodological quality, there was inconsistency across studies in terms of the demographic information provided. It was not possible to verify the exact diagnoses of mothers recruited to the reviewed studies. However, the primary aim of a metasynthesis is to summarise and understand all experiential phenomena to develop new insights from the data [24].Therefore, the iterative approach of a metasynthesis does not necessitate the need for highly specific concepts such as diagnosis [39].

Evidence gaps

This review identified several gaps in the research literature. The family and particularly partners have been recognised as important to a mother's recovery. There is a small body of research exploring the experience of postnatal mental illness from the perspectives of families and professionals [40-42]. However, to date there have been no reviews synthesising the experience of family members and their support needs. Future research may explore the partner's or other family member's experiences from the onset of postnatal mental illness to recovery because the family has a significant influence across each stage of recovery. Future research synthesising the support needs of families would be helpful in formulating systemic interventions that draw on family members to aid the mothers' recovery. Our findings highlight that relational distress (for example, not being able to care for the baby) is key to helping mothers recognise that there is a problem in the first stage of recovery. To date, there have been no studies exploring the role of the baby in recovery.

Implications

The findings of this review have implications for services that come into contact with this group of mothers. The results suggest that recovery begins by reaching a crisis point when mothers acknowledge that something is wrong. However, often mothers had to rely on others to make this acknowledgement; this is particularly true in postpartum psychosis because mothers lack insight and awareness of the onset of symptoms [43]. Other people in a mother's support network mediate access to professional help, which highlights an educative role for professionals involved in antenatal care to provide information to mothers and families. This approach facilitates early recognition of symptoms, which may also promote quicker access to professional support. Therefore, direct contact with health professionals skilled at helping mothers and their families recognise the symptoms of illness in the perinatal period is recommended. Professionals need to validate the experiences of the mothers and their families and provide help that meets the needs of the mothers and their support network. Professionals' support should include partners and families to help them with supporting the mothers. Thus, professional support should take a systemic approach and consider the needs of the wider family system at every stage in the recovery process.

Accessible information should be provided at the individual and population level to reduce stigma associated with illness, enabling sufferers and their families to recognise symptoms and approach services for help. Of equal importance is the value of informal peer support when mothers are able to begin reflecting on their experience. However, the timing of this level of support is essential: when mothers' symptoms decrease, they are more able to reflect on their experience with peers or during psychologically informed support from professionals [23,24].

CONCLUSIONS

The synthesis of mothers' descriptions of the irrecovery experiences could be attributed to *Recognising the problem*; *Seeking help*; *Achieving recovery* and *Maintaining recovery*. Mothers valued support from the family which was integral to their progression throughout the overall process. These findings have implications for services and professionals who are often the first point of contact with this group of mothers and their families.

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