Informing psychological intervention development for postpartum psychosis: A systematic review and delphi study

Bethany Jade Palmer
Candidate Registration Number: 100160048

Doctorate in Clinical Psychology
University of East Anglia
Medical School

Primary Supervisor: Dr Jo Hodgekins
Secondary Supervisors: Dr Melanie White and Dr Veronica Slavny

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Abstract

Background: Postpartum Psychosis is a severe mental health disorder featuring delusions, hallucinations and other cognitive symptoms (Friedman et al, 2023). Qualitative research suggests that difficulties continue after the resolution of acute psychotic symptoms, however there are currently no evidence-based psychological interventions specifically targeting recovery after postpartum psychosis. There are interventions for both psychosis and other mental health disorders in the perinatal context. Although these may be helpful, they were not all designed for the perinatal context. Therefore, adaption of existing interventions to the context of recovery after postpartum psychosis should be considered further.

Aims: This thesis portfolio aims to start the process of complex intervention development following the ADAPT framework (Moore et al., 2021). Firstly, the systematic review will identify difficulties that individuals have after an episode of postpartum psychosis. Then, evidence-based intervention components will be considered in relation to these difficulties, understanding which components should be included in an intervention to improve recovery after postpartum psychosis.

Methods: A summative content analysis of the literature base determined the psychological difficulties endured after an episode of postpartum psychosis. These difficulties were then used to research psychological treatment components. Expert professionals and experts by experience were asked to rate these components for importance using a two round delphi survey to determine consensus.

Results: The systematic review revealed 46 psychological difficulties occurring after an episode of postpartum psychosis, termed psychological treatment targets. A patient and public involvement group (PPI) identified 15 treatment targets deemed most important to consider within psychological intervention of these difficulties. These include anxiety, relationship with baby and harm to self. These difficulties/targets were researched and broken down into treatment components and presented during the delphi survey. This found there was consensus on psychological treatment components important to consider within an intervention after postpartum psychosis. Mutually agreed upon items can be considered to fit within seven broad categories including psychoeducation, coping strategies and understanding thoughts and worries.

Conclusions: In relation to complex intervention development, the current portfolio has determined there is a rationale for psychological intervention after postpartum psychosis and that

existing interventions could be adapted to this context. Possible psychological treatment components have also been identified. Future research should consider further steps of the ADAPT framework to begin adapting existing interventions to fit the context of postpartum psychosis.

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CHAPTER ONE

Introduction to Thesis Portfolio

Word count: 1130

This Chapter aims to give a general overview of postpartum psychosis and the key terms used throughout this portfolio. Clinical issues addressed within this thesis portfolio will also be discussed.

Postpartum psychosis is a diagnostic term to describe symptoms such as hallucinations and delusions, as well as other cognitive symptoms (Friedman et al., 2023) that commonly begin one day to two weeks after giving birth (Perry et al., 2021). Prevalence is estimated to occur in 0.89 to 2.6 in 1000 births (VanderKruik et al., 2017). Cross cultural experiences of postpartum psychosis are thought to be similar, common experiences include paranoia, unusual beliefs and perceptions, and changes in behaviour and daily functioning (Yang et al., 2023). However, there appears to be differing understanding of the mental illness depending on the cultural ideology, therefore leading to different approaches to treatment. For example, in India postpartum psychosis may be perceived as an individual having been possessed, and the first line of treatment would be seeing a spiritual healer (Yang et al., 2023). In a British context, a medical approach to understanding symptoms is taken, the recommended treatment is medication such as an antipsychotic (Jairaj et al., 2023). Research suggests that individuals are seen within both perinatal and non-perinatal services, including mother and baby units, perinatal community teams, general acute psychiatric wards, crisis teams and psychosis services (Roxburgh et al., 2023). Therefore, a wide range of professionals with different training, specialities and treatment approaches may be involved when caring for an individual with postpartum psychosis.

To date, treatment of postpartum psychosis has been mainly pharmaceutical, aiming to reduce symptoms of psychosis including hallucinations and delusions (Jairaj et al., 2023). In addition to pharmaceutical approaches, it is important to further understand postpartum psychosis through a psychological lens to offer appropriate and timely intervention, also considering the emotional impact of postpartum psychosis and the possible trauma resulting from the experience. When considering the treatment of other mental health conditions, such as depression, the literature suggests that a combination of pharmacotherapy and psychotherapy is more effective than either component alone (Cuijpers et al., 2015). Therefore, considering psychological treatment options is important for offering combined intervention, and potentially increasing the efficacy of treatment for postpartum psychosis. The primary focus of psychological research to date has been the qualitative experiences of individuals and their families (Forde et al., 2020); however there are no evidence based psychological interventions

for postpartum psychosis at present, despite the severe and enduring mental illness that can result and impact on everyday life (Lahey & Lahey, 2021).

Previous research has suggested that recovery from postpartum psychosis can be considered in stages (Chotai, 2016; Jefferies et al., 2021; McGrath et al., 2013). The first stage may be deemed acute and individuals are described as presenting with symptoms such as delusions and hallucinations. Following this stage, individuals may no longer have acute psychotic symptoms but continue to feel unwell. The third and final stage reflects longer term consequences of the postpartum psychosis, for example relational difficulties. Whilst current treatment efforts may centre around the first stage of recovery, this is relatively short in comparison to the months and years individuals may struggle through the latter stages of recovery. From a clinical perspective, it is unlikely that individuals will receive longer term support for psychological difficulties sustained as a result of postpartum psychosis. This may result in the need to access mental health support in the future on account of unresolved difficulties. Therefore, it is important to consider psychological intervention focusing on improving recovery after postpartum psychosis.

In contexts where there are no evidence-based interventions, complex intervention development frameworks can be used to inform whether a new intervention is warranted or if existing interventions may be adapted to fit the new context. Considering postpartum psychosis, appropriate frameworks include the Medical Research Council (MRC) guidance (Skivington et al., 2021) and ADAPT (Moore et al., 2021). Both set out considerations for developing complex psychological intervention, including whether there are existing interventions that could be considered for adaption. The MRC guidance takes the stance that intervention adaptation is a continuous process based on programme theory, understanding the mechanisms of how the intervention produces the outcome. In contrast, ADAPT presents a linear step by step process of adapting existing intervention, assuming the previous evidence base may also apply to the new context.

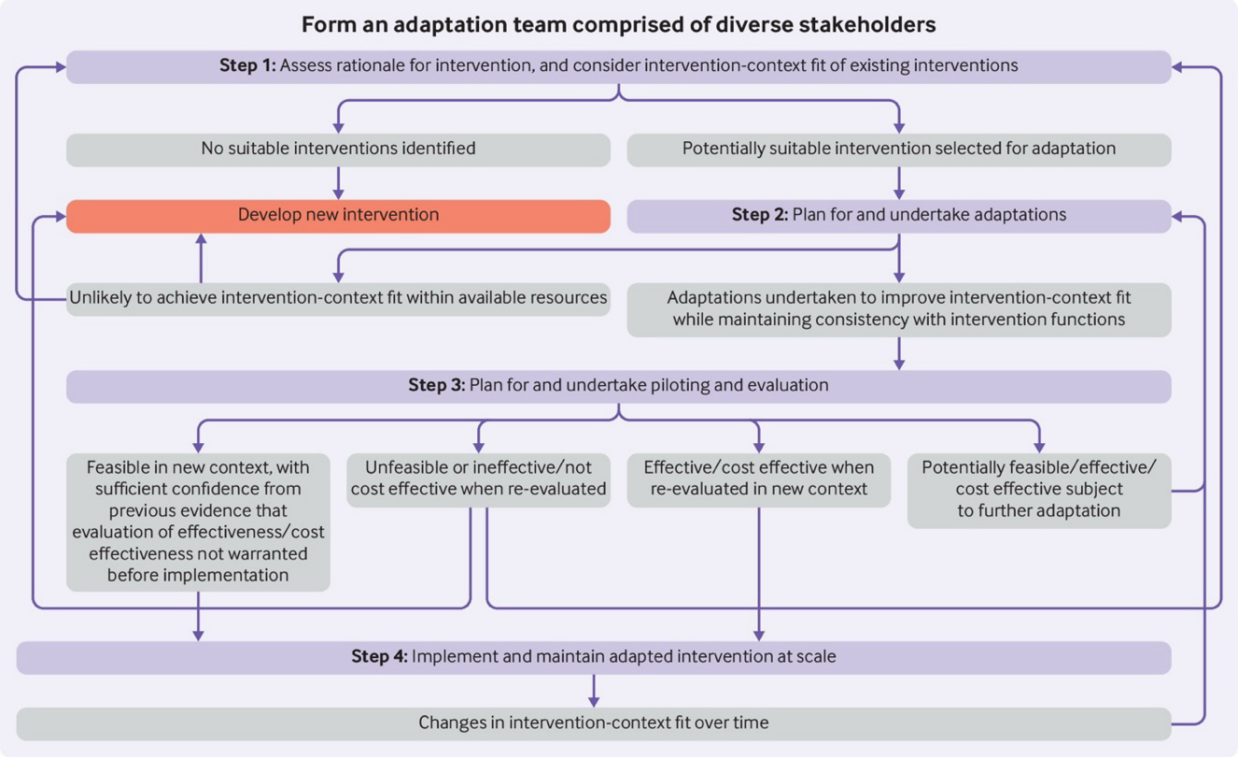
Currently, psychological interventions already exist within both perinatal and psychosis contexts, however not specifically for psychosis in the perinatal period. It is important to investigate what a psychological treatment for postpartum psychosis could consist of, to support individuals with specific difficulties caused by psychosis in the perinatal period. It is important that women's mental health, as well as reproductive mental health, is given more attention in

research to support the development of existing psychological interventions to this context. Supporting reproductive mental health is also important from an economic perspective (Bauer et al., 2016) as it enables proactive intervention for the infant/child's mental health.

For the purposes of this portfolio the ADAPT model (Moore et al., 2021) will be used to consider whether there are existing interventions for the psychological treatment of postpartum psychosis, Figure 1.

Figure 1

ADAPT process model for adapting interventions to new contexts. Taken from (Moore et al., 2021).



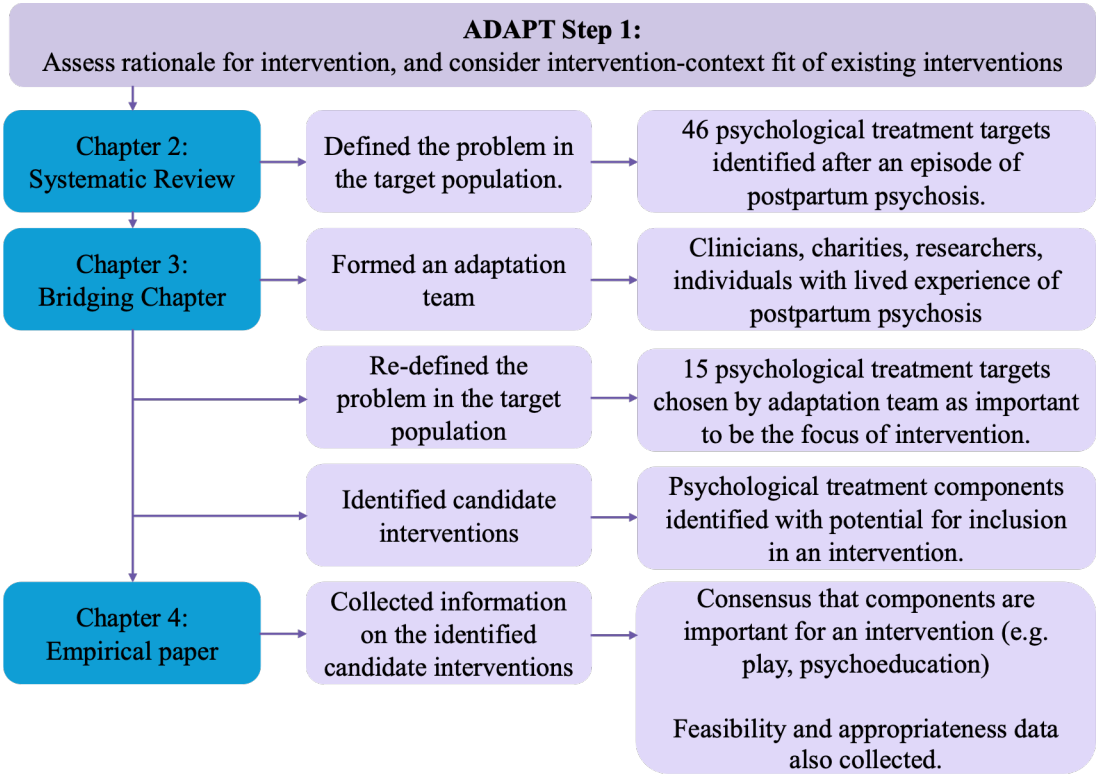
This body of work aims to continue the psychological consideration of postpartum psychosis, specifically in relation to complex intervention development (interventions with several interacting components; Hoddinott, 2015). Figure 2 shows how the current portfolio addresses different issues within "step 1" of the ADAPT framework. The systematic review presented in Chapter two surmises the difficulties experienced by individuals after an episode of postpartum psychosis, coined psychological treatment targets. In relation to the framework, these

are the problems that a psychological intervention would seek to improve after an episode of postpartum psychosis. An adaptation team was formed comprising of a range of stakeholders including clinicians, researchers, individuals with experience of postpartum psychosis and charities, explored in Chapter three. The adaptation team helped to identify the key targets that an intervention should focus on. From this, multiple evidence-based interventions were researched and related psychological treatment components extracted. Chapter four describes the process of presenting these components to expert groups to gain consensus on which are important for an intervention to improve recovery after an episode of postpartum psychosis. Additional data on feasibility and appropriateness was collected from professionals.

The results of this thesis can be used to establish whether there are existing interventions that could be adapted to the context of postpartum psychosis or if a new intervention will need to be developed, as well as beginning to understand if identified components are appropriate and feasible.

Figure 2

A diagram to show how the current portfolio addresses different issues considered within Step 1 of the ADAPT framework (Moore et al., 2021).



CHAPTER TWO

Systematic Review

Prepared for Submission to Archives of Women's Mental Health in Springer
(Author Guidelines found in Appendix A)

Word Count (excluding title page, tables, figures and references): 4,307

Recovery after postpartum psychosis: A systematic review of psychological difficulties experienced after an episode of postpartum psychosis.

Bethany Palmer[1], Lauren Powell[1], Jo Hodgekins[1*]

[1] Department of Clinical Psychology and Psychological Therapies, University of East Anglia, Norwich Research Park, Norwich, Norfolk, NR4 7TJ

*Corresponding author: J.Hodgekins@uea.ac.uk

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Statements and declarations

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Authors contributions

JH had the idea for the article. BP was responsible for establishing methodology, competing literature search and data analysis. LP was a second-independent rater for analysis. BP drafted the report which was reviewed by JH.

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Compliance with Ethical Standards

This paper is a systematic literature review of secondary data. No human participants were used in the process of this review by the authors.

Abstract

Introduction: Postpartum Psychosis (PP) is a severe mental health disorder occurring to women after birth, symptoms include hallucinations and delusions (Friedman et al., 2023). Pharmaceutical methods are the primary intervention for PP in the acute phase of the disorder. To date there has been a lack of research and guidance for psychological interventions for PP. Typically, conceptualisation of recovery of PP has been limited to the reduction and remission of psychotic symptoms. This review aims to shed light on a broader range of difficulties described after the acute phase of PP.

Methods: EBSCOhost was used to search databases for publications reporting women's perspective of psychological difficulties after an episode of PP. Initially 388 papers were identified, reducing to 18 after eligibility checks. These 18 papers were quality checked using the CASP checklist. The frequency of difficulties were recorded per article unit, giving insight into the most frequently reported difficulties.

Results: A summative content analysis revealed 46 psychological difficulties experienced by women up to 32 years after their PP. Papers most frequently reported loss and trauma as difficulties sustained after the reduction in classic psychotic symptoms.

Conclusions: This systematic review is an important step for PP research in the context of complex intervention development. The results of this review will be used to inform an empirical study investigating psychological treatment methods that could be used to develop a psychological intervention targeting recovery after PP.

Keywords: Postpartum Psychosis; Recovery; Psychological Difficulties; Literature Review

Article highlights:

- Individuals recovering from postpartum psychosis experience a vast range of psychological difficulties up to 32 years post episode
- Women reported 46 different types of psychological difficulty after the acute phase of postpartum psychosis
- Loss from psychosis and trauma were the most frequently reported psychological difficulties across reviewed publications
- Stigma, bonding, isolation, depression and understanding the psychosis experience were also highly cited difficulties

Introduction

Postpartum psychosis (PP) describes a set of rapidly occurring symptoms including delusions and hallucinations, among other severe mood and cognitive symptoms (Friedman et al., 2023). Research suggests that PP occurs in 0.89 to 2.6 in 1000 births (VanderKruik et al., 2017). Individuals with a personal or family history of bipolar disorder or PP are considered at higher risk of developing psychotic symptoms after giving birth (Jairaj et al., 2023). Whilst some symptoms of PP may reduce quickly after onset other elements can take months and years to recover from, for example trauma from the episode (Forde et al., 2019).

Currently, immediate treatment for PP is focused on pharmaceutical methods as an episode is considered a "psychiatric emergency" (Jairaj et al., 2023). However, medical intervention is suggested to continue for months after the onset of the psychosis, tapering after a period of stability before discontinuing medication (Bergink et al., 2015). Non-pharmaceutical treatment methods such as video-interactive guidance, nursing feedback, baby massage and Electroconvulsive Therapy have also been used during symptomatic phases of PP (Bergink et al., 2015; 2016).

NICE guidance for antenatal and postnatal mental health categorises PP as a "severe mental illness" (NICE, 2020). The guidelines suggest that if an individual has a diagnosis of bipolar disorder with a depressive element, Cognitive Behaviour Therapy (CBT), Interpersonal Psychotherapy (ITP) and couples therapy should be offered. Individuals with pre-existing psychosis diagnoses should be offered CBT or family intervention when they become pregnant to prevent relapse. It is of note that there are no guidelines for psychotic presentations in the postnatal period, with exception to a brief note that if the mother-infant bond is affected an intervention should be offered, neglecting further detail (NICE, 2020).

Research suggests that women are offered psychological interventions such as CBT, counselling, psychotherapy and Eye Movement Desensitisation Reprocessing (EMDR) therapy during the acute phase of their PP with varying efficacy (Forde et al., 2019). However, there are no known papers documenting the quantitative efficacy of a psychological intervention for the treatment of PP at any stage of the illness.

For psychosis outside of the perinatal period, CBT has been found the most effective treatment (Turner et al., 2014). There is increasing research evidence supporting the use of interventions without a specific focus on symptom reduction. Specifically, social recovery

therapy is a promising intervention to support social recovery after psychosis (Fowler et al., 2019) combined with Cognitive Remediation Training (CRT) for improving social and occupational function (Frawley et al., 2023).

Qualitative papers have captured that recovery from PP does not end when the individual's psychotic symptoms reduce (Forde, 2019; Heron et al., 2012). Longitudinal research suggests that women who have experienced PP are more susceptible to anxiety and depression than the general population (Burgerhout et al., 2017) with many enduring a relapse of psychotic symptoms (Gilden et al., 2020). To date there is no known paper collating the difficulties experienced by women and birthing people after an episode of PP. Prior to developing a complex intervention to support the recovery of difficulties after PP we first need to understand and define these difficulties (Moore et al., 2021). Whilst the review by Forde et al. (2020) reviewed experiences of PP from the perspective of women and family members, further exploration of difficulties after an episode of PP was needed. Methodology for the subsequent review considers directly potential candidate targets for a psychological intervention after PP, contributing new knowledge to the existing literature base. The current review is therefore situated within the context of complex intervention development to review documented difficulties, specifically "step 1" of the ADAPT framework (Moore et al., 2021). Therefore, the current systematic review aims to assess qualitative literature highlighting the experiences of individuals after the acute episode of PP to highlight the range of difficulties present during recovery, identifying candidate treatment targets in the context of intervention development.

Aims of the current study

This systematic literature review aims to collate the psychological difficulties documented in qualitative research by individuals, including reflections and interpretations of the original publishing authors and reflections of qualitative content by publishing authors after an episode of PP, with reference to frequency statistics. It is hoped the data collected and presented in the current paper will be considered within complex psychological intervention development for PP. For the purposes of this review, psychological difficulties are conceptualised as distress caused by thoughts, feelings and behaviours, including those impacting on functioning in daily life (Lahey & Lahey, 2021). This definition was chosen to reflect the varying degrees of distress that are captured within qualitative research with women who have experienced PP as well as a vast range of difficulties (e.g. anxiety, returning to work). Alternative classifications such as

those within the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychological Association, 2013) diagnostic framework were not deemed appropriate for this research as the purpose of this review is to identify difficulties significant to individuals rather than difficulties meeting clinical significance for diagnosis.

Methods

This systematic review was registered on the International Register of Prospective Systematic Reviews (PROSPERO; registration number: CRD420251041996, 17/06/2025) and followed the PRISMA reporting guidelines (Appendix M).

Literature search

Thirty databases (appendix B), including EMBASE, MEDLINE, PsycINFO and CINAHL, were searched via EBSCOhost on 28th October 2025 using the combined search terms: (Wom*n or mother* or mum* or mom* or birthing person* or birthing people) AND [Title] (Psychos*s or Psycho*c Disorder or Psycho*c illness) AND (post-natal or post-partum or postnatal or puerperal or puerperium or peripartum or peri-partum or pregnancy or childbirth or birth or perinatal or peri-natal) AND (Recovery or "after episode" or "after treatment" or "post episode" or Support or "ongoing support").

The search retrieved 388 publications matching the search terms. Publications were screened by title, abstract and full text for eligibility. An independent second rater screened 20% of publications at title (97.3% inter-rater reliability) and all full text publications. Points of conflict were discussed and the full text publication accessed to determine eligibility. No automation tools were used during the search process.

Eligibility criteria

Inclusion and exclusion criteria were applied at every stage of the screening process. Publications were deemed eligible if there was a focus on: (a) postpartum psychosis or experience of psychosis in the perinatal period, (b) perspectives of women or birthing people after the acute episode of psychosis or reflections and interpretations of qualitative content by the original publishing authors, or reflections on this content made by authors,and (c) qualitative data collection.

Publications were excluded if there was: (a) only quantitative data, (b) a systematic review, (c) perspectives were not the individual that had psychosis, for example partners or family members, (d) only experiences during the acute phase of psychosis were documented, (e)

psychosis was not after childbirth, (f) difficulties not of a psychological nature (for example the article only referred to infanticide or medical difficulties without reflecting on psychological difficulties), (g) no English language. No publications were excluded based on publication date.

Stages of recovery were defined based on the findings of Chotai (2016) and Jefferies et al. (2021). Stage one of recovery is considered acute, presenting as symptoms of psychosis including hallucinations and delusions. Stage two of recovery describes the experience of no longer having acute symptoms but individuals still feeling unwell, and stage three describes recovery of relational difficulties considered a longer-term consequence of PP. Papers were not excluded based on the documented time since the onset of PP.

Quality assessment

The Critical Appraisal Skills Programme (CASP, 2024) checklist was used to assess quality, trustworthiness and rigour of eligible publications. This tool was used to assess the strengths and limitations of qualitative research within this systematic review to understand how meaningful the data is to the review question. This tool was selected as it is endorsed by the Cochrane Qualitative and Implementation Methods Group (Long et al., 2020). A second researcher independently rated all included studies for quality; discrepancies were discussed and adjusted.

Data synthesis

Eligible publications were imported into Nvivo 14. A data extraction form was created to capture descriptive data shown in Table 1, including aims, method and demographics. Summative content analysis (Hsieh & Shannon, 2005) was used to analyse the extracted papers. Within publications, text relating to the question “what was the psychological difficulty after the acute episode of postpartum psychosis?” was extracted into a separate document. The extracted data was then coded qualitatively using a process of inductive content analysis, using a latent approach, and interpreted through a subjectivism lens, assuming that codes are subjective in nature both from the researcher and original participants perspective (Bradshaw et al., 2017). The included publications were read by the lead author whilst making memos alongside (White et al., 2006). These memos were used within the coding process to enable flexibility within the coding to reflect the content within the publications. Codes were updated as needed throughout the review. An independent second rater checked all codes, any disagreements were discussed. For

the summative element of the content analysis, publications were coded as individual units. Each unit (a publication) was assigned a score of one if a code was present, and zero if it was not. Regardless of the number of similar codes within a publication the maximum score assigned per code was one, allowing frequency of codes to be compared between papers whilst trying to account for possible homogeneity within papers. It was assumed that data between publications was heterogenous due to the different geographical areas covered.

This method most appropriately distilled the current qualitative research base into a quantitative list to understand which difficulties are most frequently reported in the literature. Other qualitative approaches such as thematic analysis (Braun & Clarke, 2021) and grounded theory (Glaser & Strauss, 1998) would not have been appropriate to the review question as it does not place value on frequency of the themes or content.

Figure 3

PRISMA flowchart of study selection.

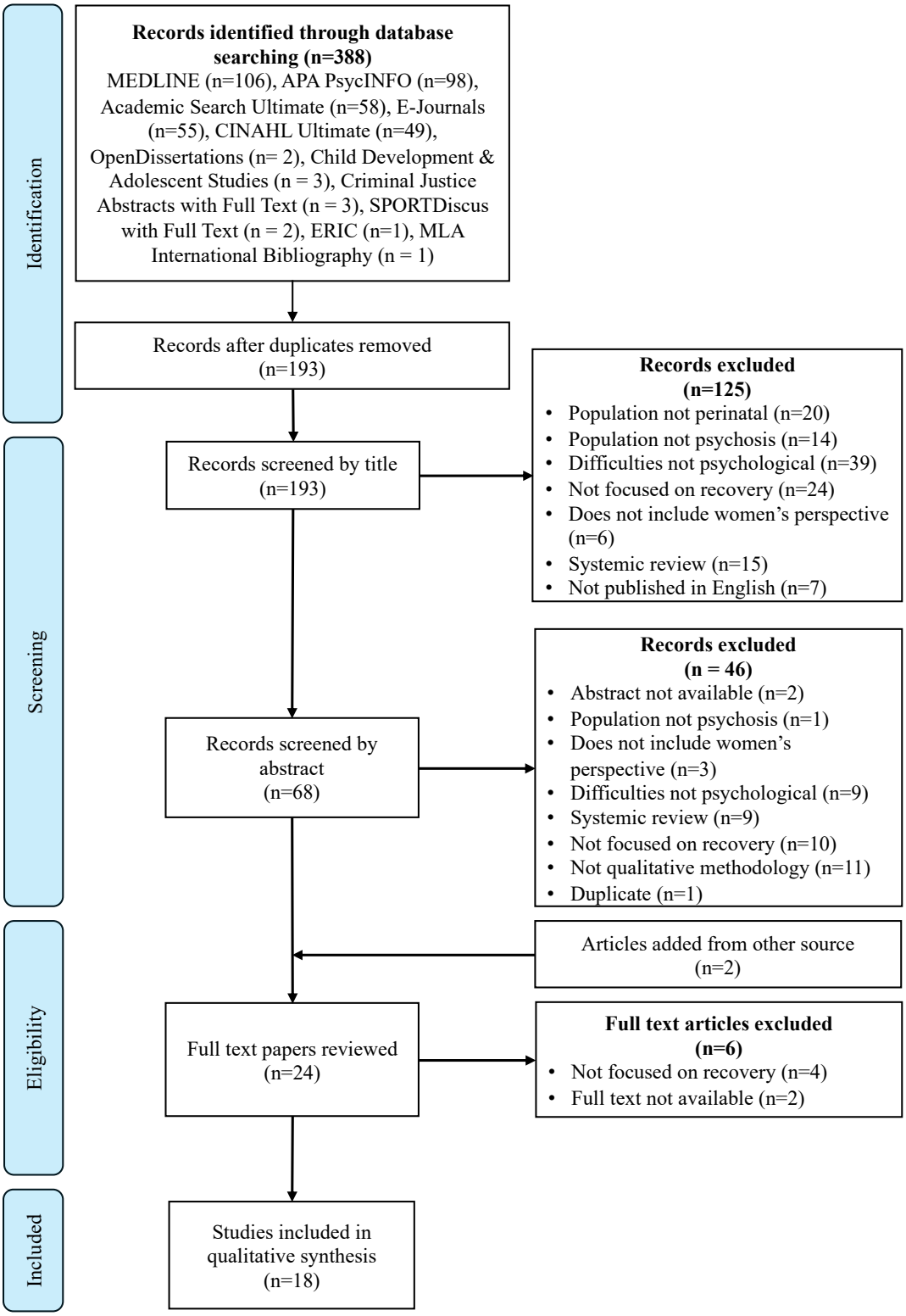


Table 1

Table of study characteristics with CASP quality checklist total score

Authors, year, location	Aim of the study	N	Description of sample	Time since episode	Recruitment method	Method of data collection	Data analysis	CASP score
1. Beck & Twomey (2023) World (US, UK, NZ, Aus)	To investigating positive changes in beliefs, emotions and behaviours resulting from PP	13	Age: 30 - 69 years. 76% White, 8% Hispanic, 8% European New Zealand, 8% Missing	Unknown	Facebook groups	Single item questionnaire	Content analysis	10
2. Chotai (2016) UK	To understand experiences of and recovery from PP.	8	Age: 30 – 56 years	1 year to 27 years	Online forums and social networking sites linked with relevant charities	Face to face semi-structured interview	IPA analysis (Smith et al., 2014)	10

Table 1 *(Continued).*

3.	Connors et al. (2024) Australia	To give insight to delusions within a PP presentation.	1	Age: early 30s	Unknown	Unknown	Interview	Unknown	6.5
4.	Doucet et al. (2012) Canada & USA	To explore support needs and barriers to support of women and partners experiencing PP.	9	7 Canadian 2 USA	Unknown	Postpartum community and hospital agencies	Semi-structured interview Time: 45 - 120 minutes	Thematic analysis	9
5.	Engqvist & Nilsson (2014) Sweden	To explore the process of recovery from PP from a range of perspectives after discharge.	7	Age: 44 – 62 years aged Age: 24 – 32 at the onset of pp	7 years to 32 years	Snowballing through radio advert to Swedish patient association	Semi-structured interview	Inductive content analysis	9

Table 1 *(Continued).*

6.	Forde et al. (2019) UK	To understand the psychological needs of women with PP including experience and preference for intervention.	13	Age: 25 – 44 years White British,	Three months to 23 years	Action on Postpartum Psychosis (APP), a Mother and Baby Unit (MBU) and perinatal mental health team	Semi-structured interview	Thematic analysis	10
7.	Franke (2023) UK & USA	To explore the experiences of PP.	3	2 British 1 Korean American.	Unknown	Internet search for autobiographies	Autobiography	Narrative analysis	10

Table 1 *(Continued).*

8.	Heron et al (2012) UK	To explore the process of recovery and beliefs about services needed for recovery.	5	4 White British, 1 White European	Three years to 20 years	Action on postpartum psychosis (APP)	Semi-structured interview	Grounded analytic induction approach (Silverman, 2006)	9
9.	Iyengar & Hunt (2024) UK	To explore the experiences of PP.	1	Unknown	Unknown	Action on postpartum psychosis (APP)	Interview	Unknown	3.5
10.	Jefferies et al. (2021) Australia	To better understand women's experiences of PP, including causes, symptoms, and support.	10	Age: 28 - 35 years at the onset of PP	Unknown	Advertised online by organisations related to perinatal mental health in Australia	Semi-structured interview Time: 60 - 131 minutes.	Thematic analysis (Clarke & Braun, 2017)	10

Table 1 *(Continued).*

11.	Kelly (2018) UK	To understand how mothers with PP experience the relationship with their baby.	7	Age 28 – 38 years at onset of PP Race: 4 White British, 1 White other 1 Black British, 1 Black African	Unknown	NHS perinatal mental health teams	Semi-structured interview	Thematic analysis	10
12.	McGrath et al. (2013) UK	To develop theoretical understanding of recovery from PP.	12	Age: 25 – 54 years	Unknown	Mother and Baby Unit (MBU) and online forums and newsletters for postnatal illness	Semi-structured interview Time: 37 - 110 minutes.	"Constant comparisons" method	10

Table 1 *(Continued).*

13.	Monger (2024) UK	To explore how Black mothers with PP experience recovery, including discrimination and hegemonic power.	17	Ange: 18 - 51 years 11 Black British African, two Black British Caribbean, four Mixed Race	Unknown	purposive sampling, and third sector UK organisations or charities supporting postpartum women	Semi-structured interviews (qualitative phenological approach)	IPA	10
14.	Moyer (2014) UK	To explore the experiences of PP.	1	Unknown		Autobiography	Autobiography	Unknown	0.5

Table 1 *(Continued).*

15.	Plunkett et al. (2017) UK	To explore the role of the baby in recovery from PP.	12	Age: 23 - 56 years 10 White British, 1 British mix race 1 Latin American	Unknown	MBU in England and online forums for PP.	Semi-structured interview	Thematic analysis	10
16.	Posmontier & Fisher (2014) USA	To explore the experiences of PP. in an Orthodox Jewish woman.	1	Orthodox Jewish	Unknown	Unknown	Unstructured telephone interview (a case-based narratology)	Structural analysis (Gee, 1991)	9.5

Table 1 *(Continued).*

17.	Robertson & Lyons (2003) UK	To explore the experiences of PP and post-episode understanding.	10	Age: 28 to 44 years	Two years to 10 years	Advertised in a twice-yearly newsletter for a clinical and genetic study	Semi-structured interview in participant's home Time: 40 – 90 minutes	Grounded theory (Glaser & Strauss, 1967)	9
18.	Vanderkruik et al. (2024) USA	To explore the experiences of PP. including context of the episode, treatment experiences and recovery.	130	Age (mean): 34.1 years. 86.2% White, 3.9% Black or African American, 3.1% Asian, 2.3% no primary race. 0.8% Native Hawaiian or other	Unknown	MGHP3 website, the Massachusetts General Hospital Centre for Women's Mental Health Website, social media, physician referrals,	Telephone Interview Approximately 90 minutes.	Content analysis (Hsieh & Shannon, 2005)	8.5

	community advocacy groups, and other means

Results

Study selection

The PRISMA flow chart, Figure 3, describes the selection process. An initial search of databases revealed 193 publications after duplicates were removed, reducing to 24 following screening of title and abstract and addition of two publications identified during scoping processes.

Two independent raters reviewed the full texts of 24 papers, concluding 18 publications, capturing data from 260 participants across the USA, UK, Australia, Sweden and New Zealand were eligible for synthesis. Characteristics of these papers and assessment of quality are shown in Table 1. Not all papers documented the duration of time since onset of PP, with the information provided it is suggested that this synthesis considers the views of individuals up to 32 years post onset of PP. Overall, half of the papers scored maximally for quality as assessed by the CASP checklist. Papers scoring low for quality using this tool neglected to be explicit about methods of analysis, ethical approval and relationship between researcher and participant, but did provide a qualitative account of recovery after postpartum psychosis relevant to the review aims; therefore, were not excluded.

Papers such as Jefferies and Horsfall (2014), Roxburgh et al. (2023) and Wyatt et al. (2015) appeared to meet the eligibility criteria but were excluded on the basis of descriptions of recovery being within the acute phase of PP.

Data synthesis procedures allowed the qualitative data in the 18 publications considered to be distilled into 46 psychological difficulties experienced by individuals after an episode of PP. These psychological difficulties are listed and defined with an example quote in Table 2. It felt important to understand the frequency of these difficulties, to make sense of which occurred most frequently in qualitative literature. Thus, the qualitative codes produced by content analysis were translated to quantitative, as set out in the data synthesis section. Using this quantitative data the psychological difficulties can be understood as generalised experiences of individuals if they occur within a number of papers, alternatively as a unique experience if occurring only once. The most frequently reported difficulties were “loss” and “trauma”, appearing in 72.2% of the publications; suggesting these are the most common psychological difficulties experienced after an episode of PP. Over half the papers in this review cited “making sense of the

experience", "depression", "isolation", "bonding with baby" and "stigma" as other psychological difficulties that individuals experience after an episode of PP.

Table 3 shows the process of synthesising the code of "Bonding with baby". Included publications were first screened for relevant content, seen under the heading of synthesised text. This text was then coded according to content analysis procedures to produce a psychological difficulty experienced by individuals after an episode of PP.

Table 2

Results of summative content analysis.

Psychological difficulty	Description of difficulty	N	% of papers
Loss	Emotional distress caused by the thoughts and beliefs that the episode of PP took something away from individuals. This may include grieving the loss of the first weeks of their baby's life to mourning the reduction in euphoric sensations. E.g. "I lost everything as a result of my postpartum psychosis." (Beck & Twomey, 2023)	13	72.2%
Trauma	Intense emotional distress resulting from the experience of PP, often resulting in longer term fear and distress from the events. E.g. "I needed, I needed something, I needed some kind of psychological support. I needed trauma therapy, I needed somebody to understand that these things were REAL TO ME" (R. Forde et al., 2019)	13	72.2%
Making sense of the experience	Distress after an episode of PP caused by the lack of understanding of how illness occurred and why it happened. E.g. "Natalie reported struggling to understand why she was affected and not being able to find an explanation." (Connors et al., 2024)	12	66.7%

Table 2 *(Continued).*

Depression	Depression and low mood experienced after an episode of PP. E.g. "I thought 'I'm out of the woods' you know…'yeah its all going to be fine', and then actually the depression afterwards, the deep, deep depression afterwards, was just such a blow, such a double whammy." (Heron et al., 2012)	12	66.7%
Isolation	Feeling alone and alienated from others after an episode of PP, presenting socially and emotionally. E.g. "they still felt isolated in their illness as a result of their friends distancing from them, which felt understandably perplexing and frustrating." (Monger, 2024)	10	55.6%
Bonding with baby	Difficulty feeling attached to or connecting with baby which may include feelings of guilt or anger, after an episode of PP. E.g. I would try to re-bond with him but each time I was hospitalized, the bonding would be hindered. I lost so much during the first 2 years of my son's life" (Moyer, 2014)	10	55.6%
Stigma	The distress caused by feeling negatively perceived by others for having had PP. E.g. "For Tamara, the negative associations with being given a 'crazy' diagnosis, led to a feeling of rejection and judgement from her own community, potentially perpetuating the long-term impact on self esteem and how she related to motherhood." (Monger, 2024)	10	55.6%
Loss of identity	Difficult thoughts, feelings and behaviours associated with individuals losing sense of who they are caused by the episode of PP. E.g. "Women reported feeling shock and bewilderment: the event did not make sense and was not consistent with their sense of self." (Heron et al., 2012)	9	50%

Table 2 *(Continued).*

Loss of self-confidence	Experiencing a reduction in beliefs about abilities after an episode of PP. E.g. "I just used to really miss, how I used to feel… I felt like I was quite a confident person and... umm nothing phased me and... I just felt like I wasn't that person anymore and umm… in more recent years I'm closer to my old self than I ever have been, but umm, but I suppose I have to accept that I'm never going to feel like that again" (Forde et al., 2019)	9	50%
Emotional impact	Emotional differences (distress/pain/flatness) resulting from an episode of PP. E.g. "Jessica made attempts to suppress memories, feelings of intolerable anxiety and battled against negative emotions." (Chotai, 2016)	9	50%
Feeling not good enough	Thoughts and beliefs that individuals are not good enough as mothers and individuals, after an episode of PP. E.g. "I still had a real thing about…it felt like I was- it felt like I'd failed I suppose. I probably felt a bit guilty." (McGrath et al., 2013)	9	50%
Guilt	Emotional distress resulting beliefs about the episode of PP that individuals did something wrong or went against their own values. This may include guilt about behaviours during the episode of PP. E.g. "Initially I think that, erm, added to the guilt of me not being able to do things, like the breastfeeding or not know what that cry meant" (Plunkett et al., 2017)	9	50%

Table 2 *(Continued).*

Anxiety	Anxiety, fear or worry presenting after PP, no related to a specific element of the PP. E.g. "When I'm able to get out of bed in the mornings, then I know that I'm about to get better; when I no longer wake up between 2-2.30 with anxiety in the mornings" (Engqvist & Nilsson, 2014)	8	44.4%
Changed identity	Psychological difficulties related to beliefs about the PP changing individuals as people resulting in understanding and accepting a new identity E.g. "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 . . . I can't think of a word, well erm pathetic that's what I was . . . 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." (Robertson & Lyons, 2003)	7	38.9%
Impact on relationships	Difficulties in thoughts, feeling and behaviours related to the relationship between the individual experiencing PP and their family or friends. This includes changes in family dynamics. E.g. "Others felt that this fear of relapse was imposed on them by friends or family, and so they could not confide in feeling down as they would cause worry or upset for other people." (Robertson & Lyons, 2003)	6	33.3%
Relationship with partner	Relational difficulties between the individual that experienced PP and their partner, after PP. These may relate to changes within the relationship or specific events occurring during the acute phase. E.g. "I felt like I was being a bad person. I was being a bad mother. I was being a bad wife to my husband… It was a difficult time for him. Actually, I feel bad… [cries] Actually feel bad about it [sobs]". (Monger, 2024)	6	33.3%

Table 2 *(Continued).*

Fear of relapse	Fear or anxiety after an episode of PP that it will happen again or there will be a return of symptoms. E.g. "Due to fear of a subsequent episode or relapse, women and family members reported ongoing monitoring for symptoms or fluctuations which resulted in possible hypervigilance." (R. Forde et al., 2019)	5	27.8%
Loss of confidence in parenting	Experiencing a reduction in beliefs about parenting abilities after an episode of PP. E.g. "With time I have much more confidence in parenting my children and my role as a mother to them now that the bond has been restored." (Beck & Twomey, 2023)	5	27.8%
(Appraisal of) Regaining independence	Feelings and beliefs causing distress that relate to regaining independence (including being left alone or having less support caring for baby), after an episode of PP. E.g. "I think, ye maybe like a family education, so to be able to go look, we now recognise she's at this particular stage, that means that she's LOADS better, you know, she's only just going through this last phase to make sure she's completely got it out of her system, but you can now start to allow her that freedom to spend a bit of time on her own and all that kind of stuff and they can then start to step away a bit, like feel a bit of relief for them" (Forde et al., 2019)	5	27.8%

Table 2 *(Continued).*

Difficult memories	After the episode of PP, recalling and remembering difficult events that cause feelings of distress from the time of the acute episode. E.g. "It is important to acknowledge how participants who described their experiences as painful to remember" (Monger, 2024)	5	27.8%
Reduced self-awareness	Thoughts, feelings and behaviours relating to beliefs that individuals were less able to identify changes in themselves, as a result of PP. E.g. "One of the things that was really bothering me, was when [partner] would say things like 'are you feeling ok?' if I was saying something, or you know, just look at me, really concerned, sort of, yeah just, it just made me feel, like it would always, like really shook me, because I'd be like 'oh gosh, am I not ok?', because I had no, no, umm self-awareness before anyway, it made me just think 'OHMYGOD, maybe something's wrong with me again' and I just can't even tell" (R. Forde et al., 2019)	4	22.2%
Fear of judgement	Fear that an individual will be judged negatively for having experienced an episode of PP. E.g. "Some women found that mixing with groups of new mothers, whose experience was so vastly different from theirs, was difficult. They feared judgement, lacked the confidence to interact, and were uncertain whether to be open about their illness with other new mothers." (Heron et al., 2012)	4	22.2%
Decisions around future pregnancy	Emotional and cognitive distress when considering whether to have more children, as a result of PP and the associated risks of reoccurrence. E.g. "We've always planned to have more children, and I think to be honest, I don't think it's put me off from having more children. It's made me feel cautious about it, because I know that reoccurrence rate is relatively high, …" (Jefferies et al., 2021)	4	22.2%

Table 2 *(Continued).*

Frustration	Feelings of frustration resulting from PP. This includes frustration with services, others, self identity and baby. E.g. "she has been feeling very sad and frustrated recently due to big identity shifts." (Vanderkruik et al., 2024)	4	22.2%
Shame	Distress caused from a feeling of inadequacy resulting from PP. This may be related to difficulties bonding or stigma due to the illness. E.g. "Women experienced conflict between their sense of self and their perceived movement toward the role of "mentally ill person." Women's perceptions of this role were influenced by the socially constructed stereotype of someone with a mental illness imposed by society. If the perception was incongruent with their identities, it caused them shame and fear of stigma." (McGrath et al., 2013)	4	22.2%
Relationships with other mums	Social and emotional difficulties engaging with other mums due to the belief that due to PP their story would be different to other mums. E.g. "She does not know what to say because her experience is so much different from theirs." (Vanderkruik et al., 2024)	4	22.2%
Anxiety about impact on baby	Emotional distress caused by worries related to the impact of the PP episode on baby. E.g. "I went through a stint of feeling really guilty around how I might have behaved around my son, and then sort of keep having to remind myself he would never know, he would never have remembered." (Kelly, 2018)	3	16.7%

Table 2 *(Continued).*

Harm to self	Emotional distress relating in thoughts and behaviours to harm oneself or end their life as a result of PP. E.g. "Participant says they were no longer psychotic, but were feeling really depressed and suicidal. They really wanted to die and were fantasizing about drinking household chemicals." (Vanderkruik et al., 2024)	3	16.7%
Embarrassment	Emotional distress caused by memories of events or behaviours during the acute episode of PP. E.g. "Although she identified embarrassing issues like being taken from her home in a nightgown, kicking and screaming, discovering black and blue marks on her body, being unkempt and disheveled, she expressed her feelings of inner strength and acknowledged that she had no control over her behavior" (Posmontier & Fisher, 2014)	3	16.7%
Cognitive	Difficulties in cognitive domains after an episode of PP including confusion, memory loss and disorientation. E.g. "Towards the end, I was aware that it was a problem with my mind and when I still just didn't feel that sharp. I was quite worried about not recovering from it." (Connors et al., 2024)	3	16.7%
Memory	Ongoing cognitive issues with memory, including gaps in memory from during the acute episode of PP or memories becoming muddled. E.g. "They needed a lot of guidance due to their confusion, disorientation, memory loss, and poor judgment resulting from their illness." (Doucet et al., 2012)	3	16.7%

Table 2 *(Continued).*

Feeling vulnerable	Emotional distress after an episode of PP relating to the belief that individuals could no longer trust their own mind and a sense of alienation from other. E.g. "Natalie acknowledged further feelings of vulnerability at the thought of not being able to rely on her own mind." (Connors et al., 2024)	3	16.7%
Fear of not recovering	Distress relating to thoughts and feelings that individuals may never get better after an episode of PP. E.g. "Towards the end, I was aware that it was a problem with my mind and when I still just didn't feel that sharp. I was quite worried about not recovering from it." (Connors et al., 2024)	2	11.1%
Paranoia	Emotional distress resulting from cognitive distortions, present after recovery from the acute episode of PP. E.g. "This woman isolated herself, which made her less paranoid. Solitude was easier on her and for her it led to improvement." (Engqvist & Nilsson, 2014)	2	11.1%
Mania	The experience of mania, being abnormally elevated or energetic, after an acute episode of PP. E.g. "'There were sometimes that I would get manic, I wasn't fully manic, but I would get a little bit manic the hour or two before I was due for my next dose of medication. I'd be running around the house doing all of the cleaning… especially late in the evening.' (Fleur)" (Jefferies et al., 2021)	2	11.1%
Psychosis	Breakthrough symptoms of psychosis after the acute episode of PP. This may include hallucinations and delusions. E.g. "in post-postscript she recounts the events of the following years in which she had yet another psychotic break." (Franke, 2023)	2	11.1%

Table 2 *(Continued).*

Balancing needs	Difficulties with thoughts, feelings and behaviours considering the needs of self after an episode of PP and others. E.g. "I did not build my life so that it suited only my child, and everything would revolve around my child, but I wanted to do my own things. And I've finally realised that I cannot do everything at once, but gradually I will be able to, in a few years' time." (Engqvist & Nilsson, 2014)	2	11.1%
Self-blame	Distress caused by thoughts that individuals were responsible for the PP. E.g. "You want to try and make sense of it, why did this happen to me, is it my fault, all of this type of stuff I'm still struggling with quite a lot of these issues (Angie)" (Chotai, 2016)	2	11.1%
Fear of understanding the PP	Worries related to fully understanding and acknowledging what had happened during the PP episode E.g. Recovery was understood as identifying and recognising difficulties that occurred and acknowledging the trauma. However, assimilation of experience was feared, as a life beyond PP was unknown and uncertain." (Chotai, 2016)	1	5.6%
Fear of child removal	Distress related to thoughts and feelings that individuals would have their baby removed from their care as a result of PP. E.g. "I was really worried that they would take my kids away …" (Connors et al., 2024)	1	5.6%

Table 2 *(Continued).*

Fear of relationship surviving	Emotional distress caused by thoughts that due to the PP causing stress on the relationship, this would come to an end. E.g. "Women expressed concern about the impact of the illness on their partner and family. They described relationship stresses caused by the episode and anxieties about the survival of their marriage." (Heron et al., 2012)	1	5.6%
Mood swings	Changes in mood after an episode of PP. E.g. "depression frequently followed the acute episode, and milder periods of mood swings, anxiety, and low mood were also common." (Heron et al., 2012)	1	5.6%
Concentration	Emotional, cognitive and behavioural difficulties resulting in changes to attention and concentration caused by an episode of PP. E.g. "Several participants reported on how their return-to-work process was often very challenging (e.g., feeling "not good enough" or struggling to focus after PP, having panic attacks and having to leave job)" (Vanderkruik et al., 2024)	1	5.6%
Feelings of resentment to baby	Feelings towards the baby that they are responsible for what happened, causing distress after the episode of PP. E.g. "I had some issues with the fact obviously my whole life had been turned upside down so there was a little bit of... maybe blame towards him and like I wish I hadn't had him and it hadn't happened (Cara)" (Chotai, 2016)	1	5.6%

Table 2 *(Continued).*

Relationship with other children	Emotional and relational difficulties caused to relationships with children other than the baby, as a result of PP. E.g. "repairing and mending the bond with their children that was weakened due to the lost time with them during the worst of their postpartum psychosis." (Beck & Twomey, 2023)	1	5.6%
Social	Behavioural difficulties resulting in socializing with others, after an acute episode of PP. E.g. "From not wanting or coping with social contacts at all, the desire to socialise with others, above all with former friends, slowly began to return." (Engqvist & Nilsson, 2014)	1	5.6%

Note: Quotes reflect direct text from qualitative papers included within the review. When quotes are not directly from the individual, quotes reflect themes noted by the authors on the qualitative information from individuals.

Table 3:

Example of the process of Synthesis and Summative Content Analysis relating to the code "Bonding with baby".

Author (year)	Page number	Synthesised text	Code
Beck (2023)	306	Most participants stressed the importance of rebuilding the bond and relationship with their children that had been interrupted by their postpartum psychosis,	Bonding with baby
Beck (2023)	307	repairing and mending the bond with their children that was weakened due to the lost time with them during the worst of their postpartum psychosis.	Bonding with baby
Beck (2023)	307	With time I have much more confidence in parenting my children and my role as a mother to them now that the bond has been restored.	Bonding with baby
Chotai (2016)	78	The women in this study shared concerns about disconnection and detachment from the infant and loss of confidence in parenting abilities following PP.	Bonding with baby
McGrath (2013)	4	Women expressed feelings of sadness, anger and guilt that they were unable to participate fully in caring for and bonding with their child.	Bonding with baby
Plunkett (2015)	1103	Mothers who feared that they could not provide a good enough experience for their baby distanced themselves within the relationship.	Bonding with baby
Plunkett (2015)	1103	Initially I think that, erm, added to the guilt of me not being able to do things, like the breastfeeding or not know what that cry meant	Bonding with baby
Plunkett (2015)	1104	For many mothers realizing that they had bonded with their baby was crucial to their recovery. Through the joy of simple interactions with their baby, mothers recognized that they were in recovery.	Bonding with baby

Table 3 *(Continued).*

Vanderkruik (2024)	374	The bonding with her baby after the hospitalization was difficult.	Bonding with baby
Engqvist (2014)	11	From being psychotic with little interest in their child, the women rediscovered the joy of their newborns, as well as the pleasure of caring and being a mother again.	Bonding with baby
Engqvist (2014)	11	So there was much joy in taking care of my baby, but it was ... well, it was probably at around six months that it began to turn a little. We had more contact with others and so.	Bonding with baby
Franke (2023)	23	Because Laura is unable to bond with her son and cannot appropriately take of him, she feels immense shame.	Bonding with baby
Franke (2023)	24	When she was finally released, Catherine felt completely detached from her son and fell into a deep depression.	Bonding with baby
Franke (2023)	28	After going through her psychotic break and being hospitalized Catherine feels completely cut off from Cato	Bonding with baby
Heron (2012)	160	Women particularly desired help in learning how to interact with their baby.	Bonding with baby
Heron (2012)	160	I wanted to learn stuff to do with my baby and for me that was massively missing. I invited over a health visitor and I asked ‘please can you teach me how to interact with [my baby] ‘cause I’m very depressed’.	Bonding with baby
Kelly (2018)	87	experiences of depression left women questioning the impact of this on their ability to care for and bond with their baby.	Bonding with baby

Table 3 *(Continued).*

Kelly (2018)	93	"I think a lot of it was because I felt I didn't love [baby] the way I should and that made me the worst, a horrible mum… It was, I just thought, I just felt because I felt I should love her more. I was like she's this perfect little baby, she's brilliant, she's such a good baby. Why don't I love her more?"	Bonding with baby
Kelly (2018)	95	Women who did experience depression following postpartum psychosis felt that this had more of a negative impact on their role as a mother and their relationship with their child than the postpartum psychosis itself.	Bonding with baby
Kelly (2018)	98	"Because when I became depressed it was almost someone had turned the love off. I'd just gone from this lovely bond to back, right back to square one of really not caring, not wanting anything to do with him, wanting to cut him off. At one point I suggested having him adopted; just couldn't have cared less."	Bonding with baby
Kelly (2018)	107	As can be seen, women with postpartum psychosis do not raise long-lasting concerns about their relationship with their child in the context of postpartum psychosis. The reported little residual impact may be explained by mothers with postpartum psychosis always trying to be a good parent.	Bonding with baby
Moyer (2014)	166	I would try to re-bond with him but each time I was hospitalized, the bonding would be hindered. I lost so much during the first 2 years of my son's life	Bonding with baby

Psychological Treatment Targets

Half of studies reported continued difficulties with "loss of identity", "loss of self-confidence", an "ongoing emotional impact of PP", "not feeling good enough" and "guilt". Heron et al. (2012) reported the most varied selection of psychological difficulties after an episode of PP. This paper specifically set out to investigate experiences of recovery so this result may not be surprising.

Posmontier and Fisher (2014) reported the least diverse range of codes with four psychological difficulties, however the publication only included one participant. Other single participant publications found low diversity of codes; Iyengar and Hunt (2024) (6), Moyer (2014) (6), with the exception of Connors et al. (2014) (11). These single participant designs highlight unique recovery experiences after PP with loss being the most common experience expressed in three of these four publications.

High number of participants did not necessarily mean a higher range of codes. Vanderkruik et al. (2024) recruited 130 participants and had synthesised a total of 22 codes which was the third highest behind Heron et al. (2012) and Forde et al. (2019). These two publications specifically aimed to investigate recovery, however VanderKruik et al. (2024) wanted to also investigate experiences of treatment and the context of the postpartum episode.

It is important to comment on the quality of the papers with regards to the results. Moyer (2014) and Iyengar and Hunt (2024) had the lowest scores on the CASP checklist as they were autobiography style publications, without published research methodology like the other publications. However, they did not contribute any unique codes or psychological difficulties, rather endorsed those that were already frequently present within the other publications such as "anxiety" (44.4%), "trauma" (72.2%) and "depression" (66.7%).

There were eight novel codes, only contributed to by a single publication within this review. It is important to consider the quality and bias of these contributions as they are not supported in other papers. "Fear of understanding the psychosis", "feelings of resentment to the baby" and "relationship with other children" were all contributed by papers scoring 10/10 on the CASP checklist (Beck & Twomey, 2023; Chotai, 2016). "Fear of child removal" was contributed by Connors et al. (2024) scoring 6.5/10 for quality, "fear of relationship surviving" and "mood swings" by Heron et al. (2012) scoring 9/10, "social" by Engquvist and Nilsson (2014) 9/10 and

Table 4:
Distribution of codes per publication, "1" indicates the code was present in the publication (publications are labelled 1 to 18 as per Table 1).

Code	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Total
Anxiety		1			1	1		1					1	1	1			1	8
Fear of understanding the PP		1																	1
Fear of relapse			1			1				1		1					1		5
Fear of judgement					1	1		1				1							4
Anxiety about impact on baby											1	1					1		3
Fear of not recovering			1					1											2
Fear of child removal			1																1
Fear of relationship surviving								1											1
Decisions around future pregnancy						1				1		1						1	4
Changed identity		1			1	1						1	1				1	1	7
Loss of identity	1	1			1	1	1	1				1					1	1	9
Reduced self awareness			1	1		1											1		4
Loss of self confidence	1					1		1		1		1	1		1		1	1	9
Loss of confidence in parenting	1	1						1			1				1				5
Balancing needs					1	1													2
Emotional impact		1	1			1		1					1		1	1	1	1	9
Mood swings								1											1
Paranoia					1					1									2
Mania										1								1	2
Psychosis						1	1												2
Trauma	1	1			1	1	1	1	1	1	1	1	1	1				1	13
Difficult memories		1	1			1		1					1						5
Making sense of the experience		1	1	1	1	1		1	1		1	1	1		1			1	12
Depression		1				1	1	1	1	1	1	1	1		1	1		1	12

Table 4 *(Continued).*

Code	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	Total
Not good enough		1				1		1			1	1	1		1		1	1	9
Loss	1	1				1	1	1	1		1	1	1	1		1	1	1	13
Harm to self					1										1			1	3
Self-blame		1				1													2
Guilt		1				1		1			1	1	1		1		1	1	9
Embarrassment		1											1			1			3
Frustration						1						1	1					1	4
Shame		1					1					1	1						4
Stigma		1				1		1	1	1	1	1	1	1				1	10
Cognitive			1	1				1											3
Concentration																		1	1
Memory				1		1		1											3
Bonding with baby	1	1			1		1	1			1	1		1	1			1	10
Feelings of resentment to baby		1																	1
Relationship with other children	1																		1
Impact on relationships			1			1		1				1					1	1	6
Relationship with partner				1				1					1	1			1	1	6
Relationships with other mums		1			1			1										1	4
Isolation		1	1		1	1		1	1	1			1				1	1	10
Social					1														1
Feeling vulnerable			1	1				1											3
Regaining independence				1	1	1		1							1				5
Total	7	21	11	7	14	25	7	26	6	9	10	18	17	6	11	4	13	22	234

Note. Publication numbers refer to the order of publications shown in Table 1.

"concentration" (Vanderkruik et al., 2024) 8.5/10. Therefore, all novel codes could be considered to originate from publications scoring highly on the CASP quality checklist.

Discussion

Findings from this review have highlighted the unique and varied experiences of women recovering from PP. After the acute phase of PP, women have reported 46 psychological difficulties, defined for the purposes of this paper as distress caused by thoughts, feelings and behaviours, including those impacting on functioning in daily life (Lahey & Lahey, 2021). This is supported by the findings in Forde et al. (2020) that the process of recovery can be long and encompass a range of experiences. The psychological difficulties coded within this review are in line with the themes synthesised by Forde et al. (2020) which included experiencing the unspeakable, loss and disruption and realigning the old self with new self. However, the current findings go beyond this, quantifying difficulties to understand which are most frequently cited within the literature. During the recovery process women have reported difficulties coming to terms with the experience of PP, as well as anxiety that the psychosis would return or the impact their behaviours had on their baby. These findings highlight the need for psychological support for women and families to extend past the reduction of hallucinations and delusions and reduce subsequent distress.

Previous research documenting recovery after PP has, at times, taken an optimistic lens to difficulties. An example of this was within Beck & Twomey (2023), reporting on the impact of posttraumatic growth rather than the initial trauma. From the perspective of researchers and participants this may be a more comfortable way to approach questioning around PP and a way of limiting distress, something to hold in mind when designing future research. The current paper has presented findings from the perspective of what women found difficult from a psychological perspective during their recovery, in the hope this can be translated efficiently to research focusing on complex intervention development.

Results of this review are also consistent with psychosis literature outside of the perinatal period. Post-psychotic depression is a common symptom reported after a psychotic episode (Guerrero-Jiménez et al., 2022). Trauma has also been documented after the presence of psychosis (Galliot et al., 2019), and has been linked to the experience of internalised and externalised shame (Turner et al., 2013). Trauma and depression were among the most frequently

cited difficulties during the current review, which may suggest that there are some similarities between the experience of psychosis within and outside of the perinatal period. However, postpartum research highlights unique findings such as those concerning the relationship with baby, bonding and feelings of resentment (Chotai, 2016).

Psychological difficulties relating to self-harm and suicide were cited during this review, however their low frequency within the literature is an unexpected finding. This is directly opposed to the findings of Shi et al. (2018) which reported that mothers in the early postpartum stage had lower scores of depression but higher suicidal ideation. It is possible that self-harm and suicidal ideation are underreported in the PP literature due to the optimistic methodological stance previously stated and a lack of direct questioning around risk elements. There is also a possibility of thoughts to end one's life being unspeakable.

It is important to consider terminology used throughout this report. The term "women" was used to describe individuals that have given birth and experienced PP. It is expected that not all individuals fitting this description will identify themselves as a woman (Freeman et al., 2024), however due to the lack of demographics collected within the reviewed papers we are unable to comment further on this.

Clinical implications

This review gives important insight to the psychological difficulties endured after an episode of PP, showing recovery is not limited to the reduction of hallucinations or delusions. In addition to identifying difficulties, quantitative data has been presented to interpret the frequency in which these appear within the literature. The results of this paper can be used to add validity to further exploring the psychological difficulties after an episode of PP and even begin to consider a psychological intervention to target the difficulties identified.

Clinically, the results of this systematic review can be used to inform psychological practice. It is hoped that by explicitly highlighting psychological difficulties known to occur after an episode of PP, they will be more easily identified within individuals with lived experience and an appropriate treatment offered. There is a potential for services to use these results from a prophylactic perspective, offering proactive psychological intervention before the occurrence of symptoms of the difficulties identified.

Strengths and limitations

It is a strength of the current review that it utilises a quantitative analysis method to understand qualitative data as this is a novel approach to the postpartum psychosis literature base. The translation of qualitative data into number can be described as reductionist and lacking reflexivity, however in this context it is helpful to convey the difficulties that are most frequently reported (Tafreshi et al., 2016).

Original datasets were not retrieved for synthesis which may be seen as a limitation. It is possible this data would have included other difficulties or explanations that would alter the findings presented in this paper. However, due to time constraints for this project it could not be justified. Heterogeneity has been assumed between the articles due to the large geographical locations covered within the eligible literature, however it is possible that some difficulties may have been over reported if a single participant contributed to more than one of the eligible publications.

Due to the use of content analysis to synthesise the qualitative data, this paper does not report the relationship between difficulties. At times, a primary psychological difficulty was cited as causing a subsequent set of difficulties. For example, difficulties with bonding may have caused depression and resentment to baby. Therefore, the current analysis referenced these difficulties as being equal in weighting, however it is possible this is not the case. It should also be highlighted that some psychological difficulties may be similar in nature. However, the method of analysis found codes to be slightly different in nature, and this was validated by a second independent rater (e.g. changed identity and loss of identity). Similar codes were considered thoroughly with regard to the impact on individuals to determine whether they were different enough. At this stage of research, it felt important to highlight the nuances within the qualitative literature, as psychological treatment of these difficulties may be different. It may have been possible to group psychological difficulties based on similar concepts (e.g. identity, confidence, anxiety), however this was not done as it would have not been in line with the chosen method of analysis by moving towards interpreting text using themes or interpreting directional mechanisms between difficulties. Therefore, future research may consider the definitions and codes within this paper and recommend groupings of difficulties.

It is considered a limitation that the original search strategy used the title only search function for certain terms, rather than the title and abstract function. It is possible this may have

reduced the number of papers retrieved. To understand the extent to this limitation, the search was repeated using the title and abstract function and no additional publications were returned.

Future research

Future research should aim to investigate the relationship between psychological difficulties, offering a theory of how psychological difficulties relate to each other and present in the recovery after PP. This will enable clinicians working with the disorder to greater understand recovery after PP and how to offer support to individuals.

The outcome of the current review is a list of difficulties that could be interpreted as treatment targets for a psychological intervention. Future research could focus on using the results of this study in the context of complex psychological intervention development. It would be important to consider whether suitable interventions already exist to target these difficulties or whether a bespoke intervention would need to be developed. When considering the ADAPT framework, this review would fit within the first step which aims to assess the rationale for intervention (Moore et al., 2021). Therefore, suggested next steps would include considering intervention data targeting the difficulties in this paper. After this, a decision can be made for whether an intervention already exists that can be adapted, or whether a new intervention should be developed.

This paper focused on the psychological difficulties experienced and reported by women recovering from PP, highlighting relational difficulties relating to offspring, family, partner and other mums. Therefore, it is important to further consider the how others may be impacted by the onset of PP.

Conclusions

This paper is the first of its kind to quantify the vast range of qualitative psychological difficulties experienced by women during recovery after PP.

Future focus should be understanding which of these difficulties are most important to consider for a psychological intervention, and which components could be used in a treatment to support recovery. This review can be considered the first step according to ADAPT framework (Moore et al., 2021) for gathering information to consider whether suitable psychological intervention already exists or whether a novel intervention is required. This research will be used to improve recovery after PP.

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CHAPTER THREE

Bridging Chapter

Word count (excluding tables and figures): 916

This Chapter aims to summarise the processes used to interpret the findings of the systematic review presented in Chapter Two and the empirical research presented in Chapter Four. In summary, firstly a Patient and Public involvement (PPI) group were asked to rate psychological treatment targets based on findings of the systematic review (Tables 5 – 7), producing a shortened list of treatment targets (Table 8). Finally, these targets were used to review psychological treatments as shown in Figure 4.

Psychological Treatment Targets

A process of PPI was completed to increase validity of the items included within the survey, ensuring the research represented the reality of what individuals with experience of postpartum psychosis felt it would be important to target within an intervention.

Methods

The systematic review presented in Chapter two determined the psychological difficulties women have after an episode of postpartum psychosis; these can be considered psychological treatment targets. A total of 46 treatment targets were identified. For the purposes of PPI these treatment targets were considered, and then grouped into 12 categories, shown in Table 5.

A survey asked the PPI group to rank the categories and then the treatment targets within each category in order of importance (Table 5). When interpreting the rankings the most important item was given the number one, the second two and so on. The total score assigned to each category and treatment target were used to understand ratings of importance, lower scores indicating higher importance.

Participants

A total of 15 people anonymously engaged in the survey. Although the demographics of the PPI group were not collected, it was known that the group was predominantly White British females and lacked ethnic diversity. Therefore, the survey was also sent to a group of ethnically diverse members of the charity Action on Postpartum Psychosis (APP). It is known that of the 15 individuals, three belonged to the ethnically diverse groups. Group members participated on a voluntary basis and were not given compensation for their time.

Following survey completion a consultation group was formed. This was led by the lead researcher and included a group of clinicians (working within NHS perinatal and psychosis contexts), researchers, individuals with personal experience of postpartum psychosis, and representatives from APP. The role of this group was to interpret the findings of the ranking survey and decide which treatment targets should be considered as a target for intervention (Figure 4). Ultimate decision making following consultation was made by the lead researcher.

Table 5

Treatment target categories, used for the purpose of PPI.

Category	Treatment Target
Anxiety	Anxiety
	Fear of judgement
	Fear of relapse
	Anxiety about the impact on baby
	Fear of child removal
	Fear of relationship surviving
Identity	Loss of / changed identity
	Loss of self confidence
	Loss of confidence in parenting
	Balancing needs
	Distress from not meeting the expectations of motherhood
	Difficult integrating expectations of motherhood with reality
	Reduced self-awareness
Mood difficulties (excluding low mood)	Mania
	Mood swings
	Emotional impact
	Difficult memories
	Panic

Table 5 *(Continued).*

Low mood	Depression
	Not good enough
	Harm to self
	Perception of being a failure
	Low mood related to difficulty bonding
	Decisions around future pregnancy
Relationship to baby	Bonding with baby
	Feelings of resentment to baby
	Difficult emotions due to bonding difficulties
	Thought to harm baby
Relationship to other	Relationships with other mums
	Feeling vulnerable
	Social
	Relationship with partner
	Isolation
	Impact on relationships
	Relationship with other children
	Regaining independence
Psychosis	Psychosis
	Fear of not recovering / understanding the psychosis
	Trauma
	Paranoia
	Making sense of the experience
Shame	Shame
	Stigma
	Self-blame
	Embarrassment

Table 5 *(Continued).*

Guilt	Guilt related to difficulty bonding
	Guilt
	Guilt related to reliance on others
	Guilt related to memories of psychosis
	Guilt related to future pregnancy
Loss	Loss
	Loss from not meeting parental expectations
	Loss from psychosis
Frustration	Anger related to bonding
	Anger related to future pregnancy
	Anger related to expectations of parenthood
	Frustration
Cognitive	Memory
	Concentration
	Cognitive

Results

The PPI group rated the three most important categories as anxiety, psychosis and relationship with baby, shown in Table 6. Scores for individual treatment targets are presented in Table 7.

The consultation group led by the lead researcher decided that the categories of "anxiety", "psychosis" and "relationship with baby", would be considered for the next step of intervention development (Figure 4) as they were rated the three most important treatment categories by the PPI group. Treatment targets of "suicidal thoughts" and "loss from psychosis" were rated as the most important item by over 50 % of the PPI group, therefore the consultation group felt these were also important to consider further. A total of 15 treatment targets (Table 8,

defined in Appendix E) were investigated with regards to the psychological intervention components that could be used in treatment.

Table 6

PPI ratings of treatment target categories.

Treatment Target Categories	N	Total	Mean	SD
Anxiety	15	46	3.04	2.15
Psychosis	15	52	3.47	2.70
Relationship with baby	15	57	3.80	2.83
Low mood	15	72	4.80	2.91
Identity	15	93	6.20	3.38
Guilt	15	104	6.93	2.58
Relationship with others	15	111	7.40	2.44
Cognitive difficulties	15	111	7.40	3.04
Shame	15	115	7.67	2.69
Other mood difficulties (not low mood)	15	124	8.27	3.41
Loss	15	127	8.47	2.97
Frustration	15	158	10.53	1.41

Table 7

PPI ratings of individual treatment targets.

	Treatment Target	N	Total	Mean	SD
Anxiety	Anxiety	15	34	2.27	1.94
	Anxiety about impact on baby	15	41	2.73	1.53
	Fear of child removal	15	47	3.13	1.64
	Fear of relapse	15	52	3.47	1.30
	Fear of relationship surviving	15	67	4.47	1.13
	Fear of judgement	15	74	4.93	1.16
Identity	Low confidence in parenting	15	36	2.40	1.35
	Loss of self confidence	15	40	2.67	1.63
	Distress from not meeting the expectations of motherhood	15	57	3.80	1.47
	Balancing needs	15	58	3.87	1.73
	Loss of / changed identity	15	58	3.87	1.51
	Difficulty integrating expectations of motherhood with reality	15	66	4.40	1.88
Mood (not low mood)	Difficult memories	15	34	2.27	1.33
	Panic	15	35	2.33	1.54
	Emotional impact	15	43	2.87	1.41
	Mania	15	51	3.40	1.12
	Mood swings	15	62	4.13	0.83
Low mood	Harm to self	15	25	1.67	1.23
	Not good enough	15	41	2.73	1.16
	Depression	15	44	2.93	1.39
	Perception of being a failure	15	60	4.00	1.51
	Low mood related to difficulty bonding	15	68	4.53	1.13
	Decisions around future pregnancy	15	77	5.13	1.25

Table 7 *(Continued).*

Relationship with baby	Thoughts to harm baby	15	30	2.00	1.46
	Bonding with baby	15	32	2.13	0.83
	Feelings of resentment to baby	15	40	2.67	0.82
	Difficult emotions due to bonding difficulties	15	48	3.20	0.94
Relationship with others	Relationship with other mums	15	43	2.87	1.51
	Relationship with partner	15	45	3.00	1.81
	Isolation	15	51	3.40	1.68
	Feeling vulnerable	15	54	3.60	1.55
	Impact on relationships	15	54	3.60	2.16
	Social	15	68	4.53	1.19
Psychosis	Trauma	15	25	1.67	0.82
	Fear of not recovering and fear of understanding the psychosis	15	28	1.87	0.74
	Psychosis	15	37	2.47	0.74
Guilt	Guilt related to difficulty bonding	15	40	2.67	1.76
	Guilt that mothering role wasn't met	15	41	2.73	1.28
	Guilt related to memories of psychosis	15	48	3.20	1.42
	Guilt	15	50	3.33	1.63
	Guilt related to reliance on others	15	56	3.73	1.75
	Guilt related to future pregnancy	15	80	5.33	1.05
Shame	Self-blame	14	26	1.86	0.66
	Stigma	14	26	1.86	0.95
	Shame	14	32	2.29	0.83
Loss	Loss from psychosis	15	22	1.47	0.74
	General feelings of loss	15	32	2.13	0.83
	Loss from not meeting parental expectations	15	36	2.40	0.63

Table 7 *(Continued).*

Frustration	Anger related to expectations of parenthood	13	19	1.46	0.52
	Anger related to bonding	13	24	1.85	0.80
	Anger related to future pregnancy	13	35	2.69	0.63
Cognitive	Cognitive	12	19	1.58	0.7
	Memory	12	26	2.17	0.9
	Concentration	12	27	2.25	0.8

Table 8

Treatment targets considered with regard to treatment components.

1. Thoughts to harm baby
2. Bonding with baby
3. Feelings of resentment to baby
4. Difficult emotions due to bonding difficulties
5. Anxiety
6. Anxiety about impact on baby
7. Fear of child removal
8. Fear of relapse
9. Fear of relationship surviving
10. Fear of judgement
11. Trauma
12. Fear of not recovering and fear of understanding the psychosis
13. Psychosis
14. Harm to self
15. Loss from psychosis

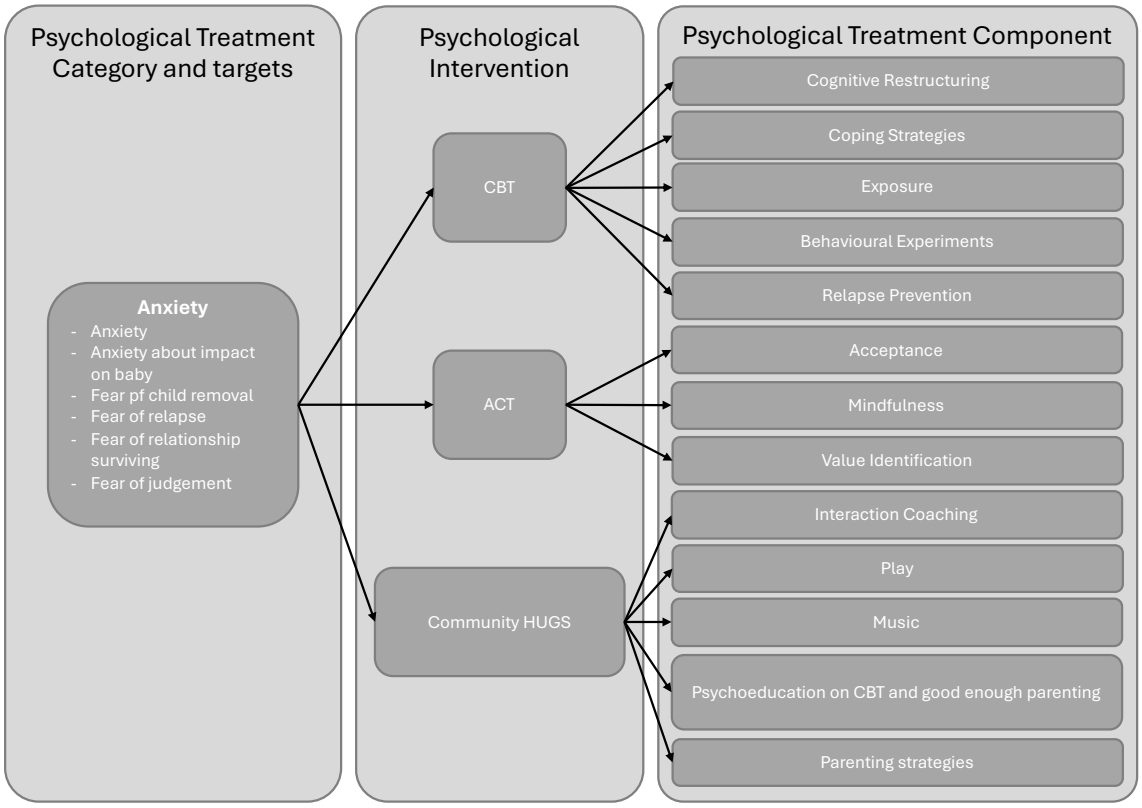
Psychological Treatment Components

A desk-based review was completed to find psychological interventions focusing on each of the 15 targets in Table 8. The review included systematic literature reviews investigating intervention efficacy, randomised control trials and National Institute for Health and Care

Excellence guidelines (NICE, 2014a, 2014b, 2020), as well as consulting with research supervisors working within perinatal and psychosis services. From the review of literature, a list of psychological interventions was created; including Cognitive Behavioural Therapy (CBT) (Cuijpers et al., 2014; Papola et al., 2024; Watkins et al., 2018), Acceptance and Commitment Therapy (ACT) (Bighelli et al., 2021; Bonacquisti et al., 2017; Petricone-Westwood et al., 2019) and Interpersonal Psychotherapy (Newton et al., 2022; Smith et al., 2022). Interventions were then broken down into their individual components, a process shown in Figure 4.

Figure 4

The process of how psychological treatment targets relate to psychological intervention and thus psychological treatment components, using the example category of Anxiety.



Following the desk-based review, there was a further period of consultation to decide which psychological treatment components should be included in the Delphi survey. Consultants were clinical psychologists working with postpartum psychosis individuals. Consultants were able to

hold in mind experiences of inpatient, community, psychosis and perinatal settings. This process included defining treatment components and integrating similar concepts, improving the validity of ratings.

Definitions of psychological treatment components were also considered by a different PPI group (N=2) to ensure they could be understood by participants wanting to engage with the delphi survey.

Delphi survey

This Chapter has presented the process of PPI involvement and consultation for consolidating the findings of the systematic review (Chapter Two) into 15 psychological treatment targets. These targets were then used to extract related psychological interventions, compiling a list of psychological treatment components that could be used in an intervention to improve the recovery after postpartum psychosis. Figure 2 depicts processes informed by the ADAPT framework (Moore et al., 2021) and outlines how this Chapter meets different elements within the first step.

The psychological treatment components extracted were compiled into a delphi survey, used within Chapter Four. Delphi methodology can be used to determine if there is consensus among experts, therefore the following Chapter aims to determine whether there is consensus on the psychological treatment targets it would be important to include when developing an intervention to improve the recovery after postpartum psychosis.

CHAPTER FOUR

Empirical Study

Prepared for submission to Archive of Women's Mental Health

(Author Guidelines found in Appendix A)

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Improving recovery after postpartum psychosis: Delphi consensus on psychological treatment components

Bethany Palmer[1*], Melanie White[2], Veronica Slavny[3], Jo Hodgekins[1]

[1] Norwich Medical School, University of East Anglia, Norwich NR4 7TJ, UK

[2] Norfolk and Suffolk NHS Foundation Trust

[3] Cambridge and Peterborough Foundation Trust

[*] Corresponding Author: Email address: J.Hodgekins@uea.ac.uk

Statements and declarations

The authors declare that they have no conflicts of interest concerning this article.

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Authors contributions

BP was responsible for writing the current paper and facilitating the research described based on ideas collaboratively designed with JH. JH provided feedback on a draft of this report. MW and VS provided consultation on recruitment and their understanding of concepts and results from a service perspective.

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I would also like to thank Action on Postpartum Psychosis for their consultation during the development of this research as well as efforts to distribute the initial survey to their members and social media followers. I would also like to thank the BPS Perinatal Faculty and Postpartum Support International for sharing the research on their platforms.

Compliance with Ethical Standards

This research was carried out in accordance to ethical approval gained by the University of East Anglia ETH2526-0230*.

Abstract

Purpose: Postpartum psychosis (PP) describes a set of rapidly occurring symptoms, often including delusions and hallucinations after giving birth (Friedman et al., 2023). Qualitative literature has highlighted that difficulties continue after the acute symptoms of psychosis have reduced (Forde et al., 2020) and has been quantified in a review by Palmer et al. (2026; Chapter Two). A process of patient and public involvement was used to distil the results of Palmer et al. (2026; Chapter Three) into the most important psychological difficulties. Psychological treatment components targeting each of these difficulties have been used in this study to investigate if there is consensus on psychological treatment components that are important to support recovery after PP.

Methods: Delphi methodology was used to establish consensus over two surveys, using two separate expert groups. Expert professionals (N=20) and experts with lived experience of PP (N=36) were asked to rate the importance of 67 psychological treatment components. If 80% of experts agreed the component was important or essential, the component gained consensus. Items with 70 – 79.9% consensus were re-rated in the second survey, and items with less that 70% consensus were rejected. Expert professionals were also asked to rate the feasibility and appropriateness of components in survey two.

Results: There was mutual consensus of importance for 34 of the psychological treatment components. An additional 11 components achieved consensus in only one expert group. Therefore, 45 out of 67 components, covering seven broad areas, are considered to have achieved consensus according to the method of the current study and should be considered in future development of a complex psychological intervention to improve the recovery after PP. These areas are psychoeducation, understanding thoughts and worries, coping strategies, therapist traits, relationship with baby, relationships with others and trying new ways of doing things. The feasibility and appropriateness ratings are helpful to consider which components are suitable for services in the current clinical climate.

Conclusion: The current study has identified 45 psychological treatment components that could be used in an intervention to improve the recovery after PP.

Article highlights:

- Overall, 45 psychological treatment components, 34 mutual, gained consensus as being important to consider in an intervention to support recovery following postpartum psychosis.
- Psychoeducation about psychosis, normalisation and exploring worries about relapse achieved highest mutual consensus.
- These results can be used to develop an intervention to improve recovery after postpartum psychosis.

Keywords: Postpartum Psychosis, Recovery, Perinatal Mental Health, psychological treatment, therapy components

Introduction

Postpartum psychosis (PP) describes the rapid onset of symptoms, typically three to 10 days after birth. Symptoms include hallucinations and delusions, as well as severe mood and cognitive symptoms (Friedman et al., 2023). To date, research has mainly focused on the experience of women and families during the acute phase of PP. However, in the post-acute phase, women describe shock, trauma, distress, disruption to life, fear, guilt and loss during PP and highlight a need for ongoing psychological support (Forde et al., 2020). Different stages of recovery from PP have been suggested based on the experience of individuals (Chotai, 2016; Jefferies et al., 2021; McGrath et al., 2013). These phases may be summarised as 1) acute / immobilisation (McGrath et al., 2013) - the individual has active symptoms of PP, 2) Post acute recovery – the individual no longer has active symptoms of PP but does not yet feel back to their baseline, 3) longer-term recovery including relational difficulties.

Post acute recovery experiences been explored less, although qualitative papers suggest women continue to have psychological difficulties after the reduction of acute symptoms due to the “unexpected and traumatic” nature of PP (Forde et al., 2020). This can leave women with feelings of loss, guilt, depression and anxiety (Forde et al., 2020). Palmer et al. (2026; Chapter 2) completed a systematic review of this literature and found 46 different psychological difficulties described after an episode of PP, including trauma and loss from psychosis.

Current treatment protocols focus on pharmaceutical methods to minimise symptoms of PP within the acute phase as well as offering preventative treatment for individuals identified as being higher risk of developing PP (Friedman et al., 2023). Mental health support for PP can include inpatient psychiatric admissions via mother and baby units (MBU) or acute psychiatric wards which would result in mother and baby being separated (Roxburgh et al., 2023). Recommendations for psychological interventions are informed from psychosis literature (Lincoln & Pedersen, 2019), however this negates the context of the illness occurring within the perinatal period. There is some evidence that PP and psychosis are 'separate forms of mental illness' considering that child birth is a large trigger for PP (Robertson & Lyons, 2003). Therefore, a specific psychological intervention is deemed necessary to support women after an episode of PP with the impact of psychosis as well as bonding and perinatal-specific worries such as decisions around future pregnancy (Mowbray et al., 2005).

Suggestions on helpful interventions supporting recovery after PP include psychoeducation to aid mothers and their families to understand the illness and emotional impact of this (Forde et al., 2019). Preconception counselling is also suggested if individuals with experience of PP plan to have additional children (Jairaj et al., 2023) and relapse prevention work (Forde et al., 2019). Chotai (2016) suggests psychological intervention should differ depending on the stage of recovery due to different needs at each stage.

Currently, an evidence-based psychological treatment does not exist to support recovery after an episode of PP. Guidance for developing complex interventions suggests that existing evidence-based interventions should be identified for adaption to the new context, assessing for feasibility before evaluating and implementing the intervention (Skivington et al., 2021). Prior to this study a systematic review was conducted to "define the problems of the target population" as suggested in intervention development guidelines (Palmer et al., 2026; Chapter Two). Results of this review were used to inform the current study with further literature searches to "identify candidate interventions" (Chapter Three) as recommended in the development of a new intervention (Moore et al., 2021). The current study uses Delphi methodology to identify which candidate intervention components should be considered within an intervention to improve the recovery after postpartum psychosis.

Delphi methodology has been considered an effective way to determine consensus on the importance of treatment components within complex intervention development (Drumm et al.,

2022). Previous research has used Delphi methodology within mental health research to make decisions about the inclusion of specific treatment approaches to psychosis (Langlands et al., 2008; Morrison & Barratt, 2009), which has been used to inform the development of a treatment protocol influencing clinical practice (Wood et al., 2022). Morrison and Barratt (2009) discuss the importance of considering service funding within intervention development. Evaluating feasibility and appropriateness are important considerations when changing clinical practice (Pearson et al., 2005) and fit within the ADAPT framework for developing a psychological intervention in a postpartum psychosis recovery context (Moore et al., 2021).

To date, literature has highlighted that psychological difficulties, conceptualised as psychological treatment targets, continue after the treatment of the acute PP (Forde et al., 2019; Palmer et al., 2026). However, currently there is no psychological intervention specifically targeting the recovery after PP. Therefore, the current study aims to establish consensus on the inclusion of psychological treatment components identified as important to adapt to the context of postpartum psychosis. Research questions are:

1) Considering experts by experience and expert professionals separately, is there consensus on which psychological treatment components are important to support recovery following postpartum psychosis?
2) To what extent do expert professionals perceive psychological treatment components to be feasible and appropriate in the context of postpartum psychosis?

Methods

Design

A two round Delphi methodology using an online questionnaire was used to collect quantitative data for the current study. These surveys were informed by a literature review (Palmer et al., 2026; Chapter Two). A process of consultation with individuals with experience of PP and professionals (perinatal and psychosis) reduced the results of Palmer et al. (2026) to the most important treatment targets; this included anxiety and relationship with baby, resulting in 15 targets (Chapter Three). Literature searches were completed to explore psychological treatment components that can be used to support these targets, again reduced through a process of consultation. At the end of this process a total of 67 treatment components were defined for inclusion in the Delphi. Data was collected between May and October 2025.

Participants

Within Delphi methodology participants are known as experts. This study used two distinct expert groups, expert professionals and experts by experience. Inclusion criteria for all experts was being over the age of 18 and having an ability to read and understand English. Experts were recruited via adverts (Appendix L) on social media platforms for the first survey and had the option to consent to be contacted with the second survey.

Expert professionals self-identified as having knowledge of services and the clinical application of psychological intervention in the context of PP. Additionally, having worked with individuals with PP in the last 12 months from an academic, clinical or research perspective. Recruitment also included an advert in the British Psychological Society (BPS) Perinatal faculty newsletter. Expert professionals were also purposefully contacted if they had published research in this area.

Experts by experience self-identified as having experienced psychosis within the perinatal period. Recruitment also included an advert shared via Action on Postpartum Psychosis (APP) and Postpartum Support International (PSI).

Measures

The online surveys used within this research were developed to answer the specific research questions following consultation between professionals and individuals with experience of PP. The survey used a series of 5-point Likert scales (Figure 5).

Survey one

Experts answered a series of screening questions based upon the inclusion criteria, followed by demographic questions based on expert group membership. All experts were given a brief introduction to the task before being asked to rate 67 psychological treatment components (Appendix F) on a 5-point Likert scale of importance as the primary measure in the current study. This scale was used in a delphi survey by Morrison and Barratt (2009) to understand intervention components, therefore was deemed appropriate to use in the current study.

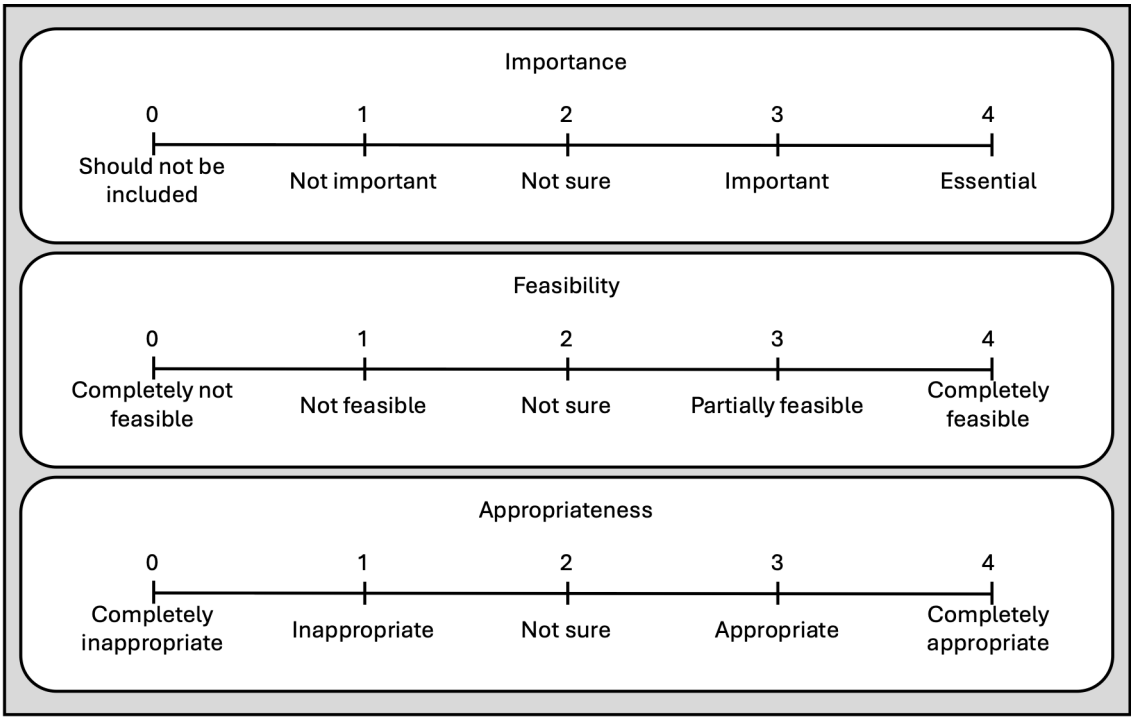
Survey two

All Experts were asked to re-rate importance of psychological treatment components that did not achieve consensus for their expert group in the first round.

Additionally, expert professionals were asked to rate feasibility and appropriateness using a 5 point Likert scale (Appendix G). Feasibility is defined as the extent to which the treatment component is practical and practicable, accounting for physical, cultural or financial practical elements in the context of UK psychological services. Appropriateness is defined as the extent to which the intervention component related to the treatment of the targets in the recovery of postpartum psychosis. Definitions of feasibility and appropriateness were adapted from Pearson et al. (2005).

Figure 5

Scales used in the delphi survey.



Procedure

After recruitment, experts completed the first survey. At the end they were debriefed and could choose to consent for future contact via a separate survey (Appendix I). Survey one was closed after four months due to need to continue with the research timeline.

Survey two was sent via email to consenting individuals two weeks after the closing of survey one. Survey two was constructed based on the analysis of the prior survey, items achieving between 70 – 79.9% of expert consensus were rerated according to the rules below. Time between the survey rounds was kept minimal to reduce the rate of dropout (Haynes & Shelton, 2018). Survey two was open for four weeks and experts were prompted one and two weeks prior to the survey closing.

Experts could consent after each survey to be entered into a prize draw for a £20 voucher. Three vouchers were available for each survey.

Ethics

Informed consent (Appendix K) was gained at the beginning of each survey and experts were debriefed (Appendix H) on completion of the survey. Confidentiality was maintained throughout the study and data was managed as described in the participant information sheet (Appendix J) and ethics application. Experts were able to withdraw from the study by closing the survey without submitting or not responding. This research was given ethical approval (ref: ETH2526-0230*) by the University of East Anglia Faculty of Medical and Health Sciences (FMH) ethics committee; Appendix B.

Data Analysis

Quantitative data from each expert group was analysed in isolation to maintain the unique perspectives of each group. Due to recruitment and survey completion being online, trustworthiness of responses was screened based on considerations from Xu et al. (2022) completion times less than five minutes for a 30-minute survey, start and ending at the same time or completed on an impossible date were removed to reduce the chance of robot responses.

Consensus was defined prior to analysis of responses as a minimum of 80% of experts rating an item as important or essential, consistent with other studies investigating psychological intervention components (Langlands et al., 2008; Morrison & Barratt, 2009).

When analysing consensus in survey one the following rules were applied, consistent with Langlands et al. (2008):

- If 80% or more of the experts rate a psychological treatment component as essential or important, it was included as a recommendation for those recovering with PP.

- If 70-79% of experts rate a psychological treatment component as essential or important, it was re-rated in round two.
- Any items that did not meet the above criteria were removed from future analysis.

In addition to the above rules, if an item could achieve consensus as important by either group the item was rated for feasibility and appropriateness by expert professionals in the second survey.

Items rated in survey two were considered according to the same criteria. Over 80% of experts rating as important or essential were included, items with less than 80% consensus were removed. Likert ratings of feasibility and appropriateness were analysed using descriptive statistics (mean).

The data output for this study was a list of psychological treatment components deemed important to include within an intervention to improve the recovery after PP. Feasibility and appropriateness of these components from the perspective of expert professionals are also described.

Results

Demographics

In the initial survey there were 36 experts in the experience group and 20 expert professionals. The geographical location of experts can be seen in Table 9. Most expert professionals (95%) were based in the UK compared to 69.44% of the expert by experience group. Most experts identified as White British (58.33 – 60%), as shown in Table 9.

As expected, all experts by experience identified their sex as female. In the expert professional group, 70% of experts were female and 30% male (Table 9). All expert professionals identified as Cisgender, but there was more variation in the experts by experience (non-binary=1, other=3; Table 9). This variation was also seen in sexuality (Table 9). Whilst all expert professionals identified as heterosexual, 83.22% of experts by experience identified as heterosexual, 8.33% identified as pansexual, and 2.78% as homosexual, bisexual and asexual.

Table 9

Demographics of experts (Experience n=36; Professional n=20) completing survey one.

	Experience		Professional	
	n	%	n	%
Geographical location				
England	20	55.56%	18	90%
Scotland	3	8.33%	0	0%
Northern Ireland	2	5.56%	0	0%
Other Countries	11	30.56%	1	5%
Australia	4	11.11%	0	0%
Germany	2	5.56%	0	0%
US	3	8.33%	0	0%
Canada	2	5.56%	0	0%
India	0	0%	1	5%
Ethnicity				
White – British	21	58.33%	12	60%
White – Irish	0	0%	1	5%
White – Any other white background	11	30.56%	4	20%
Mixed – White and Black African	0	0%	1	5%
Mixed – White and Asian	0	0%	1	5%
Asian or Asian British – Indian	1	2.78%	1	5%
Asian or Asian British – Pakistani	1	2.78%	0	0%
Not stated	2	5.56%	0	0%
Sex				
Male	0	0%	6	30%
Female	36	100%	14	70%

Table 9 (*Continued).*

Gender				
Cisgender	32	88.89%	20	100%
Non-binary	1	2.78%	0	0%
Transgender	0	0%	0	0%
Other	3	8.33%	0	0%
Sexuality				
Straight/Heterosexual	30	83.33%	-	-
Gay/Homosexual	1	2.78%	-	-
Bisexual	1	2.78%	-	-
Pansexual	3	8.33%	-	-
Polysexual	0	0%	-	-
Asexual	1	2.78%	-	-

Note. Location: There were no responses from Wales, Scotland – North, Northern Ireland (Southern, South Eastern). Ethnicity: There were no participants from Mixed – White and Black Caribbean, Mixed – Any other mixed background, Asian or Asian British – Bangladeshi, Asian or Asian British – Any other Asian background , Black or Black British – Caribbean , Black or Black British – African, Black or Black British – Any other, Black background , Other Ethnic Groups – Chinese, Other Ethnic Groups – Any other Ethnic group.

Table 10

Demographics of experts by experience related to episode of postpartum psychosis (n=36).

Years since PP	n	%
0 to 4 years	19	52.78%
5 to 9 years	11	30.56%
10 to 14 years	2	5.56%
15 or more years	4	11.11%

Experts by experience reported their episode of PP to be less than a year to over 15 years prior (mode = 1 year prior), Table 10. Experts by experience had noted contact with several mental health services during their PP (Table 11), perinatal community services were accessed

the most (44.44%), followed by mother and baby units and general acute inpatient (41.67%). Most experts by experience (58.33%) had previously experienced mental health difficulties, prior to the onset of PP. Anxiety and depression were the most frequently cited disorders (47.22%), 25% of experts by experience named trauma as a past disorder (Table 12).

Of the expert professionals, most were clinicians (80%) identifying as clinical psychologists (60%; Table 13). Most clinicians worked in perinatal community services (43.75%) and mother and baby units (37.50%; Table 13).

Table 11

Mental health services used by experts by experience.

Mental health services	n	%
MBU	15	41.67%
Perinatal community	16	44.44%
Non-perinatal community	6	16.67%
General acute inpatient	15	41.67%
Early intervention	1	2.78%
Other	4	11.11%
None	5	13.89%

Table 12

Prior mental health disorders experienced by experts by experience.

Prior mental health disorders	n	%
Bipolar	1	2.78%
Psychosis (including schizophrenia)	1	2.78%
Depression	17	47.22%
Anxiety	17	47.22%
Personality disorder	2	5.56%
Trauma	9	25.00%

Table 13

Demographics of expert professionals (n=20).

	n	%
Expert classification		
Clinician	16	80%
Researcher	2	10.00%
Academic	2	10.00%
Service context of clinicians		
Mother and baby unit	6	37.50%
Perinatal Community	7	43.75%
General acute inpatient ward	2	12.5%
Early Intervention for Psychosis	2	12.5%
Job roles		
Clinical Psychologist	12	60%
Parent Infant Psychotherapist	2	10%
Academic Psychologist	1	5%
Other	5	25%

Note. Service context of clinicians: No expert professionals identified as working within non-perinatal community teams or other. Job roles: No expert professionals identified as a CBT therapist or researcher. "Other" was not expanded on in this survey.

Delphi analysis

Delphi methodology was used to establish consensus on psychological treatment components deemed important by expert professionals and experts by experience. Results found that experts by experience agreed 39 psychological treatment components were important for an intervention to improve recovery after an episode of PP (Table 14). Consensus was achieved in round one for 36 components, an additional three components achieved consensus after being re-rated in round two. Expert professionals agreed that 41 psychological treatment components were important for improving recovery after PP, 35 components achieved consensus in round one and an additional six after being re-rated in round two (Table 14).

There were some differences in the psychological treatment components achieving consensus between expert groups, however there was mutual consensus for 34 components, see Appendix N. Only expert professionals agreed the following components were important: “Mentalising the baby’s thoughts and feelings”, “Role modelling communication with baby”, “Interaction coaching / observation”, “Psychoeducation about baby cues”, “Taking time to understand the religious, spiritual and cultural needs of the individual”, “Understanding how the generational impact of parenting is impacting the current situation with baby”. Contrary, only experts by experience agreed the following components were important: “Cognitive diffusion”, “Movement techniques”, “Relaxation”, “Goal Setting”.

Expert professionals were asked to rate the feasibility and appropriateness of items that could have achieved importance during survey 2 (Table 14). Psychological treatment components rated low for feasibility include “strengthening family support network” (2.0), “movement techniques” (2.25), “systemic family therapy” (2.5), “behavioural family therapy” (2.5), and “relationship training” (2.5). The least appropriate items include “mirroring” (2.5), and “mindfulness” (2.5).

When considering the combined consensus of expert groups “Psychoeducation about psychosis”, “normalisation” and “Exploring worries about relapse” gained the highest mutual consensus of importance. When grouping the components by similarity of modality, psychoeducation components were generally rated as having high consensus of importance by both expert groups. Experts by experience did not reach consensus on importance for components related to the baby, with the exception of play. Both expert groups found consensus in cognitive elements being important after PP, for example challenging negative thoughts and beliefs. Strengthening support network and peer support also had mutual consensus, however only experts by experience found consensus in systemic family therapy as an important component. These findings suggest that it is important to both expert groups that other individuals are included within an intervention after an episode of PP. There was also mutual consensus that “coping strategies”, “relapse prevention” and “understanding about how thoughts and feelings are connected” are important to include in an intervention. However, there was no consensus that components of trauma therapy would be important for an intervention (Table 14). Components relating to the conduct of the psychologist reached consensus for being important,

Table 14

Table of results showing consensus of importance and ratings of feasibility (Feas) and Appropriateness (Appr).

Psychology Treatment Component	Experience		Professional		Professional	
	1 (N=36)	2 (N=13)	1 (N=20)	2 (N=4)	Feas	Appr
Psychoeducation about psychosis	97.22%**		100.0%**		4	4
Psychoeducation about parenting and attachment	83.33%**		90.00%**		4	4
Psychoeducation about anxiety	86.11%**		85.00%**		4	3.75
Psychoeducation about suicidal thoughts	80.56%**		80.00%**		4	4
Psychoeducation about baby cues	69.55%		80.00%**		4	3.5
Psychoeducation about baby development/milestones	63.89%		75%	75%	3.75	3.25
Normalisation	97.22%**		75.00%	100%*	4.00	3.75
Empathy	97.22%**		95.00%**		4	4
Fostering hope and optimism	97.22%**		90.00%**		3.75	3.75
Sense of safety	91.67%**		95.00%**		3.75	3.5
Validation	88.89%**		90.00%**		3.75	3.0
Promoting self-reflection	75.00%	92.31%*	85.00%**		3.25	3.5
Attunement between therapist and client	80.56%**		90.00%**		3.50	3.5
Taking time to understand the religious, spiritual and cultural needs of the individual	61.11%		90.00%**		3.75	3.50
Mirroring	63.89%		80.00%**		3.75	2.5

Table 14 *(continued).*

Strengthening social support network	94.44%**		90.00%**		2.00	3.25
Peer support	91.67%**		85.00%**		3.50	3.5
Systemic family therapy	75.00%	84.62%*	60%		2.50	3.25
Developing communication skills	63.89%		70%	50%	3.25	2.75
Relationship training	69.44%		75%	75%	2.50	2.75
Behavioural family therapy	72.22%	76.92%	55%		2.5	3.25
Identifying thoughts related to specific events or memories	88.89%**		90.00%**		3.75	3.25
Attention focus training	75.00%	61.54%	70%	75%	3.0	2.75
Cognitive diffusion	80.56%**		65%		3.50	3.50
Cognitive scheduling	47.22%		45%			
Accepting self	94.44%**		90.00%**		3.50	2.75
Using compassion to challenge negative thoughts	91.67%**		85.00%**		3.50	3.5
Accepting the situation	91.67%**		80.00%**		3.50	3
Imagery training/visualisation	47.22%		60%			
Exploring worries about relapse	94.44%**		100%**		4	4
Thoughts and beliefs about recovery from postpartum psychosis	94.44%**		90.00%**		3.75	4
Thoughts and beliefs about the unusual experiences	88.89%**		75%	100%*	4	3.75
Challenging negative thoughts and beliefs	86.11%**		70%	100%*	3.50	4
Building positive thoughts and beliefs about self	94.44%**		90.00%**		3.75	3

Table 14 *(continued).*

Relapse prevention	94.44%**		95%**		4.0	4
Coping strategies for anxiety	91.67%**		95.00%**		4.0	3.5
Coping strategies to regulate emotions	88.89%**		95.00%**		4.0	3.75
Coping strategies for psychotic symptoms	86.11%**		95.00%**		3.25	3.75
Coping strategies to tolerate distress	83.33%**		90.00%**		4.0	3.75
Identifying triggers and connections between thoughts feelings and behaviours	94.44%**		90.00%**		3.75	3.75
Processing the trauma narrative	77.78%	61.54%	75%	75%	3.0	3.5
Imagery rescripting	55.56%		60%			
Event restructuring	61.11%		50%			
Bilateral stimulation	44.44%		40%			
Play	94.44%**		80.00%**		3.25	3.25
Understanding how the generational impact of parenting is impacting the current situation with baby	61.11%		75%	100%*	3.25	3.25
Interaction coaching / observation	75.00%	53.85%	90.00%**		3.75	3.75
Role modelling communication with baby	58.33%		85.00%**		4.00	3.5
Mentalising the baby's thoughts and feelings	55.56%		80.00%**		3.25	3.5
Infant massage	58.33%		45%			
Music	75.00%	38.46%	60%		3.50	3.0

Table 14 *(continued).*

Risk assessing and safety planning	77.78%	92.31%*	100%**		4.0	4
Promoting sense of agency	83.33%**		90.00%**		3.5	3.75
Focusing on values	80.56%**		80.00%**		3.5	3.5
Doing things that feel pleasurable	94.44%**		75%	100%*	3.50	3.25
Behavioural activation	83.33%**		70%	100%*	3.75	3.5
Mindfulness	75.00%	76.92%	60%		2.75	2.50
Goal Setting	88.89%**		65%		4	3.5
Breathing techniques	75.00%	76.92%	55%		3.25	2.75
Relaxation	86.11%**		55%		3.75	3.25
Movement techniques	80.56%**		45%		2.25	3
Behavioural experiments	44.44%		65%			
Dropping safety behaviours	41.67%		60%			
Exposure	27.78%		55%			
Problem solving	69.44%		65%			
Solution focused strategies	69.44%		45%			
Motivational interviewing	63.89%		45%			

Note: ** Consensus gained in round one, * consensus gained in round two

so should be considered as important to the feel of sessions rather than explicit components.

Discussion

Key findings of this study include 34 psychological treatment components achieving consensus by both expert groups. Overall, 45 of 67 components achieved consensus in at least one expert group. This is significant as it shows a commonality between what expert professionals would deliver based on their clinical and evidence-based experience, as well as what experts by experience feel it is important to receive based on having endured PP.

Treatment components achieving consensus fell into seven broad groups: psychoeducation, understanding thoughts and worries, coping strategies, therapist traits, relationship with baby, relationships with others and trying new ways of doing things. Psychoeducation components were consistently rated as important by professionals and lived experience, as well as feasible for delivery and mostly appropriate to the context of PP. Psychoeducation is regarded as an important part of psychological intervention for a range of difficulties identified by Palmer et al. (2026; Chapter Two) including anxiety (Rodrigues et al., 2018), psychosis (Prasko et al., 2011), and parenting and attachment difficulties (Missler et al., 2018).

These findings are important for establishing next steps in complex intervention development. This study builds on the rationale for intervention found in Palmer et al. (2026; Chapter Two) and suggests that suitable intervention components do exist according to the ADAPT framework (Moore et al., 2021). The results of this study can be used to consider how interventions should be adapted to the context of recovery after PP. Therefore, this research provides meaningful insight into the psychological treatment components that should be considered for an intervention to improve recovery after PP, in terms of consensus of components that are important but also feasible, the extent to which components can be used in services and appropriate for the goal of supporting recovery after PP.

There is an existing evidence base for psychological intervention targeting psychosis outside of the perinatal period (Lincoln & Pedersen, 2019) and social recovery after psychosis (Fowler et al., 2019). It is important to hold the findings of the current study in mind with the context in which they occur. Treatment within the perinatal period requires additional consideration of not just the individual but also the infant and the relationship between them, the

dyad, hence the inclusion of components that include the infant. Play gained consensus as being an important component for intervention which successfully considers overtly the perinatal dyad. However, the component "mentalising the baby's thoughts and feelings" was only rated important by professionals; but may be considered to be a significant part of attuned play (Terradas et al., 2021).

It was an unexpected finding of the study that exposure and behavioural experiments did not reach consensus by either expert group. There is an extensive literature base for exposure in the psychological treatment of anxiety (Parker et al., 2018), named as psychological difficulty after an episode of PP (Palmer et al., 2026). Therefore, this finding may be surprising when considering the expert professional group. It is possible that, due to the nature of PP occurring in the perinatal period, expert professionals want to address psychological distress sensitively, without causing additional distress, or that clinicians do not feel effective treatment methods would be appropriate in the presence of baby (Millett et al., 2018). It would be important for future intervention development to consider when it is appropriate for baby to be present in treatment.

Strengths

It is a strength of the current study that experts have reached consensus on psychological treatment components it would be important to consider within an intervention supporting recovery after postpartum psychosis. The results of this study can be used in future research to inform further steps in intervention development frameworks.

The involvement of both professionals and those with lived experience is very important, capturing the unique perspectives of both groups. It may be considered a strength that these views have been studied separately, allowing for further reflection on the preferences of each group. Completing separate analysis offers a base for future research to build on, taking consensus data and understanding qualitative reasons for this.

Limitations

It is a limitation of this study that only quantitative information was collected, therefore limiting our understanding about why participants rated items the way they did.

For the purposes of this research, treatment components and psychological processes were defined as anything that could be considered within an intervention to improve recovery after postpartum psychosis. This included psychological techniques and considerations for facilitators. However, it may be seen as a limitation that not all items included within the delphi could be defined as treatment components in other research. For example, some items may be considered as psychological processes (e.g. changing thoughts), treatment approaches (e.g. sense of safety) and mechanisms (e.g. maintenance between trauma memories and related thoughts). The current definition is purposefully broad to develop an initial understanding of what is important to include within an intervention targeting recovery after postpartum psychosis. However, it is considered a limitation that the psychological components as defined in the current paper may cover a range of concepts, potentially causing difficulties within later stages of intervention development. It is therefore important that future research understands further the mechanisms behind difficulties occurring after postpartum psychosis to interpret the findings of this study further.

Many of the components are not exclusive, by nature there are similarities in how they may be used within psychological intervention, for example play involving the ability to mentalise baby's thoughts and feelings. Therefore, it may be difficult to exclude items that did not achieve consensus, when considering the implication of these findings and what is considered in next steps for intervention development.

Delphi methodology is traditionally flexible by design. Studies typically begin with a qualitative round to allow participants to suggest ideas. The decision not to include a qualitative round within this study was based on the thorough research completed during the design of this delphi, including a systematic review, desk-based review and PPI work. There is already substantial qualitative literature in this area. The combined participant sample within this literature review (N = 260) was much greater than the numbers that could have feasibly been recruited for the Delphi study. Therefore, the decision was made that using existing qualitative literature would be more beneficial than collecting new qualitative data. It may be viewed as a limitation that participants were not able to suggest their own components, however consultation with professionals and individuals with lived experience was completed prior to design in an attempt to control for this. It was an additional consideration to minimise the delphi rounds for this study due to known attrition rates between rounds and a likely small participant pool.

Clinical implications

This paper will have significant clinical implications for developing a complex psychological intervention for individuals after an episode of PP. The results of this paper will be used in future research to understand further what treatment components should be considered in a psychological intervention. Feasibility ratings suggest that it may be possible to adapt current interventions to the context of PP. In the context of the ADAPT framework (Moore et al., 2021) the next step would be to understand how the identified components can be adapted for the treatment of PP and understanding the barriers around this. It has been recognised qualitatively that individuals continue to have difficulties after the acute episode of psychosis has been treated. It is hoped that this study is the first step to understanding the psychological treatment components needed to support survivors of PP throughout their recovery.

Collecting data from both professionals and individuals with lived experience has shed light on the differences in perspective on what is conceptualised as important within psychological treatment. Research has historically considered development of treatments from the perspective of professionals. Recent literature is accounting more for the experiences of individuals with mental health difficulties, and it is important that they have a voice in complex intervention development.

Future research

The feasibility results of this study suggest that adaptation may be possible. It is recommended that future research will consider how adaptation of interventions may be conducted as well as identifying barriers for adaptation. It would also be important to consider service context within this research to further understand when individuals may need support with different psychological difficulties after an episode of PP. Competencies and needs of professionals should also be considered in future research to understand training needs for those administering an intervention to individuals. There are plans for the data in this study to be used in a series of focus groups to further understand what a complex psychological intervention supporting the recovery after postpartum psychosis may look like.

Conclusion

This is the first known paper to begin considering what a psychological intervention to improve recovery after postpartum psychosis might look like. Both expert professionals and experts by experience rated their perceived importance of psychological components in the context of including them in an intervention, a total of 45 components covering seven broad areas (psychoeducation, understanding thoughts and worries, coping strategies, therapist traits, relationship with baby, relationships with others and trying new ways of doing things). The findings of this research are an important contribution to complex intervention development. There are plans to use these findings in a piece of qualitative research to further understand the needs for an intervention improving recovery after an episode of postpartum psychosis.

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CHAPTER FIVE

Critical Evaluation

Word Count: 3,092

The following Chapter will discuss the overall findings of the systematic review and empirical paper, as well as reflecting on the wider context of the research. A critical review of both papers will be presented, considering the next steps for future research. Finally, a summary of the researcher's reflections on the portfolio will be discussed.

Discussion of overall findings

The aims of this portfolio were to understand the difficulties individuals experience after an episode of postpartum psychosis and consider what an intervention to improve recovery could look like. The systematic review highlighted a long list of psychological difficulties presented within qualitative literature. This was reduced by a public and patient involvement group with personal experience of postpartum psychosis, surmising anxiety, relationship with baby, psychosis, loss from psychosis and harm to self were the most important areas to focus an intervention. Psychological treatment components to improve these specific difficulties were considered. Finally, professionals and experts by experience were asked to rate psychological treatment components to determine whether there was consensus on items that should be included in an intervention to improve recovery after an episode of postpartum psychosis. This found professionals and those with lived experience feel it is important to include components that can be categorised as psychoeducation, understanding thoughts and worries, coping strategies, therapist traits, relationship with baby, relationships with others and trying new ways of doing things in an intervention to improve recovery after postpartum psychosis.

The findings of the portfolio as a whole are situated within the context of complex intervention development, specifically step 1 of the ADAPT framework (Moore et al., 2021; Figure 2). As discussed in the introduction, there are no evidence-based psychological interventions for postpartum psychosis. However, there are existing interventions within both perinatal and psychosis contexts. The ADAPT framework (Moore et al., 2021) has been used throughout the current portfolio to guide research into complex intervention development to improve recovery after postpartum psychosis, Figures 1 and 2. Within this step, the systematic review assessed the rationale for intervention, investigating the difficulties that individuals experience. Existing interventions were considered within the desk-based review and consultation to develop the survey used in the empirical paper, the outcome of which can be considered within future research to address "step 2" of the ADAPT framework. At this point

interventions can begin the process of adaptation. The overall findings suggest that psychological interventions do exist that could support recovery after postpartum psychosis, but adaptation will need to be considered.

It has been noted that the psychological treatment components identified within this research are situated within different theories, models and frameworks. Therefore, it is likely a psychological intervention would be multimodal. Our findings suggest that without modification it is unlikely that existing interventions are sufficient to address the unique and complex context of recovery after postpartum psychosis; however, it may be possible to adapt an intervention rather than developing a new one from scratch. Therefore, future research should focus on subsequent steps of complex intervention development frameworks to undertake necessary adaptations.

Critical appraisal of systematic review

The aim of the systematic review was to produce a list of psychological difficulties experienced by individuals after an episode of postpartum psychosis. Summative content analysis was chosen to interpret qualitative experiences. This allowed psychological difficulties of postpartum psychosis to be understood with regard to the frequency in which they had been cited within the literature. It may be considered a weakness that the data was reduced in this way, however it was seen as a necessary step to understand the experiences of individuals to define a rationale for intervention. This bottom-up approach is cited within the ADAPT framework to define the problem in the target population prior to considering candidate interventions (Moore et al., 2021). Definitions were created for each psychological difficulty using the original qualitative codes, hoping to maintain some of the richness of the qualitative data.

It may be considered a limitation that original transcripts for the reviewed studies were not requested, it is possible some psychological difficulties may have been missed due to not being included in the published material. Given the chosen methodology for the systematic review, it may not have been essential to request access to the original transcripts but should still be considered through a critical lens.

Heterogeneity was assumed between publications due to the large geographical area and demographics of the sample covered by the included literature; this means it is unlikely that the same individual will have been represented in more than one publication. If individuals were

represented across multiple papers, this could lead to unique and individual difficulties being misrepresented in terms of frequency. Due to anonymity, it would not be possible to investigate the issue of heterogeneity further. To try and account for heterogeneity within the papers the frequency of codes was not considered as a total per paper, rather as present or not present. Thus, attempting to account for one individual citing a unique difficulty multiple times within a publication, which could over represent a difficulty in the overall analysis. Attempting to account for this may be considered a strength of the chosen analysis.

It is noted that the systematic review is representative of predominantly white individuals, however, it does account for a large geographical area when considering the different countries included. All countries represented in the review may be considered western and may therefore be similar in their ideology of mental illness, extending to postpartum psychosis. Due to the lack of research from non-westernised countries, it is not possible to assume the psychological difficulties resulting from the review are universal and can account for experiences of all individuals after an episode of postpartum psychosis. Representation within research is important, it should be considered whether the demographics of the reviewed research are representative of the postpartum psychosis population. Research has also shown that whilst postpartum psychosis may present similarly across cultures, treatments and language used may differ (Yang et al., 2023). It may be considered a weakness of the review paper, that the synthesis is not representative of all individuals that have experienced postpartum psychosis, perhaps only those in western cultures. However, it was only possible to use the published research available.

The outcome of the systematic review was a long list of difficulties, deduced via content analysis, to be considered within the context of intervention development. It is with this in mind that the methodology was chosen and it may be considered a strength that the results were able to be used for this purpose. However, the nature of analysis meant that the relationship between codes was neglected. It is suggested that future research could understand how the difficulties reported in the current study relate to each other, promoting a formulation-based understanding of difficulties after an episode of postpartum psychosis. For example, it was anecdotally noticed during data synthesis that difficulties with relationships (with baby, partner or family) may then cause emotional difficulties such as lowered mood, guilt and anxiety. The current review simplifies the literature into a list of difficulties for the purpose of intervention development;

however, the true experience is likely to be far more complex and oscillating. Future reviews may consider using metasynthesis methodology to develop a model of how these difficulties relate to one another, helping professionals and individuals with postpartum psychosis to understand the experiences further.

Critical appraisal of empirical project

The aim of the empirical project was to understand whether there was consensus on the psychological intervention components it would be important to consider within an intervention after postpartum psychosis. Both professionals and individuals with lived experience did agree that some components were important, as well as professionals rating how feasible and appropriate these would be to put into clinical practise.

As with the systematic review, the method chosen for the empirical project held in mind the context of complex intervention development, which has been considered a strength. Consensus was established using quantitative measures, meaning it cannot be understood why experts rated items as they did. It is possible, had a qualitative methodology of considering different intervention components been chosen it would have yielded different findings. Delphi methodology was chosen as it clearly met the research aims of considering which components may be important, feasible and appropriate for an intervention focusing on recovery after postpartum psychosis, using the ADAPT framework (Moore et al., 2021). A weakness of the chosen methodology is that it doesn't allow participants to explain their rationale for rating items. It is suggested future research use qualitative methods to understand why consensus was gained on certain components and not others. When establishing how an intervention may be adapted it would be important to understand whether judgements were based on current experience of practice, personal experience of intervention or the local service provision, therefore highlighting a need for supplementary qualitative data.

It is a strength that the empirical project attracted an international audience, however it is difficult to understand fully the culture of mental health in these countries and the current treatment methods. Therefore, it is possible the views of national and international participants differ, however due to the analysis this has not been explored. The authors have a working knowledge of the NHS mental health system, so interpretations have been made through this lens. It is advised that future development focuses specifically on a local context, for example the

NHS, as it is possible that cross culturally there will be differences in how interventions are delivered.

Whilst professionals partaking in the research worked in a range of settings, a large proportion of the staff identified as working in a perinatal setting. Ratings of importance, feasibility and appropriateness were not analysed in relation to the setting professionals were working in, this would be an important consideration for future research. It is possible that some ratings were due to lack of resources in certain settings or a lack of training, however as qualitative information was not collected it is not possible to know this.

It is important to acknowledge the attrition between rounds of the delphi survey, particularly professionals, due to the low number of responses. This reduces the reliability of the ratings of feasibility and appropriateness as it is unlikely the sample would be representative. This is a significant weakness of the study, and it is suggested that future research consider understanding qualitatively the impact of feasibility and appropriateness on intervention development.

It is an interesting finding that only one of the expert by experience sample had previous diagnosis of bipolar and/or psychosis, despite research suggesting these are strong predictors of postpartum psychosis (Di Florio et al., 2021). It is possible that individuals with experience of these disorders and postpartum psychosis felt their experiences were different in some way or expected due to preconception counselling. Previous research has strongly defined the difference between first episode of psychosis in the perinatal period and non-first episode, more research is needed into the qualitative experiences of these groups and whether there are clear differences in experience.

Clinical implications

It is a strength of the portfolio that the methodologies were designed specifically holding intervention development in mind, producing a list of psychological treatment targets and psychological treatment components. Concluding that there is a need for psychological intervention after an episode of postpartum psychosis and identifying possible components of treatment. Thus, there are significant clinical implications resulting from this portfolio of research as it sets the foundation for developing a complex psychological intervention for recovery after postpartum psychosis. Previously, research has focused on the experiences of

postpartum psychosis during an acute episode. This portfolio draws on a body of research highlighting that difficulties continue beyond the treatment of psychotic symptoms, demonstrating a clinical need for psychological support following resolution of acute symptoms. The findings identify potential psychological treatment components for these difficulties; as well as consensus on the components important to consider within an intervention. Thought is also given to appropriateness and feasibility. Clinically, this is meaningful as it begins to offer an evidence base on which to provide a psychological intervention for recovery after postpartum psychosis.

In the future, clinical implications could include an evidence based psychological intervention to support individuals after an episode of postpartum psychosis. This could have consequences for not only individuals that experience this disorder but also partners, families and children.

Future Research

The results of this portfolio suggest that suitable interventions exist and have potential to be adapted to a new context, to improve recovery after postpartum psychosis. As suggested previously, future research should focus on subsequent steps of the ADAPT framework, specifically considering how psychological components in the current portfolio can be adapted. Whilst the current portfolio has been situated within step 1 of this framework, Figure 1, this portfolio has not completely fulfilled all suggested considerations. It would be important for future research to formally consider and evidence the effectiveness of the intervention components identified in this portfolio, as well as considering similarities and differences for existing contexts using the intervention and that of postpartum psychosis. The ADAPT framework (Moore et al., 2021) suggests the next step would be to plan and undertake adaptations, using the results presented in the current portfolio. It is suggested that a qualitative research method is utilised, for example focus groups, to promote discussion to generate ideas regarding how adaptation may need to be undertaken. This may include considering when the intervention is offered, what intervention is possible within healthcare contexts (e.g. NHS), which services should be delivering the intervention (perinatal, psychosis, charity), how the intervention is delivered (digital, in person, group, individual) and order of delivery of the components. Focus group members could form part of the adaptation team. The ADAPT

framework (Moore et al., 2021) recommends members of this group have knowledge of the new context and the interventions being considered, making roles clear and considering how group membership may change over time. In addition to ADAPT recommendations, this research should aim to be representative of the population using services, including ethnic minorities. Once an intervention has been developed or adapted from existing interventions it is recommended that future research focuses on pilot studies and then efficacy studies to understand whether the intervention is effective at reducing the psychological difficulties determined within the current systematic review.

Gaps remain in the literature when considering the postpartum psychosis timeline. Future qualitative research could focus on reviewing current literature to understand the evolving nature of the disorder to inform intervention. In addition, it would be helpful for research to consider a formulation-based approach to reviewing the literature. This would help professionals and individuals to understand the illness, maintenance factors and precipitating events. The systematic review identified psychological difficulties, but it would be helpful to understand if these are related to each other.

The work of charities, such as Action on Postpartum Psychosis (APP), supporting individuals through and after postpartum psychosis are invaluable to improving the lives of many impacted by perinatal mental illness. It is important that future research is collaborative with members, ensuring public and patient involvement to design studies and continue improving treatment efforts in this area. It is important that members of these charities continue to collect their data routinely to inform the field and psychological intervention.

Reflections

Postpartum psychosis has been acknowledged for centuries, described in 400BC by Hippocrates, describing symptoms of hallucinations and confusion six days after child birth (Friedman & Sorrentino, 2012). Despite this, no published psychological interventions exist. This may highlight a lack of research into women's health and familiarity with the context, consequently a lack of focus on developing psychological interventions in this area. Our findings contribute to existing theory that recovery after mental illness is on a continuum and recovery does not stop after the resolution of acute symptoms. As well as individual recovery, these findings place importance on the recovery of relationships with others, including partner, family

and the attachment with baby. This is what makes mental illness in the perinatal period so unique from others in the lifespan, there is importance on the mother, baby and their relationship.

Whilst mental illness is becoming more socially accepted, the systematic review highlights that stigma around postpartum psychosis remains. Reflecting on the number of diverse difficulties uncovered within this portfolio, it is important to reflect on those possibly not captured due to stigma surrounding the illness. An example of this was found during consultation processes, highlighting the need for suicidal ideation and thoughts to harm self to be considered within an intervention after an episode of postpartum psychosis; however, these difficulties were reported in only three of the publications. Thus, it may be considered that there is a gap between the true experience of postpartum psychosis, and what is documented in literature. It is hypothesised that individuals may worry about the consequences of saying their thoughts out loud, and whether this will result in being labelled 'not good enough' as a mother. Perhaps in some cases extending to worries about whether they will be separated from their child. It is hoped that as more research is published in the context of perinatal mental health, more will feel able to share their stories and contribute to the growing literature base, as well as reducing stigma and shame associated with psychological difficulties as a parent.

Conclusion

This portfolio concludes that there is a need for psychological intervention targeting recovery after postpartum psychosis. It is suggested that an intervention should focus on psychological difficulties including anxiety, loss from psychosis, relationship with baby, the impact of psychosis and harm to self. This portfolio has identified existing interventions that could be used in the psychological treatment of these difficulties. Professionals and individuals with lived experience of postpartum psychosis have agreed components covering seven broad areas should be considered within an intervention to improve recovery after postpartum psychosis. These component areas are psychoeducation, understanding thoughts and worries, coping strategies, therapist traits, relationship with baby, relationships with others and trying new ways of doing things.

The ADAPT framework (Moore et al., 2021) has been used consistently throughout this portfolio to structure aims and design, thinking specifically about developing a complex intervention. The individual Chapters of this thesis consider components within step 1 of this

framework. Future research is needed to understand further similarities and differences to other mental health contexts, before beginning to undertake adaptations.

In summary, this portfolio has defined what the psychological needs for treatment are and gained consensus on possible psychological components of treatment, this is an important step forward in clinical psychology and complex intervention development to improve recovery after postpartum psychosis.

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Appendix A

Author guidelines for Archives of Women's mental health - Springer

Types of papers

Original Contributions/Research Articles

Original Contributions/Research Articles should be arranged into sections conforming to standard scientific reporting style, i.e., under the following headings:

- **Abstract:** Should not exceed 150–250 words and be structured as follows: Purpose, Methods, Results, Conclusions
- **Keywords:** Not more than five, separated by semicolons
- **Introduction:** A brief outline of the background literature leading to the objective(s) of the study and the hypotheses.
- **Materials and Methods:** Describe the basic study design. State the setting (e.g., primary care, referral centre). Explain selection of study subjects and state the system of diagnostic criteria used. Specify the dates in which data were collected (month/year to month/year). Describe all assessment methods and instruments used. Specify all statistical methods. Describe any interventions and include their duration and method of administration. Indicate the main outcome measure(s).
- **Results:** Include the key findings. Give specific data and their statistical significance - Subset Ns should accompany percentages if the total N is ‹100.
- **Discussion and Conclusions:** Discuss your findings critically in comparison to existing literature and considering your methodological and other limitations. Make sure not to interpret mere associations as causal relationship. Conclusions should highlight the potential meaning for the field given the limitations.

The main text (i.e., without abstract, references, figures, tables, or supplementary material) should not exceed 3000 words. Additional information can be given in the supplementary material.

Please note: For intervention studies, trials must be registered beforehand and the registration number must be mentioned in the manuscript.

Reviews/Meta-analyses:

We only accept rigorous systematic reviews and meta-analyses according to well-known reporting guidelines such as PRISMA, Preferred Reporting Items for Systematic Reviews. Reviews are not meant to be encyclopaedic and the main text (i.e., without abstract, references, figures, tables, or supplementary material) should not exceed 4000 words. Additional information can be given in the supplementary material.

Letters to the Editor:

Should be a maximum of 750 words and may include one table or figure and up to five references.

Please note:

- Submissions should bring new knowledge and be relevant for an international audience.
- All manuscripts will be checked for statistics, so please ensure the data has been examined by a statistician.
- We do not accept mere translations of instruments or validation studies for specific languages, but only original developments

Full guidelines are available at https://link.springer.com/journal/737/submission-guidelines

Appendix B

UEA FMH ethical approval letter

University of East Anglia

Study title: Improving recovery after Postpartum Psychosis: Delphi consensus on psychological treatment components

Application ID: ETH2526-0230 (significant amendments)

Dear Beth,

Your application was considered on 30th September 2025 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **30th September 2026**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Stanley Musgrave, Deputy Chair, FMH-sREC

Ethics ETH2526-0230 (Significant amendments): Miss Beth Palmer

Appendix C

Papers included in systematic review

1 (Beck & Twomey, 2023)
2 (Chotai, 2016)
3 (Connors et al., 2024)
4 (Doucet et al., 2012)
5 (Engqvist & Nilsson, 2014)
6 (Forde et al., 2019)
7 (Franke, 2023)
8 (Heron et al., 2012)
9 (Iyengar & Hunt, 2024)
10 (Jefferies et al., 2021)
11 (Kelly, 2018)
12 (McGrath et al., 2013)
13 (Monger, 2024)
14 (Moyer, 2014)
15 (Plunkett et al., 2017)
16 (Posmontier & Fisher, 2014)
17 (Robertson & Lyons, 2003)
18 (Vanderkruik et al., 2024)

Appendix D

List of databases searched

EBSCOhost was used to search the following databases on 28th October 2025:

1. Academic Search Ultimate,
2. AMED – The allied and Complimentary Medicine Database,
3. APA PsycArticles,
4. APA Psycinfo,
5. British Education Index,
6. Business Source Ultimate,
7. Child Development & Adolescent Studies,
8. CINAHL Ultimate,
9. Communication % Mass Media Complete,
10. Criminal Justice Abstracts with Full Text,
11. eBook Academic Collection (EBSCOhost),
12. eBook Collection (EBSCOhost),
13. eBook Open Access (OA) Collection (EBSCOhost),
14. EconLit with Full Text,
15. Education Abstracts (H.W. Wilson),
16. Educational Administration Abstracts, E-Journals,
17. ERIC,
18. European Views of the Americas: 1493 to 1750,
19. GreenFILE,
20. Library,
21. Information Science & Technology Abstracts,
22. MathSciNet via EBSCOhost,
23. MEDLINE Ultimate,
24. MLA Directory of Periodicals,
25. MLA International Bibliography,
26. OpenDissertations,
27. Philosopher's Index with Full Text,
28. Regional Business News,
29. SPORTDiscus with Full Text,
30. Teacher Reference Center.

Appendix E

Psychological Treatment Targets selected for inclusion in the delphi survey, with definitions.

Treatment target	Definition
1. General feelings of anxiety	Anxiety, fear or worry after an episode of postpartum psychosis, not related to a specific element of the mental illness.
2. Anxiety about the impact on baby	Anxiety, fear and worry after an episode of postpartum psychosis, related to the perceived impact the postpartum psychosis may have on the baby their welling or development.
3. Anxiety about reoccurrence of psychosis	Anxiety, fear or worry after an episode of postpartum psychosis that psychosis will reoccur in the future.
4. Fear of baby being removed	Anxiety, fear or worry after an episode of postpartum psychosis that due to having had psychosis that the baby will be removed from the mother's care.
5. Fear of relationship surviving	Anxiety, fear or worry after an episode of postpartum psychosis related to thoughts that their relationship with a significant partner may end.
6. Fear of judgement from others	Anxiety, fear or worry after an episode of postpartum psychosis relating to being negatively judged for having experienced an episode of postpartum psychosis.
7. Difficulty bonding with baby	The perception of difficulties bonding and connecting to baby, after an episode of postpartum psychosis.
8. Distressing emotions from having thoughts to harm baby	The experience of distressing emotions after an episode of postpartum psychosis, relating to thoughts during the episode of psychosis to harm the baby.
9. Feelings of resentment to baby	Experiencing feelings of resentment to the baby, after an episode of postpartum psychosis.

10. Difficult emotions due to bonding difficulties	The experience of difficult emotions after an episode of postpartum psychosis, relating to difficulties bonding.
11. Traumatic experiences of psychosis	Recognising after an episode of postpartum psychosis that the experience of psychosis was traumatic.
12. Distress relating to psychosis	The experience of distress after an episode of postpartum psychosis relating to the experience or timing of having psychosis.
13. Breakthrough symptoms of psychosis	The experience of breakthrough symptoms of psychosis after an acute episode of postpartum psychosis.
14. Suicidal thoughts	The experience of suicidal thoughts, after an episode of postpartum psychosis.
15. Loss from psychosis	The experience of loss after an episode of postpartum psychosis, relating to the experience or timing of psychosis.

Appendix F

Delphi Round one survey

Prior to this survey there was a period of consultation with clinical and academic professionals working within psychosis and perinatal service and individuals with lived experience of postpartum psychosis or supporting individuals that have experienced lived experience to determine what a talking therapy to improve recovery after postpartum psychosis should focus on.

These important items were:

- Anxiety
    - general feelings of anxiety
    - fear of judgement from others
    - anxiety about reoccurrence of psychosis
    - Anxiety about the impact of psychosis on the baby
    - fear of baby being removed
    - fear of relationship surviving
- Relationship with baby
    - Difficulty bonding with baby
    - Feelings of resentment to baby,
    - Difficult emotions due to bonding difficulties,
    - Thought to harm baby,
- Psychosis
    - Breakthrough symptoms of psychosis,
    - Distress relating to the psychosis,
    - Traumatic experiences of psychosis,
- Suicidal thoughts
- Loss from psychosis.

Holding these items in mind, please rate how important the following psychological treatment components are to be included within an intervention after the experience of postpartum psychosis.

Mentalising the baby's thoughts and feelings

Taking time to consider what the baby is thinking and feeling at a specific moment in time.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Understanding how the generational impact of parenting is impacting the current situation with baby

Considering how the impact of your own experience of being parented is contributing to the way you are parenting your baby. This may involve thinking about things that you were previously unaware of in the relationship with your parents and your own baby and making changes to this

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Role modelling communication with baby

In front of the mother, the therapist communicates with baby using techniques such a mirroring and speaking through what baby might be thinking. For example when applying cream to baby the therapist might say "oh, that's cold" guessing what baby might be experiencing.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Interaction coaching / observation

Providing supportive feedback whilst observing how a mother and baby are interacting with each other. This may include commenting on the baby's needs, cures or emotional state. Video recording may be used to allow the mother to see the interaction.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Infant massage

Training on massage strokes that can be used with baby. This may also include an aspect of learning about responsivity to infant cues

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Play

A structured way of mother and baby being together and playing with different things. This may include the use of music and movement as well as games.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Music

The use of sounds, instruments and songs to engage mother and baby.

How important is this for an intervention supporting the	Should not be included	Not important	Not sure	Important	Essential

recovery after postpartum psychosis?					

Identifying thoughts related to specific events or memories

Recognising thoughts that arise in specific situations. This may include thoughts about being a parent or thoughts related to distressing emotions.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Attention focus training

Developing skills to have more conscious control of where attention is applied. This includes selective attention, sustained attention, shifting attention, internal and external focus.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Cognitive diffusion

Creating mental distance from distressing thoughts, feelings or situations. This may include reframing a situation, taking a third person perspective, mindfulness, "I'm having the thought that…" exercise.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Cognitive scheduling

Assigning a designated time for thoughts and worries.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Accepting self

Training to embrace thoughts and feelings about yourself without trying to change, avoid or judge them. This includes self-forgiveness.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Accepting the situation

Training to embrace thoughts and feelings about the situation without trying to change, avoid or judge them. This includes forgiveness of others.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Using compassion to challenge negative thoughts

Using positive phrases and statements to develop compassion that can be used to challenge negative thoughts and beliefs about the self and others.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Imagery training/ visualisation

Using mental images to practise actions or situations, as if they were happening in real life. Used of imagery may be to rehearse how someone will respond in a situation or exposing someone to a feared situation.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Challenging negative thoughts and beliefs

The use of techniques to change thoughts or beliefs. This may include thinking of evidence for and against a given thought.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Building positive thoughts and beliefs about self

Gaining evidence that supports the development of positive thoughts and beliefs about the self. This may increase self esteem.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Thoughts and beliefs about the unusual experiences

Exploring thoughts and deeper beliefs that an individual may have about their unusual experiences during the episode of postpartum psychosis.

How important is this for an intervention supporting the	Should not be included	Not important	Not sure	Important	Essential

recovery after postpartum psychosis?					

Thoughts and beliefs about recovery from postpartum psychosis

Exploring thoughts and beliefs an individual may have about their recovery, for example waiting until they feel better or more confident.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Exploring worries about relapse

Taking time to think about how someone thinks and feels about their future with regards to possibility of relapse.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Developing communication skills

Learning skills to communicate more clearly. This includes verbal and non-verbal communication, empathy and assertiveness skills. Role play may be used to practise these skills.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Relationship training

Being taught skills to enhance the relationship you have with others, including partners, family or baby.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Behavioural family therapy

A structured process of identifying problems, generating, evaluating and prioritising solutions that helps you to address and resolve challenges within a family.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Systemic family therapy

Providing evidence-based information to the family that will allow you to better understand the illness and how relationships within the family may be helpful or unhelpful in recovery.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Strengthening social support network

Improving the relationships to strengthen the support network. This may include partners, friends or family.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Peer support

Having support from someone that has experienced postpartum psychosis and may have had similar experiences.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Coping strategies for anxiety

Techniques or skills designed to reduce intense feelings of anxiety.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Coping strategies for psychotic symptoms

Techniques or skills designed to reduce the experience of psychotic symptoms.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Coping strategies to regulate emotions

Techniques or skills designed to reduce emotional dysregulation.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Coping strategies to tolerate distress

Techniques or skills designed to reduce intense emotional distress. This may include suicidal thoughts.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Relapse prevention

Identifying skills that can be used in the future to prevent reoccurrence of mental illness. This may include recognising early warning signs of psychosis and planning for future conception.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Behavioural activation

Engaging in activities that give a sense of purpose and mastery.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Doing things that feel pleasurable

Taking part in activities that are enjoyable. This may include scheduling time to do things like hobbies, sports or journalling.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Mindfulness

Learning to be fully present in the moment, paying attention to thoughts, feelings, bodily sensations and surroundings with no judgement.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Breathing techniques

Learning to regulate breathing using a variety of techniques which may include box breathing, counting or belly breathing.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Movement techniques

Use of yoga and other movement-based activities to reduce the impact of antipsychotic side effects.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Relaxation

Techniques or skills to lower heart rate, blood pressure and slow down breathing. This can include progressive muscle relaxation.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Exposure

Exposing someone to a situation that caused them anxiety, this can be done in a gradual way. Exposure over time can reduce feelings of anxiety.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Dropping safety behaviours

Resisting the urge to react to compulsions in a situation that causes anxiety.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Behavioural experiments

Gathering information to test the accuracy of thoughts and beliefs an individual holds about a specific situation or themself. Conducting an experiment usually involves considering what you believe will happen in a situation, testing this out, and then evaluating what happened and reflecting on this.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Risk assessing and safety planning

Explicit questioning focusing on the presence of thoughts to harm self or other, as well as plans to end life.

How important is this for an intervention supporting the	Should not be included	Not important	Not sure	Important	Essential

recovery after postpartum psychosis?					

Promoting sense of agency

Use of activity scheduling and thought challenging to increase feelings of independence and mastery.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Focusing on values

Focusing on what is important in life and how these values can be applied to actions made.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Problem solving

A structured process of identifying problems, generating, evaluating and prioritising solutions to solve problems.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Solution focused strategies

Focusing on strengths that can be used to focus and meet goals. Rather than focusing on overcoming problems, there is a focus of working towards the solution.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Goal setting

A way of focusing on what is important in treatment and the steps to achieve the goal.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Motivational interviewing

A technique to overcome barriers to making positive changes.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Psychoeducation about psychosis

Providing evidence-based information to better understand psychosis. This information can help individuals make sense of their experiences and how to manage them.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Psychoeducation about anxiety

Providing evidence-based information to better understand anxiety. This information can help individuals make sense of their experiences and how to manage them.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Psychoeducation about parenting and attachment

Providing evidence-based information to better understand parenting skills and attachment. This information can help individuals make sense of their experiences and how to manage them

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Psychoeducation about baby cues

Providing evidence-based information to better understand baby cues and communication. This information can help individuals make sense of their experiences and how to manage them

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Psychoeducation about baby development/milestones

Providing evidence-based information to better understand baby development and milestones. This information can help individuals make sense of their experiences and how to manage them.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Psychoeducation about suicidal thoughts

Providing evidence-based information to better understand suicidal thoughts. This information can help individuals make sense of their experiences and how to manage them.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Identifying triggers and connections between thoughts feelings and behaviours

Making connections between an event happening and the thoughts, feelings and behaviours experienced after. This can be done through the process of writing, talking or thinking.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Imagery rescripting

A therapeutic technique to change a memory by changing the mental images associated with the memory.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Processing the trauma narrative

Making sense of traumatic experiences by remembering the event of the trauma and integrating the memory into a more meaningful narrative.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Bilateral stimulation

A way of processing information using alternative sides of the brain to store information in a more adaptive way. This may involve watching a therapist's move their fingers left and right.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Event restructuring

The use of techniques to change how one related to an event. This may include rethinking the event from multiple perspectives.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Taking time to understand the religious, spiritual and cultural needs of the individual

Asking about spiritual, religious and cultural practises that are important for an individual and how they intend to raise their baby.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Promoting self-reflection

A therapeutic skill whereby the therapist will guide an individual to think deeply about their thoughts, feeling and behaviours or why an event occurred.

How important is this for an intervention supporting the	Should not be included	Not important	Not sure	Important	Essential

recovery after postpartum psychosis?					

Validation

Acknowledging an individual's emotions without agreeing, judging or trying to change them.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Sense of safety

The therapist taking time to promote a sense of safety within the therapeutic space. This can help to explore conscious and unconscious emotions.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Empathy

The therapist showing the ability to understand the feelings or someone else.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Mirroring

The therapist using verbal and non-verbal communication that is similar to the individual to aid connection.

How important is this for an intervention supporting the	Should not be included	Not important	Not sure	Important	Essential

recovery after postpartum psychosis?					

Attunement between therapist and client

Developing the therapeutic relationship to the stage where emotions can be felt by both the therapist and client when shared in the therapy session. This can occur through the process of active listening and validation.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Fostering hope and optimism

Promoting a sense of positivity within the therapeutic space that the situation will get better.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Normalisation

Telling an individual that how they are thinking or feeling is normal for the situation they are in. Promoting a sense that they are not on their own.

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Appendix G

Delphi round two professionals survey

Prior to this survey there was a period of consultation with clinical and academic professionals working within psychosis and perinatal service and individuals with lived experience of postpartum psychosis or supporting individuals that have experienced lived experience to determine what a talking therapy to improve recovery after postpartum psychosis should focus on.

These important items were:

- Anxiety
  - general feelings of anxiety
  - fear of judgement from others
  - anxiety about reoccurrence of psychosis
  - Anxiety about the impact of psychosis on the baby
  - fear of baby being removed
  - fear of relationship surviving
- Relationship with baby
  - Difficulty bonding with baby
  - Feelings of resentment to baby,
  - Difficult emotions due to bonding difficulties,
  - Thought to harm baby,
- Psychosis
  - Breakthrough symptoms of psychosis,
  - Distress relating to the psychosis,
  - Traumatic experiences of psychosis,
- Suicidal thoughts
- Loss from psychosis.

Holding these items in mind, please rate how important the following psychological treatment components are to be included within an intervention after the experience of postpartum psychosis.

Understanding how the generational impact of parenting is impacting the current situation with baby

Considering how the impact of your own experience of being parented is contributing to the way you are parenting your baby. This may involve thinking about things that you were previously unaware of in the relationship with your parents and your own baby and making changes to this*

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Attention focus training

Developing skills to have more conscious control of where attention is applied. This includes selective attention, sustained attention, shifting attention, internal and external focus.*

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Challenging negative thoughts and beliefs

The use of techniques to change thoughts or beliefs. This may include thinking of evidence for and against a given thought.*

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Thoughts and beliefs about the unusual experiences

Exploring thoughts and deeper beliefs that an individual may have about their unusual experiences during the episode of postpartum psychosis.*

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Developing communication skills

Learning skills to communicate more clearly. This includes verbal and non-verbal communication, empathy and assertiveness skills. Role play may be used to practise these skills.*

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Relationship training

Being taught skills to enhance the relationship you have with others, including partners, family or baby.*

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Behavioural activation

Engaging in activities that give a sense of purpose and mastery.*

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Doing things that feel pleasurable

Taking part in activities that are enjoyable. This may include scheduling time to do things like hobbies, sports or journalling.*

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Psychoeducation about baby development/milestones

Providing evidence-based information to better understand baby development and milestones. This information can help individuals make sense of their experiences and how to manage them.*

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Processing the trauma narrative

Making sense of traumatic experiences by remembering the event of the trauma and integrating the memory into a more meaningful narrative. *

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

Normalisation

Telling an individual that how they are thinking or feeling is normal for the situation they are in. Promoting a sense that they are not on their own.*

How important is this for an intervention supporting the recovery after postpartum psychosis?	Should not be included	Not important	Not sure	Important	Essential

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You will now be asked to rate feasibility (the extent to which the treatment component is practical and practicable, accounting for physical, cultural or financial practical elements in the context of UK psychological services) of psychological treatment components that could be used in an intervention supporting recovery after postpartum psychosis.

Mentalising the baby's thoughts and feelings

Taking time to consider what the baby is thinking and feeling at a specific moment in time.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Understanding how the generational impact of parenting is impacting the current situation with baby

Considering how the impact of your own experience of being parented is contributing to the way you are parenting your baby. This may involve thinking about things that you were previously unaware of in the relationship with your parents and your own baby and making changes to this*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Role modelling communication with baby

In front of the mother, the therapist communicates with baby using techniques such a mirroring and speaking through what baby might be thinking. For example when applying cream to baby the therapist might say “oh, that’s cold” guessing what baby might be experiencing.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Interaction coaching / observation

Providing supportive feedback whilst observing how a mother and baby are interacting with each other. This may include commenting on the baby’s needs, cures or emotional state. Video recording may be used to allow the mother to see the interaction.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Play

A structured way of mother and baby being together and playing with different things. This may include the use of music and movement as well as games.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Music

The use of sounds, instruments and songs to engage mother and baby.*

How feasible is this for an intervention supporting the	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

recovery after postpartum psychosis?					

Identifying thoughts related to specific events or memories

Recognising thoughts that arise in specific situations. This may include thoughts about being a parent or thoughts related to distressing emotions.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Attention focus training

Developing skills to have more conscious control of where attention is applied. This includes selective attention, sustained attention, shifting attention, internal and external focus.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Cognitive diffusion

Creating mental distance from distressing thoughts, feelings or situations. This may include reframing a situation, taking a third person perspective, mindfulness, “I’m having the thought that…” exercise.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Accepting self

Training to embrace thoughts and feelings about yourself without trying to change, avoid or judge them. This includes self-forgiveness.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Accepting the situation

Training to embrace thoughts and feelings about the situation without trying to change, avoid or judge them. This includes forgiveness of others.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Using compassion to challenge negative thoughts

Using positive phrases and statements to develop compassion that can be used to challenge negative thoughts and beliefs about the self and others.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Challenging negative thoughts and beliefs

The use of techniques to change thoughts or beliefs. This may include thinking of evidence for and against a given thought.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Building positive thoughts and beliefs about self

Gaining evidence that supports the development of positive thoughts and beliefs about the self. This may increase self esteem.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Thoughts and beliefs about the unusual experiences

Exploring thoughts and deeper beliefs that an individual may have about their unusual experiences during the episode of postpartum psychosis.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Thoughts and beliefs about recovery from postpartum psychosis

Exploring thoughts and beliefs an individual may have about their recovery, for example waiting until they feel better or more confident.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Exploring worries about relapse

Taking time to think about how someone thinks and feels about their future with regards to possibility of relapse.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Developing communication skills

Learning skills to communicate more clearly. This includes verbal and non-verbal communication, empathy and assertiveness skills. Role play may be used to practise these skills.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Relationship training

Being taught skills to enhance the relationship you have with others, including partners, family or baby.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Behavioural family therapy

A structured process of identifying problems, generating, evaluating and prioritising solutions that helps you to address and resolve challenges within a family.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Systemic family therapy

Providing evidence-based information to the family that will allow you to better understand the illness and how relationships within the family may be helpful or unhelpful in recovery.*

How feasible is this for an intervention supporting the	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

recovery after postpartum psychosis?					

Strengthening social support network

Improving the relationships to strengthen the support network. This may include partners, friends or family.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Peer support

Having support from someone that has experienced postpartum psychosis and may have had similar experiences.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Coping strategies for anxiety

Techniques or skills designed to reduce intense feelings of anxiety.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Coping strategies for psychotic symptoms

Techniques or skills designed to reduce the experience of psychotic symptoms.*

How feasible is this for an intervention supporting the	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

recovery after postpartum psychosis?					

Coping strategies to regulate emotions

Techniques or skills designed to reduce emotional dysregulation.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Coping strategies to tolerate distress

Techniques or skills designed to reduce intense emotional distress. This may include suicidal thoughts.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Relapse prevention

Identifying skills that can be used in the future to prevent reoccurrence of mental illness. This may include recognising early warning signs of psychosis and planning for future conception.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Behavioural activation

Engaging in activities that give a sense of purpose and mastery.*

How feasible is this for an intervention supporting the	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

recovery after postpartum psychosis?					

Doing things that feel pleasurable

Taking part in activities that are enjoyable. This may include scheduling time to do things like hobbies, sports or journalling.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Mindfulness

Learning to be fully present in the moment, paying attention to thoughts, feelings, bodily sensations and surroundings with no judgement.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Breathing techniques

Learning to regulate breathing using a variety of techniques which may include box breathing, counting or belly breathing.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Movement techniques

Use of yoga and other movement-based activities to reduce the impact of antipsychotic side effects.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Relaxation

Techniques or skills to lower heart rate, blood pressure and slow down breathing. This can include progressive muscle relaxation.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Risk assessing and safety planning

Explicit questioning focusing on the presence of thoughts to harm self or other, as well as plans to end life.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Promoting sense of agency

Use of activity scheduling and thought challenging to increase feelings of independence and mastery.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Focusing on values

Focusing on what is important in life and how these values can be applied to actions made.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Goal setting

A way of focusing on what is important in treatment and the steps to achieve the goal.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Psychoeducation about psychosis

Providing evidence-based information to better understand psychosis. This information can help individuals make sense of their experiences and how to manage them.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Psychoeducation about anxiety

Providing evidence-based information to better understand anxiety. This information can help individuals make sense of their experiences and how to manage them.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Psychoeducation about parenting and attachment

Providing evidence-based information to better understand parenting skills and attachment. This information can help individuals make sense of their experiences and how to manage them.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Psychoeducation about baby cues

Providing evidence-based information to better understand baby cues and communication. This information can help individuals make sense of their experiences and how to manage them*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Psychoeducation about baby development/milestones

Providing evidence-based information to better understand baby development and milestones. This information can help individuals make sense of their experiences and how to manage them.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Psychoeducation about suicidal thoughts

Providing evidence-based information to better understand suicidal thoughts. This information can help individuals make sense of their experiences and how to manage them.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Identifying triggers and connections between thoughts feelings and behaviours

Making connections between an event happening and the thoughts, feelings and behaviours experienced after. This can be done through the process of writing, talking or thinking.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Processing the trauma narrative

Making sense of traumatic experiences by remembering the event of the trauma and integrating the memory into a more meaningful narrative. *

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Taking time to understand the religious, spiritual and cultural needs of the individual

Asking about spiritual, religious and cultural practises that are important for an individual and how they intend to raise their baby.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Promoting self-reflection

A therapeutic skill whereby the therapist will guide an individual to think deeply about their thoughts, feeling and behaviours or why an event occurred.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Validation

Acknowledging an individual's emotions without agreeing, judging or trying to change them.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Sense of safety

The therapist taking time to promote a sense of safety within the therapeutic space. This can help to explore conscious and unconscious emotions.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Empathy

The therapist showing the ability to understand the feelings or someone else.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Mirroring

The therapist using verbal and non-verbal communication that is similar to the individual to aid connection.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Attunement between therapist and client

Developing the therapeutic relationship to the stage where emotions can be felt by both the therapist and client when shared in the therapy session. This can occur through the process of active listening and validation.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Fostering hope and optimism

Promoting a sense of positivity within the therapeutic space that the situation will get better.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

Normalisation

Telling an individual that how they are thinking or feeling is normal for the situation they are in. Promoting a sense that they are not on their own.*

How feasible is this for an intervention supporting the recovery after postpartum psychosis?	Completely not feasible	Not feasible	Not sure	Partially feasible	Completely feasible

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You will now be asked to rate appropriateness (the extent to which the treatment component related to the treatment of the target in the recovery of postpartum psychosis) of psychological treatment components that could be used in an intervention supporting recovery after postpartum psychosis.

Mentalising the baby's thoughts and feelings

Taking time to consider what the baby is thinking and feeling at a specific moment in time.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Understanding how the generational impact of parenting is impacting the current situation with baby

Considering how the impact of your own experience of being parented is contributing to the way you are parenting your baby. This may involve thinking about things that you were previously unaware of in the relationship with your parents and your own baby and making changes to this*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Role modelling communication with baby

In front of the mother, the therapist communicates with baby using techniques such a mirroring and speaking through what baby might be thinking. For example when applying cream to baby the therapist might say “oh, that’s cold” guessing what baby might be experiencing.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Interaction coaching / observation

Providing supportive feedback whilst observing how a mother and baby are interacting with each other. This may include commenting on the baby’s needs, cures or emotional state. Video recording may be used to allow the mother to see the interaction.*

How appropriate is this for an intervention supporting	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

the recovery after postpartum psychosis?					

Play

A structured way of mother and baby being together and playing with different things. This may include the use of music and movement as well as games.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Music

The use of sounds, instruments and songs to engage mother and baby.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Identifying thoughts related to specific events or memories

Recognising thoughts that arise in specific situations. This may include thoughts about being a parent or thoughts related to distressing emotions.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Attention focus training

Developing skills to have more conscious control of where attention is applied. This includes selective attention, sustained attention, shifting attention, internal and external focus.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Cognitive diffusion

Creating mental distance from distressing thoughts, feelings or situations. This may include reframing a situation, taking a third person perspective, mindfulness, "I'm having the thought that…" exercise.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Accepting self

Training to embrace thoughts and feelings about yourself without trying to change, avoid or judge them. This includes self-forgiveness.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Accepting the situation

Training to embrace thoughts and feelings about the situation without trying to change, avoid or judge them. This includes forgiveness of others.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Using compassion to challenge negative thoughts

Using positive phrases and statements to develop compassion that can be used to challenge negative thoughts and beliefs about the self and others.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Challenging negative thoughts and beliefs

The use of techniques to change thoughts or beliefs. This may include thinking of evidence for and against a given thought.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Building positive thoughts and beliefs about self

Gaining evidence that supports the development of positive thoughts and beliefs about the self. This may increase self esteem.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Thoughts and beliefs about the unusual experiences

Exploring thoughts and deeper beliefs that an individual may have about their unusual experiences during the episode of postpartum psychosis.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Thoughts and beliefs about recovery from postpartum psychosis

Exploring thoughts and beliefs an individual may have about their recovery, for example waiting until they feel better or more confident.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Exploring worries about relapse

Taking time to think about how someone thinks and feels about their future with regards to possibility of relapse.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Developing communication skills

Learning skills to communicate more clearly. This includes verbal and non-verbal communication, empathy and assertiveness skills. Role play may be used to practise these skills.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Relationship training

Being taught skills to enhance the relationship you have with others, including partners, family or baby.*

How appropriate is this for an intervention supporting	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

the recovery after postpartum psychosis?					

Behavioural family therapy

A structured process of identifying problems, generating, evaluating and prioritising solutions that helps you to address and resolve challenges within a family.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Systemic family therapy

Providing evidence-based information to the family that will allow you to better understand the illness and how relationships within the family may be helpful or unhelpful in recovery.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Strengthening social support network

Improving the relationships to strengthen the support network. This may include partners, friends or family.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Peer support

Having support from someone that has experienced postpartum psychosis and may have had similar experiences.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Coping strategies for anxiety

Techniques or skills designed to reduce intense feelings of anxiety.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Coping strategies for psychotic symptoms

Techniques or skills designed to reduce the experience of psychotic symptoms.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Coping strategies to regulate emotions

Techniques or skills designed to reduce emotional dysregulation.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Coping strategies to tolerate distress

Techniques or skills designed to reduce intense emotional distress. This may include suicidal thoughts.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Relapse prevention

Identifying skills that can be used in the future to prevent reoccurrence of mental illness. This may include recognising early warning signs of psychosis and planning for future conception.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Behavioural activation

Engaging in activities that give a sense of purpose and mastery.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Doing things that feel pleasurable

Taking part in activities that are enjoyable. This may include scheduling time to do things like hobbies, sports or journalling.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Mindfulness

Learning to be fully present in the moment, paying attention to thoughts, feelings, bodily sensations and surroundings with no judgement.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Breathing techniques

Learning to regulate breathing using a variety of techniques which may include box breathing, counting or belly breathing.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Movement techniques

Use of yoga and other movement-based activities to reduce the impact of antipsychotic side effects.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Relaxation

Techniques or skills to lower heart rate, blood pressure and slow down breathing. This can include progressive muscle relaxation.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Risk assessing and safety planning

Explicit questioning focusing on the presence of thoughts to harm self or other, as well as plans to end life.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Promoting sense of agency

Use of activity scheduling and thought challenging to increase feelings of independence and mastery.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Focusing on values

Focusing on what is important in life and how these values can be applied to actions made.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Goal setting

A way of focusing on what is important in treatment and the steps to achieve the goal.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Psychoeducation about psychosis

Providing evidence-based information to better understand psychosis. This information can help individuals make sense of their experiences and how to manage them.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Psychoeducation about anxiety

Providing evidence-based information to better understand anxiety. This information can help individuals make sense of their experiences and how to manage them.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Psychoeducation about parenting and attachment

Providing evidence-based information to better understand parenting skills and attachment. This information can help individuals make sense of their experiences and how to manage them.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Psychoeducation about baby cues

Providing evidence-based information to better understand baby cues and communication. This information can help individuals make sense of their experiences and how to manage them*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Psychoeducation about baby development/milestones

Providing evidence-based information to better understand baby development and milestones. This information can help individuals make sense of their experiences and how to manage them.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Psychoeducation about suicidal thoughts

Providing evidence-based information to better understand suicidal thoughts. This information can help individuals make sense of their experiences and how to manage them.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Identifying triggers and connections between thoughts feelings and behaviours

Making connections between an event happening and the thoughts, feelings and behaviours experienced after. This can be done through the process of writing, talking or thinking.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Processing the trauma narrative

Making sense of traumatic experiences by remembering the event of the trauma and integrating the memory into a more meaningful narrative. *

How appropriate is this for an intervention supporting	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

the recovery after postpartum psychosis?					

Taking time to understand the religious, spiritual and cultural needs of the individual

Asking about spiritual, religious and cultural practises that are important for an individual and how they intend to raise their baby.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Promoting self-reflection

A therapeutic skill whereby the therapist will guide an individual to think deeply about their thoughts, feeling and behaviours or why an event occurred.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Validation

Acknowledging an individual's emotions without agreeing, judging or trying to change them.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Sense of safety

The therapist taking time to promote a sense of safety within the therapeutic space. This can help to explore conscious and unconscious emotions.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Empathy

The therapist showing the ability to understand the feelings or someone else.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Mirroring

The therapist using verbal and non-verbal communication that is similar to the individual to aid connection.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Attunement between therapist and client

Developing the therapeutic relationship to the stage where emotions can be felt by both the therapist and client when shared in the therapy session. This can occur through the process of active listening and validation.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Fostering hope and optimism

Promoting a sense of positivity within the therapeutic space that the situation will get better.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Normalisation

Telling an individual that how they are thinking or feeling is normal for the situation they are in. Promoting a sense that they are not on their own.*

How appropriate is this for an intervention supporting the recovery after postpartum psychosis?	Completely inappropriate	Inappropriate	Not sure	Appropriate	Completely appropriate

Appendix H

Debrief form

Debrief page with link to survey to collect email address

Thank you for taking part in the first round of two in the study: Improving recovery after Postpartum Psychosis: Delphi consensus on psychological treatment components.

If you would like to be entered into a prize draw to win a £20 Love2shop voucher, complete the second part of this study or receive the results of this study please follow the link below to give your contact details.
[INSERT LINK]

The information collected within this survey will be used to inform the next survey round by analysing whether there was consensus (agreement) on the importance of psychological treatment components (e.g. psychoeducation and mindfulness). You were also asked to rate the importance of psychological treatment targets (e.g. low self-esteem), this will be used to see what the most important targets for psychological treatment are, from the perspective of individuals with lived experience and professionals.

If you identified yourself as a professional, you would have also been asked to rate the treatment components on feasibility and appropriateness. These scores will be considered with regards to how the components may be used within psychological services in the UK.
Treatment components that are close to achieving consensus on importance in the current survey will be included within the final survey and participants will be asked to re-rate them. If you consented to being contacted for the next survey you will receive an email in the coming months with a link to this.

If you have any further questions about this study, please contact Bethany Palmer via Bethany.Palmer@UEA.AC.UK

If you experienced distress whilst completing the survey, please seek support through your GP. Support can also be found through the following charities:

- Mind: www.mind.org.uk
- Infoline: 0300 123 3393
- Samaritans Helpline: 116 123
- Action on Postpartum Psychosis: https://www.app-network.org

Appendix I

Survey for collecting email addresses

Round 1

Thank you for completing survey 1 for the study:

Improving recovery after Postpartum Psychosis: Delphi consensus on psychological treatment components

By providing your email address below you are consenting for this to be stored according to the participant information sheet.

If you would like to be contacted please give your email address below:

_____

Please indicate your contact preferences below:

	Contact me	DO NOT contact me
Entry into the prize draw		
To complete the second part of this survey		
Results of this study		
To be contacted in the future about postpartum psychosis research conducted at the University of East Anglia.		

Round 2

Thank you for completing survey 2 for the study:

Improving recovery after Postpartum Psychosis: Delphi consensus on psychological treatment components

By providing your email address below you are consenting for this to be stored according to the participant information sheet.

If you would like to be contacted please give your email address below:

_____

Please indicate your contact preferences below:

	Contact me	DO NOT contact me
Entry into the prize draw		

Appendix J

Participant information sheet

Participant information sheet (Expert by experience)

Bethany Palmer
Trainee Clinical Psychologist
01/05/2025

Faculty of Medical and Health Sciences
School of Medicine
University of East Anglia
Norwich Research Park
Norwich NR4 7TJ
United Kingdom

Email: Bethany.palmer@uea.ac.uk
Web: www.uea.ac.uk

PARTICIPANT INFORMATION SHEET

Improving recovery after Postpartum Psychosis: Delphi consensus on psychological treatment components

(1) What is this study about?

We are hoping to develop a new talking therapy to support recovery following an episode of postpartum psychosis. We are interested in your views on what would be important to include in a new talking therapy. We are asking you to rate the importance of psychological methods of treatment.

You have been invited to participate in this study because you have lived experience of postpartum psychosis and are considered an 'expert by experience'. This Participant Information Sheet tells you about the research study. Knowing what is involved will help you decide if you want to take part in the study. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. By giving consent to take part in this study you are telling us that you:

✓ Understand what you have read.

✓ Agree to take part in the research study as outlined below.

✓ Agree to the use of your personal information as described.

✓ You have received a copy of this Participant Information Sheet to keep.

(2) Who is running the study?

The study is being carried out by the following student: Bethany Palmer who is conducting this study as the basis for the doctoral degree in Clinical Psychology at the University of East Anglia.

The study is being carried out by the following researcher(s): Bethany Palmer (Trainee Clinical Psychologist), Faculty of Medical and Health Sciences.

This study will take place under the supervision of Jo Hodgekins (Clinical Psychologist), j.hodgekins@uea.ac.uk

This study is being funded by University of East Anglia.

(3) What will the study involve for me?

Prior to this study there was a period of consultation with professionals that have worked with postpartum psychosis, as well as individuals with lived experience. This produced a list of 15 important aspects to target with talking therapy in the recovery from postpartum psychosis. These include:

- Anxiety
    - General feelings of anxiety
    - Fear of judgement from others
    - Anxiety about reoccurrence of psychosis
    - Anxiety about the impact of psychosis on the baby
    - Fear of baby being removed
    - Fear of relationship surviving
- Relationship with baby
    - Difficulty bonding with baby
    - Feelings of resentment to baby,
    - Difficult emotions due to bonding difficulties,
    - Thought to harm baby,

- Psychosis
    - Breakthrough symptoms of psychosis,
    - Distress relating to the psychosis,
    - Traumatic experiences of psychosis,
- Suicidal thoughts
- Loss from psychosis.

From the target items above, a literature search was completed to look at evidence based psychological treatments that could be used in a new talking therapy, supporting recovery after postpartum psychosis. We are inviting you to take part in two online surveys to rate how important each technique is to be included within a talking therapy for postpartum psychosis. Each of the survey rounds will be outlined below:

Round 1: You will be sent a list of proposed psychological treatments that could be used in therapy to support recovery after postpartum psychosis (e.g. psychoeducation, mindfulness). You will be asked to rate importance of each in the context of Postpartum Psychosis using a 5-point scale (should not be included, not important, not sure, important, essential).

Round 2: You will be sent a similar, shorter, survey like round 1. You will be asked to re-rate the importance of treatment components on the same 5-point scale.

You will be taken to the round 1 survey after giving consent after this information sheet. You will be contacted for the second survey around July 2025.

(4)How much of my time will the study take?

The current length of the first survey is 30 minutes. The length of the next round cannot be known due to dependence on the initial round, but this will not take longer than 30 minutes.

(5) Do I have to be in the study? Can I withdraw from the study once I have started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of East Anglia now or in the future.

If you decide to take part in the study and then change your mind, you are free to withdraw by closing the browser tab. If you have submitted your survey, you will not be able to withdraw as your results will be anonymous.

If you give your email address via the separate form you will be able to withdraw your contact details by emailing Bethany.palmer@uea.ac.uk and these will be destroyed.

(6) What are the consequences if I withdraw from the study?

There will be no consequences if you withdraw your data from the study.

(7) Are there any risks or costs associated with being in the study?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study. You will not be asked to recall your experience of postpartum psychosis directly within this study.

(8) Are there any benefits associated with being in the study?

There are no direct health benefits as a result of taking part in the study. However, we think that this study will help improve the psychological support given to those recovering from Postpartum Psychosis.

If you consent, you will be entered into a prize draw to win a £20 love2shop e-gift card. There will be three £20 e-gift cards available for each survey.

(9) What will happen to information provided by me and data collected during the study?

During the study you can choose to give your email address via a separate online form. You can state your preference to be:

- Entered into the prize draw
- Contacted for the second survey
- Contacted for the results of the study
- Contacted in the future about postpartum psychosis research conducted at the University of East Anglia.

As your email address will be collected on a separate survey, your survey responses will remain anonymous. Only researchers named in this document will have access to your email address and access will be on a need-to-know basis. Personal information will be stored securely in accordance with UEA policies, stored separately from survey responses in a password protected

document. When the study has come to an end and there is no longer a need to contact you, your personal information will be destroyed be the researchers.

If you consent to you email being retained for the purposes of future research, your email address will be stored on a password protected document by Dr Jo Hodgekins (Clinical Associate Professor) and accessed by researchers at the University of East Anglia on a need-to-know basis. You will be contacted within 12 months of this study ending, at which point your information will be destroyed. If you wish to remove your email from this database you can contact Dr Jo Hodgekins via j.hodgekins@uea.ac.uk

Your personal data and information will only be used as outlined in this Participant Information Sheet, unless you consent otherwise. Data management will follow the Data Protection Act 2018 (DPA 2018) and UK General Data Protection Regulation (UK GDPR), and the University of East Anglia's Research Data Management Policy.

The information you provide will be stored securely and your identity will be kept strictly confidential, except as required by law. Study findings may be published and may also be used for other scholarly and educational purposes such as in teaching, but you will not be identified if you decide to participate in this study. The data will be kept for at least 10 years beyond the last date the data were used. The study findings may be deposited in a repository to allow it to facilitate its reuse. The deposited data will not include your name or any identifiable information about you.

(10) What if I would like further information about the study?

When you have read this information, Bethany Palmer Bethany.palmer@uea.ac.uk will be available to discuss it with you further and answer any questions you may have about the study.

(11) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You have the choice to give your email in a separate survey at the end of the study and can consent to be contacted with the result of the study.

This feedback will be in the form of a plain summary of the study and findings along with the abstract.

This feedback will be sent on the completion of the study which is likely to be in the summer of 2026.

(12) What if I have a complaint or any concerns about the study?

If there is a problem, please let me know. You can contact me via the University at the following address:

Bethany Palmer
Faculty of Medical and Health Sciences
Bethany.palmer@uea.ac.uk

If you would like to speak to someone else, you can contact my supervisor:

Jo Hodgekins j.hodgekins@uea.ac.uk

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact Richard Meiser-Stedman (Professor of Clinical Psychology) r.meiser-stedman@uea.ac.uk.

(13) How do I know that this study has been approved to take place?

To protect your safety, rights, wellbeing and dignity, all research in the University of East Anglia is reviewed by a Research Ethics Body. This research was approved by UEA, Faculty of Medical and Health Sciences Research Ethics Committee.

(14) What is the general data protection information I need to be informed about?

According to data protection legislation, we are required to inform you that the legal basis for processing your data as listed in Article 6(1) of the UK GDPR is because this allows us to process personal data when it is necessary to perform our public tasks as a University.

Our processing of your personal data will be based on Article 9(2)(j), which relates to archiving, research and statistics purposes, and Schedule 1, Part 1(4) of the DPA 2018, which relates to research.

In addition to the specific information provided above about why your personal data is required and how it will be used, there is also some general information which needs to be provided for you:

- The data controller is the University of East Anglia.
- For further information, you can contact the University's Data Protection Officer at dataprotection@uea.ac.uk
- You can also find out more about your data protection rights at the Information Commissioner's Office (ICO).
- If you are unhappy with how your personal data has been used, please contact the University's Data Protection Officer at dataprotection@uea.ac.uk in the first instance.

(15) OK, I want to take part – what do I do next?

If you are happy and consent to take part in the study, simply continue to complete the consent form on the next page. After this you will be able to complete the first questionnaire. By submitting your responses, you are agreeing to the researcher using the data collected for the purposes described above. Please keep the information sheet for your information. You can download it via the link below:

https://docs.google.com/document/d/1t60QrI0zA4gTy_GwrjDozCAzCXzQ7RGe/edit?usp=sharing&ouid=104307975655732107052&rtpof=true&sd=true

(16) Further information

This information was last updated on 01/05/2025, participant information sheet – Expert by experience version 5.

Ethics reference: ETH2425-0767

This information sheet is for you to keep

Participant information sheet (Expert professionals)

Bethany Palmer
Trainee Clinical Psychologist
01/05/2025

Faculty of Medical and Health Sciences
School of Medicine
University of East Anglia
Norwich Research Park
Norwich NR4 7TJ
United Kingdom

Email: Bethany.palmer@uea.ac.uk
Web: www.uea.ac.uk

PARTICIPANT INFORMATION SHEET

Improving recovery after Postpartum Psychosis: Delphi consensus on psychological treatment components

(1) What is this study about?

We are hoping to develop a new talking therapy to support recovery following an episode of postpartum psychosis. We are interested in your views on what would be important to include in a new talking therapy. We are asking you to rate the importance, feasibility and appropriateness of psychological methods of treatment.

You have been invited to participate in this study because you are a clinician, academic or researcher working recently with postpartum psychosis. This Participant Information Sheet tells you about the research study. Knowing what is involved will help you decide if you want to take part in the study. Please read this sheet carefully and ask questions about anything that you don't understand or want to know more about.

Participation in this research study is voluntary. By giving consent to take part in this study you are telling us that you:

- ✓ Understand what you have read.
- ✓ Agree to take part in the research study as outlined below.

✓ Agree to the use of your personal information as described.

✓ You have received a copy of this Participant Information Sheet to keep.

(2) Who is running the study?

The study is being carried out by the following student: Bethany Palmer who is conducting this study as the basis for the doctoral degree in Clinical Psychology at the University of East Anglia. This study will take place under the supervision of Jo Hodgekins, j.hodgekins@uea.ac.uk

This study is being funded by University of East Anglia.

(3) What will the study involve for me?

Prior to this study there was a period of consultation with professionals that have worked with postpartum psychosis, as well as individuals with lived experience. This produced a list of 15 important aspects to target with talking therapy in the recovery from postpartum psychosis. These include:

- Anxiety
    - General feelings of anxiety
    - Fear of judgement from others
    - Anxiety about reoccurrence of psychosis
    - Anxiety about the impact of psychosis on the baby
    - Fear of baby being removed
    - Fear of relationship surviving
- Relationship with baby
    - Difficulty bonding with baby
    - Feelings of resentment to baby,
    - Difficult emotions due to bonding difficulties,
    - Thought to harm baby,
- Psychosis
    - Breakthrough symptoms of psychosis,
    - Distress relating to the psychosis,
    - Traumatic experiences of psychosis,
- Suicidal thoughts
- Loss from psychosis.

From the target items above, a literature search was completed to look at evidence based psychological treatments that could be used in a new talking therapy, supporting recovery after postpartum psychosis. We are inviting you to take part in two online surveys to rate how important each technique is to be included within a talking therapy for postpartum psychosis. Each of the survey rounds will be outlined below:

Round 1: You will be asked to rate the importance of psychological treatment components (e.g. psychoeducation, mindfulness) in the context of treating the above targets in the recovery from Postpartum Psychosis, using a 5-point Likert scale (should not be included, not important, not sure, important, essential).

Round 2: You will be sent a shortened list of psychological treatment components and asked to re-rate these for importance. You will also be asked to rate feasibility (the extent to which the treatment component is practical and practicable) and appropriateness (the extent to which the treatment component related to the treatment of the target in the recovery of postpartum psychosis) using similar 5-point Likert scales.

You will take part in round 1 after reading this document and giving consent. You will be contacted for round 2 around July 2025.

(4) How much of my time will the study take?

The current length of the first round is 30 minutes. The length of the next round cannot be known due to dependence on the initial round, but this will not take longer than 30 minutes.

(5) Do I have to be in the study? Can I withdraw from the study once I have started?

Being in this study is completely voluntary and you do not have to take part. Your decision whether to participate will not affect your current or future relationship with the researchers or anyone else at the University of East Anglia now or in the future.

If you decide to take part in the study and then change your mind, you are free to withdraw by closing the browser tab. If you have submitted your survey, you will not be able to withdraw as your results will be anonymous.

If you give your email address via the separate form you will be able to withdraw your contact details by emailing Bethany.palmer@uea.ac.uk and these will be destroyed.

(6) What are the consequences if I withdraw from the study?

There will be no consequences if you withdraw your data from the study.

(7) Are there any risks or costs associated with being in the study?

Aside from giving up your time, we do not expect that there will be any risks or costs associated with taking part in this study.

(8) Are there any benefits associated with being in the study?

There are no direct health benefits as a result of taking part in the study. However, we think that this study will help improve the psychological support given to those recovering from Postpartum Psychosis. Therefore, this could help you as professionals and the individuals you support in the future.

If you consent, you will be entered into a prize draw to win a £20 love2shop e-gift card. There will be three £20 e-gift cards available for each survey.

(9) What will happen to information provided by me and data collected during the study?

During the study you can choose to give your email address via a separate online form. You can state your preference to be:

- Entered into the prize draw
- Contacted for the second survey
- Contacted for the results of the study
- Contacted in the future about postpartum psychosis research conducted at the University of East Anglia.

Only researchers named in this document will have access to your email address and access will be on a need-to-know basis. Personal information will be stored securely in accordance with UEA policies, stored separately from survey responses in a password protected document. When the study has come to an end and there is no longer a need to contact you, your personal information will be destroyed by the researchers.

If you consent to you email being retained for the purposes of future research, your email address will be stored on a password protected document by Dr Jo Hodgekins (Clinical Associate Professor) and accessed by researchers at the University of East Anglia on a need-to-know basis. You will be contacted within 12 months of this study ending, at which point your information

will be destroyed. If you wish to remove your email from this database you can contact Dr Jo Hodgekins via j.hodgekins@uea.ac.uk

Your personal data and information will only be used as outlined in this Participant Information Sheet, unless you consent otherwise. Data management will follow the Data Protection Act 2018 (DPA 2018) and UK General Data Protection Regulation (UK GDPR), and the University of East Anglia's Research Data Management Policy.

The information you provide will be stored securely and your identity will be kept strictly confidential, except as required by law. Study findings may be published and may also be used for other scholarly and educational purposes such as in teaching, but you will not be identified if you decide to participate in this study. The data will be kept for at least 10 years beyond the last date the data were used. The study findings may be deposited in a repository to allow it to facilitate its reuse. The deposited data will not include your name or any identifiable information about you.

(10) What if I would like further information about the study?

When you have read this information, Bethany Palmer Bethany.palmer@uea.ac.uk will be available to discuss it with you further and answer any questions you may have about the study.

(11) Will I be told the results of the study?

You have a right to receive feedback about the overall results of this study. You have the choice to give your email in a separate survey at the end of the study and can consent to be contacted with the result of the study.

This feedback will be in the form of a lay summary of the study and findings along with the abstract.

This feedback will be sent on the completion of the study which is likely to be in the summer of 2026.

(12) What if I have a complaint or any concerns about the study?

If there is a problem, please let me know. You can contact me via my university email:

Bethany Palmer

(Faculty of Medical and Health Sciences)

Bethany.palmer@uea.ac.uk

If you would like to speak to someone else, you can contact my supervisor:

Jo Hodgekins j.hodgekins@uea.ac.uk

If you are concerned about the way this study is being conducted or you wish to make a complaint to someone independent from the study, please contact Richard Meiser-Stedman (Professor of Clinical Psychology) r.meiser-stedman@uea.ac.uk.

(13) How do I know that this study has been approved to take place?

To protect your safety, rights, wellbeing and dignity, all research in the University of East Anglia is reviewed by a Research Ethics Body. This research was approved by UEA, Faculty of Medical and Health Sciences Research Ethics Committee.

(14) What is the general data protection information I need to be informed about?

According to data protection legislation, we are required to inform you that the legal basis for processing your data as listed in Article 6(1) of the UK GDPR is because this allows us to process personal data when it is necessary to perform our public tasks as a University.

Our processing of your personal data will be based on Article 9(2)(j), which relates to archiving, research and statistics purposes, and Schedule 1, Part 1(4) of the DPA 2018, which relates to research.

In addition to the specific information provided above about why your personal data is required and how it will be used, there is also some general information which needs to be provided for you:

- The data controller is the University of East Anglia.
- For further information, you can contact the University's Data Protection Officer at dataprotection@uea.ac.uk
- You can also find out more about your data protection rights at the Information Commissioner's Office (ICO).
- If you are unhappy with how your personal data has been used, please contact the University's Data Protection Officer at dataprotection@uea.ac.uk in the first instance.

(15) OK, I want to take part – what do I do next?

If you are happy and consent to take part in the study, simply continue to complete the consent form on the next page. After this you will be able to complete the first questionnaire. By submitting your responses, you are agreeing to the researcher using the data collected for the purposes described above. Please keep the information sheet for your information. You can download it via the link below:

https://docs.google.com/document/d/16qTDYHdY1v1Ig5k307feaipHUl4ZQCq-/edit?usp=sharing&ouid=104307975655732107052&rtpof=true&sd=true

(16) Further information

This information was last updated on 01/05/2025, participant information sheet – Expert professionals version 5.

Ethics reference: ETH2425-0767

This information sheet is for you to keep

Appendix K

Consent form

Consent form v3.0 01/05/2025

Ethics reference: ETH2425-0767

Improving recovery after Postpartum Psychosis: Delphi consensus on psychological treatment components. In giving my consent, I state that:

	Yes
• I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.	
• I have read the Participant Information Sheet, which I may keep, for my records, and have been able to discuss my involvement in the study with the researchers if I wished to do so.	
• The researchers have answered any questions that I had about the study, and I am happy with the answers.	
• I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of East Anglia now or in the future.	
• I understand that I have the option to give my email address via a separate form at the end of the survey.	
• I understand that I can withdraw from this study by closing the browser tab and after submitting the survey I will not be able to withdraw my data as the results are anonymous.	
• I understand that I may stop the research activity at any time if I do not wish to continue, and that unless I contact the researchers to withdraw my data, data collected from submitted questionnaires will be included anonymously within the study results.	
• I understand that the results of this study will be used in the way described in the information sheet.	
• I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.	
• I understand that the data collected in this study may be deposited with a repository to allow it to be made available for scholarly and educational purposes, but the data will only be used in the way that it is described in the information sheet.	

I consent to completing the current study YES o NO o

Appendix L

Study Advert

Can you help to improve the recovery after Postpartum Psychosis?

University of East Anglia

Who can take part?

1. Over 18 years old
2. Ability to read and understand English
3. Lived experience of postpartum psychosis (including psychosis within the perinatal period)

If you are interested in taking part or finding out more information, please scan the QR code for further information!



Chance to win a £20 Love2Shop voucher

What is involved?

- Two online surveys
- You will be asked your view on the importance of various psychological treatment methods that could be used in a talking therapy to aid recovery after an episode of Postpartum Psychosis.

Need to ask some questions?
Contact Beth Palmer (primary researcher)
via Bethany.Palmer@UEA.AC.UK

Version 4.0 (01/05/2025)
UEA FMH Ethical approval ref:
ETH2425-0767

Can you help to improve the recovery after Postpartum Psychosis?

University of East Anglia

Who can take part?

1. Over 18 years old
2. Ability to read and understand English
3. Worked with individuals with postpartum psychosis in the last 12 months
4. A clinician, academic or researcher with familiarity of psychological treatment components

If you are interested in taking part or finding out more information, please scan the QR code for further information!



What is involved?

- Two online surveys
- You will be asked your view on the importance of various psychological treatment methods that could be used in a talking therapy to aid recovery after an episode of Postpartum Psychosis.

Chance to win a £20 Love2Shop voucher

Need to ask some questions?
Contact Beth Palmer (primary researcher)
via Bethany.Palmer@UEA.AC.UK

Version 4.0 (01/05/2025)
UEA FMH Ethical approval ref:
ETH2425-0767

Appendix M

PRISMA checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	Page 14
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	Page 15
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	Pages 16, 17
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	Page 17
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	Pages 18, 19
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	Pages 18, 119
Search	7	Present the full search strategies for all databases, registers and websites, including any	Page 18

Section and Topic	Item #	Checklist item	Location where item is reported
strategy		filters and limits used.	
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	Pages 18, 19, 21
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	Pages 19, 20
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	Pages 19, 20
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	Pages 22 - 28
Study risk of bias	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked	Pages 19, 29

Section and Topic	Item #	Checklist item	Location where item is reported
assessment		independently, and if applicable, details of automation tools used in the process.	
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	NA
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	Pages 19, 20
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	NA
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	NA
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	Pages 19, 20
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	NA
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	NA
Reporting	14	Describe any methods used to assess risk of bias due to missing results in a synthesis	NA

Section and Topic	Item #	Checklist item	Location where item is reported
bias assessment		(arising from reporting biases).	
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	NA
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	Page 30
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	Page 30
Study characteristics	17	Cite each included study and present its characteristics.	Pages 22 - 28
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	Page 29
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	NA

Section and Topic	Item #	Checklist item	Location where item is reported
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	Pages 30 - 49
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	NA
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	NA
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	NA
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	NA
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	NA
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	Pages 49 – 52
	23b	Discuss any limitations of the evidence included in the review.	Page 51

Section and Topic	Item #	Checklist item	Location where item is reported
	23c	Discuss any limitations of the review processes used.	Page 51
	23d	Discuss implications of the results for practice, policy, and future research.	Pages 51, 52
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	Page 18
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	Page 18
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	NA
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	Page 14
Competing interests	26	Declare any competing interests of review authors.	Page 14
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	NA

From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71.
https://www.prisma-statement.org/prisma-2020-checklist

Appendix N

The distribution of the psychological treatment components where consensus on importance was gained

Professional important	Mutually important	Lived experience important
• Mentalising the baby's thoughts and feelings • Role modelling communication with baby • Interaction coaching / observation • Psychoeducation about baby cues • Taking time to understand the religious, spiritual and cultural needs of the individual • Understanding how the generational impact of parenting is impacting the current situation with baby	• Play • Identifying thoughts related to specific events or memories • Accepting self • Accepting the situation • Using compassion to challenge negative thoughts • Challenging negative thoughts and beliefs • Building positive thoughts and beliefs about self • Thoughts and beliefs about the unusual experiences • Thoughts and beliefs about recovery from postpartum psychosis • Exploring worries about relapse • Strengthening social support network • Peer support • Coping strategies for anxiety • Coping strategies for psychotic symptoms • Coping strategies to regulate emotions	• Cognitive diffusion • Movement techniques • Relaxation • Goal Setting • Systemic family therapy

- Coping strategies to tolerate distress
- Relapse prevention
- Behavioural activation
- Doing things that feel pleasurable
- Promoting sense of agency
- Focusing on values
- Psychoeducation about psychosis
- Psychoeducation about anxiety
- Psychoeducation about parenting and attachment
- Psychoeducation about suicidal thoughts
- Identifying triggers and connections between thoughts feelings and behaviours
- Validation
- Sense of safety
- Empathy
- Attunement between therapist and client
- Fostering hope and optimism
- Normalisation
- Risk assessing and safety planning
- Promoting self-reflection

Appendix O

Definitions of psychological treatment components

Psychological treatment component	Definition
Mentalising the baby's thoughts and feelings	Taking time to consider what the baby is thinking and feeling at a specific moment in time.
Understanding how the generational impact of parenting is impacting the current situation with baby	Considering how the impact of your own experience of being parented is contributing to the way you are parenting your baby. This may involve thinking about things that you were previously unaware of in the relationship with your parents and your own baby and making changes to this.
Role modelling communication with baby	In front of the mother, the therapist communicates with baby using techniques such a mirroring and speaking through what baby might be thinking. For example when applying cream to baby the therapist might say "oh, that's cold" guessing what baby might be experiencing.
Interaction coaching / observation	Providing supportive feedback whilst observing how a mother and baby are interacting with each other. This may include commenting on the baby's needs, cures or emotional state. Video recording may be used to allow the mother to see the interaction.
Infant massage	Training on massage strokes that can be used with baby. This may also include an aspect of learning about responsivity to infant cues.

Play	A structured way of mother and baby being together and playing with different things. This may include the use of music and movement as well as games.
Music	The use of sounds, instruments and songs to engage mother and baby.
Identifying thoughts related to specific events or memories	Recognising thoughts that arise in specific situations. This may include thoughts about being a parent or thoughts related to distressing emotions.
Attention focus training	Developing skills to have more conscious control of where attention is applied. This includes selective attention, sustained attention, shifting attention, internal and external focus.
Cognitive diffusion	Creating mental distance from distressing thoughts, feelings or situations. This may include reframing a situation, taking a third person perspective, mindfulness, "I'm having the thought that…" exercise.
Cognitive scheduling	Assigning a designated time for thoughts and worries.
Accepting self	Training to embrace thoughts and feelings about yourself without trying to change, avoid or judge them. This includes self-forgiveness.
Accepting the situation	Training to embrace thoughts and feelings about the situation without trying to change, avoid or judge them. This includes forgiveness of others.

Using compassion to challenge negative thoughts	Using positive phrases and statements to develop compassion that can be used to challenge negative thoughts and beliefs about the self and others.
Imagery training/ visualisation	Using mental images to practise actions or situations, as if they were happening in real life. Used of imagery may be to rehearse how someone will respond in a situation or exposing someone to a feared situation.
Challenging negative thoughts and beliefs	The use of techniques to change thoughts or beliefs. This may include thinking of evidence for and against a given thought.
Building positive thoughts and beliefs about self	Gaining evidence that supports the development of positive thoughts and beliefs about the self. This may increase self esteem.
Thoughts and beliefs about the unusual experiences	Exploring thoughts and deeper beliefs that an individual may have about their unusual experiences during the episode of postpartum psychosis.
Thoughts and beliefs about recovery from postpartum psychosis	Exploring thoughts and beliefs an individual may have about their recovery, for example waiting until they feel better or more confident.
Exploring worries about relapse	Taking time to think about how someone thinks and feels about their future with regards to possibility of relapse.

Developing communication skills	Learning skills to communicate more clearly. This includes verbal and non-verbal communication, empathy and assertiveness skills. Role play may be used to practise these skills.
Relationship training	Being taught skills to enhance the relationship you have with others, including partners, family or baby.
Behavioural family therapy	A structured process of identifying problems, generating, evaluating and prioritising solutions that helps you to address and resolve challenges within a family.
Systemic family therapy	Providing evidence-based information to the family that will allow you to better understand the illness and how relationships within the family may be helpful or unhelpful in recovery.
Strengthening social support network	Improving the relationships to strengthen the support network. This may include partners, friends or family.
Peer support	Having support from someone that has experienced postpartum psychosis and may have had similar experiences.
Coping strategies for anxiety	Techniques or skills designed to reduce intense feelings of anxiety.
Coping strategies for psychotic symptoms	Techniques or skills designed to reduce the experience of psychotic symptoms.

Coping strategies to regulate emotions	Techniques or skills designed to reduce emotional dysregulation.
Coping strategies to tolerate distress	Techniques or skills designed to reduce intense emotional distress. This may include suicidal thoughts.
Relapse prevention	Identifying skills that can be used in the future to prevent reoccurrence of mental illness. This may include recognising early warning signs of psychosis and planning for future conception.
Behavioural activation	Engaging in activities that give a sense of purpose and mastery.
Doing things that feel pleasurable	Taking part in activities that are enjoyable. This may include scheduling time to do things like hobbies, sports or journalling.
Mindfulness	Learning to be fully present in the moment, paying attention to thoughts, feelings, bodily sensations and surroundings with no judgement.
Breathing techniques	Learning to regulate breathing using a variety of techniques which may include box breathing, counting or belly breathing.
Movement techniques	Use of yoga and other movement-based activities to reduce the impact of antipsychotic side effects.

Relaxation	Techniques or skills to lower heart rate, blood pressure and slow down breathing. This can include progressive muscle relaxation.
Exposure	Exposing someone to a situation that caused them anxiety, this can be done in a gradual way. Exposure over time can reduce feelings of anxiety.
Dropping safety behaviours	Resisting the urge to react to compulsions in a situation that causes anxiety.
Behavioural experiments	Gathering information to test the accuracy of thoughts and beliefs an individual holds about a specific situation or themself. Conducting an experiment usually involves considering what you believe will happen in a situation, testing this out, and then evaluating what happened and reflecting on this.
Risk assessing and safety planning	Explicit questioning focusing on the presence of thoughts to harm self or other, as well as plans to end life.
Promoting sense of agency	Use of activity scheduling and thought challenging to increase feelings of independence and mastery.
Focusing on values	Focusing on what is important in life and how these values can be applied to actions made.
Problem solving	A structured process of identifying problems, generating, evaluating and prioritising solutions to solve problems.

Solution focused strategies	Focusing on strengths that can be used to focus and meet goals. Rather than focusing on overcoming problems, there is a focus of working towards the solution.
Goal setting	A way of focusing on what is important in treatment and the steps to achieve the goal.
Motivational interviewing	A technique to overcome barriers to making positive changes.
Psychoeducation about psychosis	Providing evidence-based information to better understand psychosis. This information can help individuals make sense of their experiences and how to manage them.
Psychoeducation about anxiety	Providing evidence-based information to better understand anxiety. This information can help individuals make sense of their experiences and how to manage them.
Psychoeducation about parenting and attachment	Providing evidence-based information to better understand parenting skills and attachment. This information can help individuals make sense of their experiences and how to manage them.
Psychoeducation about baby cues	Providing evidence-based information to better understand baby cues and communication. This information can help individuals make sense of their experiences and how to manage them.
Psychoeducation about baby development/milestones	Providing evidence-based information to better understand baby development and milestones. This information can

	help individuals make sense of their experiences and how to manage them.
Psychoeducation about suicidal thoughts	Providing evidence-based information to better understand suicidal thoughts. This information can help individuals make sense of their experiences and how to manage them.
Identifying triggers and connections between thoughts feelings and behaviours	Making connections between an event happening and the thoughts, feelings and behaviours experienced after. This can be done through the process of writing, talking or thinking.
Imagery rescripting	A therapeutic technique to change a memory by changing the mental images associated with the memory.
Processing the trauma narrative	Making sense of traumatic experiences by remembering the event of the trauma and integrating the memory into a more meaningful narrative.
Bilateral stimulation	A way of processing information using alternative sides of the brain to store information in a more adaptive way. This may involve watching a therapist's move their fingers left and right.
Event restructuring	The use of techniques to change how one related to an event. This may include rethinking the event from multiple perspectives.

Taking time to understand the religious, spiritual and cultural needs of the individual	Asking about spiritual, religious and cultural practises that are important for an individual and how they intend to raise their baby.
Promoting self-reflection	A therapeutic skill whereby the therapist will guide an individual to think deeply about their thoughts, feeling and behaviours or why an event occurred.
Validation	Acknowledging an individual's emotions without agreeing, judging or trying to change them.
Sense of safety	The therapist taking time to promote a sense of safety within the therapeutic space. This can help to explore conscious and unconscious emotions.
Empathy	The therapist showing the ability to understand the feelings or someone else.
Mirroring	The therapist using verbal and non-verbal communication that is similar to the individual to aid connection.
Attunement between therapist and client	Developing the therapeutic relationship to the stage where emotions can be felt by both the therapist and client when shared in the therapy session. This can occur through the process of active listening and validation.
Fostering hope and optimism	Promoting a sense of positivity within the therapeutic space that the situation will get better.

Normalisation	Telling an individual that how they are thinking or feeling is normal for the situation they are in. Promoting a sense that they are not on their own.

Appendix P

Outcomes of the CASP checklist quality assessment for the 18 included studies.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
1. Was there a clear statement of the aims of the research?	1	1	1	1	1	1	1	1	CT	1	1	1	1	0	1	1	1	1
2. Is a qualitative methodology appropriate?	1	1	1	1	1	1	1	1	CT	1	1	1	1	0	1	1	1	1
3. Was the research design appropriate to address the aims of the research?	1	1	CT	1	1	1	1	1	CT	1	1	1	1	0	1	1	1	1
4. Was the recruitment strategy appropriate to the aims of the research?	1	1	0	1	1	1	1	1	CT	1	1	1	1	0	1	1	1	CT
5. Was the data collected in a way that addressed the research issue?	1	1	1	1	1	1	1	1	CT	1	1	1	1	0	1	1	1	1
6. Has the relationship between researcher and participants been adequately considered?	1	1	0	0	0	1	1	0	0	1	1	1	1	CT	1	1	1	0
7. Have ethical issues been taken into consideration?	1	1	1	1	1	1	1	1	0	1	1	1	1	0	1	CT	0	1
8. Was the data analysis sufficiently rigorous?	1	1	0	1	1	1	1	1	0	1	1	1	1	0	1	1	1	1
9. Is there a clear statement of findings?	1	1	1	1	1	1	1	1	CT	1	1	1	1	0	1	1	1	1
10. How valuable is the research?	1	1	1	1	1	1	1	1	CT	1	1	1	1	0	1	1	1	1
Total score	10	10	6.5	9	9	10	10	9	3.5	10	10	10	10	0.5	10	9.5	9	8.5

Note. 1 = Yes, 0.5 = CT (Can't tell), 0 = No. Publications are labelled 1 to 18 as per Table 1