A 'best-fit' framework synthesis exploring mothers' experiences of custody loss and qualitative exploration of mental health in care experienced mothers using Multi-perspectival Interpretative Phenomenological Analysis: A portfolio thesis

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For Dad

I hope you would have been proud.

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Thesis Portfolio Abstract

Aims: This portfolio thesis is split into two parts. The first part aimed to explore the experience of women who have their children forcibly removed from their care following involvement with Child Protection Services (CPS). The second part aimed to explore how care experienced women perceive and manage the impact of motherhood on their mental health from two perspective: mothers' own perspective; and the perspective of a group of professionals who provide support to care experienced mothers.

Method: The first aim was addressed by means of Systematic Review and 'Best-fit' Framework Synthesis of qualitative data. To address the second aim, a group of care experienced mothers and a group of professionals engaged in semi-structured interviews. Transcripts were analysed by means of Interpretative Phenomenological Analysis.

Results: 'Best-fit' Framework synthesis of 15 studies included in the review article yielded three analytic themes: *Adverse life histories and context of child removal; Immediate psychosocial crisis;* and *Cumulative and enduring consequences*. A further nine subthemes were captured within these three superordinate themes. Four superordinate themes emerged from analysis of participant interviews in the empirical study: *The value and fragile benefits of motherhood; When the past and present collide; The value and power of identities; and Engagement with services: the push and pull.* Within these, a further six subordinate themes emerged.

Conclusions: Findings from the systematic review suggest that mothers whose children are forcibly removed by CPS could benefit from: additional recognition and support for their grief; the provision of safe, non-judgemental spaces to explore their experiences; finding new way of defining their relationship with their children; and opportunities to connect with other

custody losing mothers. Findings from the empirical study suggest that developing mindfulness skills or increasing self-compassion may have some utility in reducing mental health difficulties for care leaver mothers. Parenting interventions such as Mellow Bumps may also support reflection on mothers' experiences of being parented and how this impacts their own parenting. As relatively little is known about care leaver mothers and their ongoing mental health, an important first step in addressing this gap will be the routine collection of data, in work ideally co-produced with care leaver mothers, to better understand their mental health care needs.

Thesis Portfolio Lay Summary

Aims: Two studies are included in this portfolio thesis. The first study reviews existing studies which explore the experiences of mothers who have had their children removed from their care by Child Protection Services (CPS). The second study is a new empirical research project exploring how a group of care experienced mothers make sense of and manage the impact of motherhood on their mental health from two points of view: care experienced mothers; and professionals who support care experienced mothers.

Method: The review article combined results from fifteen studies and analysed them using 'Best-fit Framework Synthesis to identify common themes. The empirical study interviewed five care experienced mothers, and four professionals who support them. Their interviews were analysed using Interpretative Phenomenological Analysis to identify common themes.

Results: Analysis from the review article resulted in the identification of three main themes: *Adverse life histories and context of child removal; Immediate psychosocial crisis;* and *Cumulative and enduring consequences.* Within these main themes, nine subthemes were identified. Four themes emerged in the empirical study: *The value and fragile benefits of motherhood; When the past and present collide; The value and power of identities; and Engagement with services: the push and pull.* Within these, a further six subordinate themes emerged.

Conclusion: Findings from the first study suggest that mothers whose children are removed by CPS could benefit from: extra recognition and support for their grief; safe, non-judgemental spaces to explore their experiences; finding new way of describing their relationship with their children; and opportunities to connect with other similar mothers. Findings from the second study suggest that developing mindfulness skills or increasing self-compassion may help reduce mental health difficulties for care leaver mothers. Parenting

groups such as Mellow Bumps may also help mothers link their experiences of being parented to how they parent their own children. As not much is known about care leaver mothers and their mental health, an important first step in filling this gap will be the routine collection of data, in work ideally co-produced with care leaver mothers, to better understand their mental health care needs.

Systematic Review

Exploring the experiences of mothers who have their children removed from their care by Child Protection Services: A qualitative systematic review and 'best-fit' framework synthesis.

Brodie McGougan

Ingrid Obsuth

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Systematic Review Abstract

Mothers who have children removed from their care by Child Protection Services (CPS) are far more likely to have suffered significant adversity in their own childhoods and adult lives and are more likely to lose custody of further children. The aim of this systematic review was to identify, review and synthesise qualitative studies exploring the experiences of mothers who have lost custody of their child or children following CPS intervention. A 'best-fit' framework synthesis drew upon a conceptual model developed by Broadhurst and Mason (2020), which provided a preliminary framework against which included studies could be compared. Analysis of data broadly supported those themes outlined in the original framework and suggested the need for some expansion to describe the experiences of child custody loss more comprehensively. Fifteen studies were synthesised from which three themes were identified: *Adverse life histories and context of child removal; Immediate psychosocial crisis;* and *Cumulative and enduring consequences.* Results, their clinical implications and avenues for future research are discussed.

Introduction

A growing body of evidence shows that mothers who lose custody of their children following Child Protection Services (CPS) intervention have often experienced significant childhood adversity themselves. For example, in a sample of 354 mothers subject to recurrent court proceedings, 66% had experienced childhood neglect, 67% had experienced emotional abuse, 52% physical abuse, and 53% childhood sexual abuse. A further 54% had some experience of being looked after out of home and were often subject to multiple placement moves (Broadhurst et al, 2017). Adverse childhood experiences such as these impoverish outcomes in later life, leading to a 'clustering of disadvantage' (Bradshaw & Finch, 2003). Despite increasing awareness of the adversity heaped upon this marginalised group, scant attention has been paid to the subsequent impact of custody loss. The aim of this review, therefore, is to synthesise relevant qualitative studies exploring the experiences of mothers who have lost custody of their child/children following CPS intervention. It is hoped that a better understanding of their experiences will identify more clearly their needs following custody loss and contribute to the development of compassionate supports.

The process of losing custody of a child can be long and extremely distressing. Several studies have noted the 'adversarial nature' of court proceedings which can elicit feelings of frustration and shame for birth parents (Mason & Selman, 1997). In studies exploring the experiences of parents involved with CPS, many reported feeling as though they had little power to influence proceedings, that professionals acted on their preconceptions and not always in the best interests of the children, and that they were given little information about what was happening (Drumbill, 2006; Ghaffar et al., 2012). The result is that many parents feel excluded from proceedings and as though they have 'lost ownership' of their stories (Smeeton & Boxhall, 2011, p.5).

This feeling may be further compounded once care proceedings have been concluded as CPS involvement with birth parents ceases. The Adoption and Children Act (2002) in England and Wales, and the Adoption and Children Act (2007) in Scotland state that birth families should be entitled to independent support during and after adoption processes. The National Minimum Standards for Adoption state that birth parents should be "helped to work through their concerns through the counselling they receive" (Department of Education, 2014, p38). Despite these recommendations, there is no duty placed upon the courts to ensure such services are provided.

Indeed, for mothers who have one child removed from their care by CPS, the likelihood of further children being removed increases (Morriss, 2018). This may be due, at least in part, to limited opportunities to address those issues leading to custody loss in the first place. The Children and Families Act (2014) requires cases to be concluded within 26 weeks, meaning mothers have 26 weeks to demonstrate their fitness as parents. With no statutory oversight of the rehabilitation of mothers, be that through drug and alcohol services, psychological therapies or other interventions, they are highly vulnerable to the loss of further children (Broadhurst et al., 2015).

For this and other reasons, in the last decade there has been increasing interest in birth mothers' experiences of CPS proceedings and its aftermath, and an emerging recognition that these mothers require ongoing support to prevent further losses or rehabilitate children back into their care (Cox et al. 2017; Roberts et al., 2018). As birth mothers frequently maintain some ongoing contact with their children through formal contact arrangements, the impact of custody loss for mothers will also have some bearing on the wellbeing of children removed from their care (Neil, 2013). Continued contact with a mother who has had little or no opportunity to address those factors leading to custody loss in the first place may lead to a continuation of harmful relational dynamics, perhaps now compounded by the destabilizing

effects of custody loss, which can be harmful to the child (Moyers et al., 2006; Selwyn, 2004).

Research into the experiences of birth mothers who lose custody of their children has largely focussed on those who have voluntarily relinquished custody. Rynearson's (1982) study reported that eight of 20 mothers interviewed were so distressed by the signing of adoption papers that they could no longer remember it; Condon's (1986) study found that 10 out of 20 women surveyed continued to suffer from disabling grief long after adoption and used alcohol or sedatives to cope; Logan's (1996) study found that 21% of women (n=28) had made attempts on their lives; Kelly's (1999) study found that 63% of women (n=79) reported suicidal ideation; and Crowell's (2007) study showed that 82% of women (n=274) reported suffering from depression, 80% described feeling inadequate, 68% struggled to trust others and 57% reported feelings of anger. Initial grief reactions described by these women appear to be maintained or indeed worsen over time, leading to complicated or 'pathological' grief (Askren & Bloom, 1999; Winkler & van Keppel, 1984; Condon 1986). However, losing a child in this way is rarely accorded the same recognition or validation as other forms of grief, or the loss of children for other, perhaps more socially acceptable, reasons (e.g. death) (Blanton & Deschner, 1990). While the experience of voluntary relinquishment and having a child forcibly removed from one's care are arguably unique and very different, evidence suggests that many women who relinquished care reported doing so under duress, perhaps due to significant pressure from family (Wells, 1994). Thus, there may be some similarities in these experiences.

Mothers who lose custody of their children may experience a kind of 'disenfranchised grief' – a 'grief that is not openly acknowledged, socially accepted or publicly mourned' (Doka, 1989, p. 4). Social constructions of grief dictate what losses one grieves, how one grieves them, who legitimately can grieve, and how to and to whom others respond with

sympathy and support (Doka, 1989). For women who are cast in the role of 'failed mother', as having failed to live up to our cultural idealisations of motherhood as "ever bountiful, ever giving" and "self-sacrificing" (Bassin et al., 1994, p. 2), their grief may not be afforded the same legitimacy, and the mother the same sympathy and support, as mothers who may lose their child under circumstances such as death. The normal grieving process for these women may, therefore, be hampered by internalised guilt and shame, and their isolation from social supports.

Not only might their grief be viewed as illegitimate, but birth mothers' voices are often minimalised or discounted and they may be characterised as deviant, unnatural and wilful in their perpetration of harm against their children (e.g. Allen & Taylor, 2012). These mothers may be publicly shamed and 'othered' due to their parenting supposedly falling too far short of ideals of motherhood. Parker and Aggleton (2003) suggest that stigma is the enactment of social control whereby positions of power can be maintained within an unequal social order. The stigma often ascribed these mothers following custody loss may place the burden of responsibility solely on the individual, the 'failed' mother, forcing her to the margins of society and freeing those in positions of relative advantage from blame.

Social policy, it would seem, continues to cast disadvantaged mothers as personally responsible. For example, the Children's Commissioner (2017, p. 13) referred to 36,000 teenage mothers, in the context of a report on vulnerable children, as "children and young people whose actions put their lives at risk". One possible reading of this is that teenage women who become pregnant are placing themselves at risk through personal choice. In her paper, Morriss (2018) describes the 'Pause' service – a government funded national programme designed to tackle the problem of repeated custody loss. To access this programme women must be fitted with a Long-Acting Reversible Contraceptive (LARC). The success of the project lies in the reduction of births and the subsequent savings to the

taxpayer of fewer children being taken into care. Rather than addressing issues of social inequality and rising child poverty, factors which impact on mothers' abilities to provide for their children and parent effectively (Bywaters et al., 2016; Hooper et al., 2007), the 'problem', Morriss argues, is defined as women, often of low socio-economic status, having children, the 'solution' for which appears to be state control of their reproductive capacities (Morriss, 2018). In seeking to understand the experiences of mothers who have had children removed from their care, it is hoped that policy makers and support providers can move away from narratives which problematise mothers and instead focus on what they might need to recover.

The current study

As mentioned above, women who have children removed from their care following CPS intervention are an under researched population. These women have often experienced a range of childhood adversities leading to poorer outcomes and clustering of disadvantage in later life (Bradshaw & Finch, 2003). Losing custody of one child increases the likelihood of further removals (Morriss, 2018). The negative impact on both mothers and their children can be significant (Broadhurst & Mason, 2020; Neil, 2013). There has been increasing interest in mothers' experiences of child custody loss and recognition that mothers require ongoing support (Cox et al. 2017; Roberts et al., 2018). Broadhurst and Mason (2017; 2020) presented a conceptual framework describing the immediate and enduring consequences of child removal based first on a literature review and subsequently on qualitative interviews with 72 mothers. Using a 'Best Fit' Framework Synthesis, this study seeks to build on this conceptual framework by reviewing and synthesising qualitative studies published to date which explore the experiences of women who have lost custody of children following CPS proceedings. Qualitative research methodologies allow the foregrounding of participant voices, and best practice within health and social care settings increasingly involves 'experts by experience' to

help practitioners better understand the lived experience of service users, leading to greater practitioner sensitivity (Lathlean et al., 2006; Suikkala et al., 2016). This is in keeping with the aims of this study which are to increase understanding of mothers' experiences of child custody loss and to support policy makers and support providers to move away from narratives which problematise custody losing mothers and instead focus on what they need to recover.

Methods

Objective

The purpose of a systematic review is to employ rigorous, transparent and replicable methods of synthesising primary research in order to answer a specific question (Petticrew & Roberts, 2006). This review sought to answer the question: 'What do we know about mothers' experiences of child custody loss following intervention by Child Protection Services?' This review was conducted in accordance with best practice guidance outlined by Popay and colleagues (2006).

The first step in this review was to establish whether the research question was suitable for review and that no other similar reviews had already been conducted. Initially, the research question posed related to both mothers' and fathers' experiences of child custody loss following intervention by child protective services. Following review of all studies returned in this search, the decision was taken to focus on mothers' experiences only. For the sake of complete transparency, a full description of the literature search pertaining to both mothers *and* fathers is described below with further discussion around why the decision was taken to exclude the experiences of fathers from this review.

A search for similar systematic reviews was conducted across multiple databases including the Cochrane Library, Google Scholar, Psych Info, CINAHL, EMBASE, Medline,

ASSIA and Social Care Online. As no other reviews were identified, a review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO: Reference CRD42022304057).

Search strategy

In order to conduct a systematic search of research databases, the SPIDER (sample, phenomenon of interest, design, evaluation, research type) tool was used. This tool was designed specifically for use in the systematic review of qualitative data. The SPIDER tool supports highly specific searches and is recommended for use when the aim of a search is to achieve theoretical saturation, in the context of time and resource constraints, as opposed to returning an exhaustive list of relevant studies (Methley et al., 2014).

The final search terms were defined in collaboration with an experienced librarian. The following text string was applied to MEDLINE, PsychInfo, CINAHL, EMBASE and ASSIA: (parent* OR paternal* OR father* OR dad* OR Mum* OR mother* OR maternal*) AND (Experience* OR account* OR perspective* OR impact*) AND ((remov* OR custod* OR welfare* OR "social service*" OR "child protect*") NEAR/3 (Child* OR infant* OR baby OR babies)) AND (interview* OR qualitativ*). Social Care Online does not utilize the same syntax rules and so an adapted search strategy was applied as follows: (parent OR mother OR maternal OR mum OR dad OR father OR paternal) AND (child OR children OR baby OR babies OR infant OR infants) AND (removal OR removed OR custody OR welfare OR "social services" OR "child protection" OR "child protective") AND (experience OR perspective OR impact OR account OR belief OR feel OR feelings) AND (qualitative OR interview). Searches were performed on November 2nd, 2021.

Eligibility criteria

To be included in the review, research papers were required to meet the following criteria:

1. The study is a published primary research paper. Reviews of studies, books and book chapters were all excluded. Grey literature was excluded due to potential concerns regarding the quality of literature not subject to peer review.
2. The study uses qualitative methodologies such as interviews, focus groups or case studies, either on their own or as part of a mixed methods design. Any studies utilizing survey data or statistical reporting of results were excluded, as well as commentaries and discussions, as these were not thought to address the review question or provide the first-hand perspective which was of interest.
3. The study primarily explores the views, perceptions, accounts or experiences of mothers. Where the views of other relatives, friends or professionals are included they should be clearly attributed and distinguishable from those of mothers.

   * The initial search strategy focussed on studies primarily exploring the views, perceptions, accounts of experiences of both mothers *and* fathers. Following review of studies returned by this search, the focus was further refined to focus on mothers only. This refinement represents the final eligibility criterion to be applied and is represented as the last step in the Preferred Reporting Items for Systematic Reviews (PRISMA) flow chart. See below for further illustration (Figure 1) and discussion.
4. The study is primarily concerned with experiences of child custody loss following the intervention of Child Protection Services where relinquishment is involuntary.
5. Published from 1973 onwards following the establishment of the modern child protection system in the UK, which preceded similar legislative developments across western nations (Parton, 2014).

6. All studies were required to be published in the English language due to the limited resources available for this review and the relative resource burden of translation.

Screening

Database searches returned a total of 5,325 studies. Once duplicates were removed (N = 1686) studies were imported to Covidence reference management software (https://www.covidence.org/home). Studies were screened in a series of stages as outlined in the PRISMA protocol shown in Figure 1. Study titles and abstracts were compared against eligibility criteria. Where there was any ambiguity, studies were subject to full text review. It has been previously noted that the effectiveness of search strategies for qualitative literature can be hampered by variability in the quality of indexing of studies (Dixon-Woods et al., 2006). To reduce the risk of potential omission of relevant studies, forward citation searches were conducted on all papers returned by the search protocol meeting eligibility criteria as well as hand searching of references.

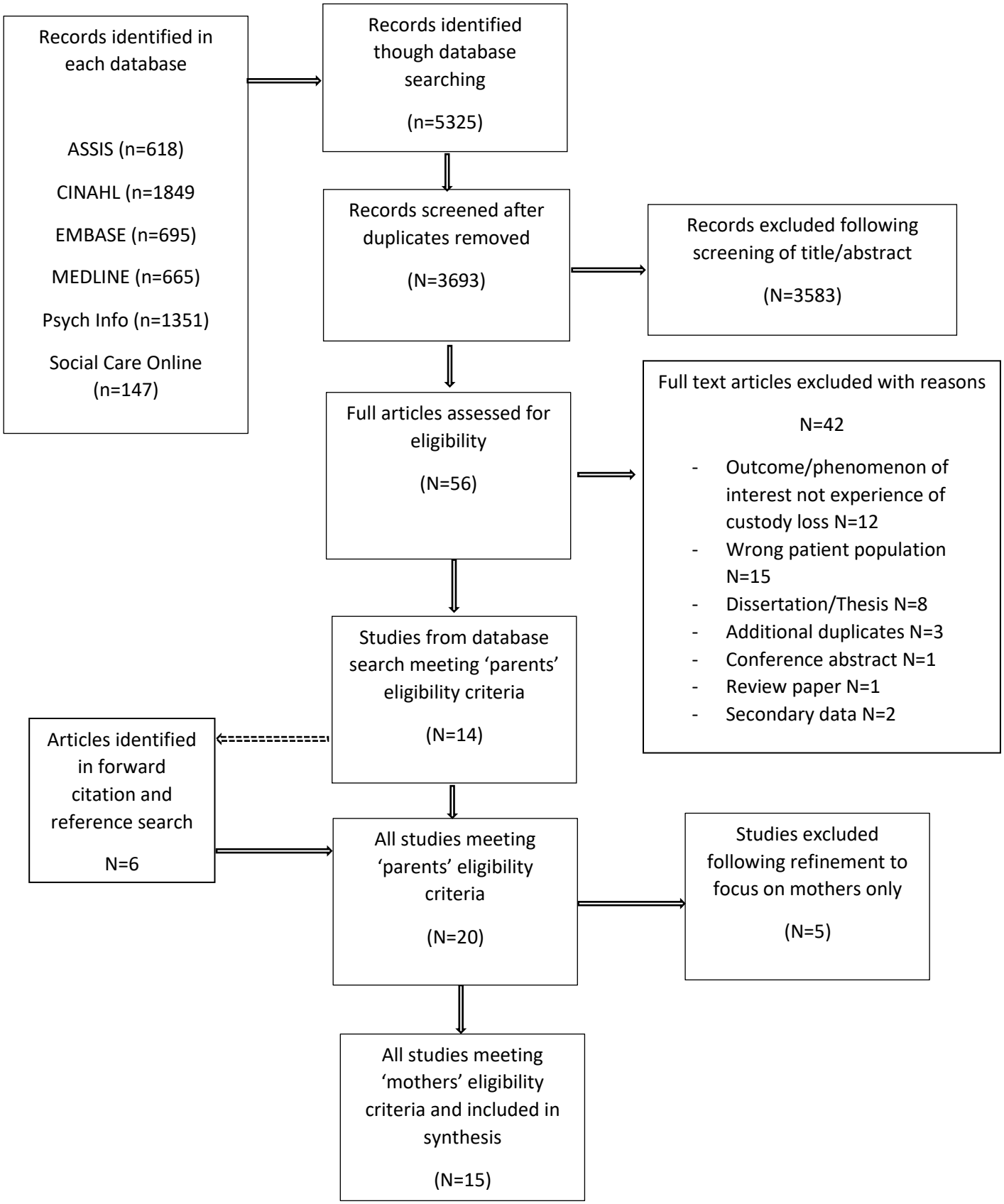
Exclusion of fathers

As mentioned above, the search conducted and detailed in Figure 1 initially included the experiences of both mothers and fathers. This search returned a total of 20 eligible studies. Following review of these papers, the decision was made to refine the focus of this review to mothers' experiences only, resulting in the exclusion of five studies. The researcher acknowledges the underrepresentation of fathers in child welfare literature, which reflects a pervasive tendency among child protection services to overlook the contributions and involvement of fathers in welfare-involved families (Cameron et al., 2012; English et al., 2009; Dubowitz et al., 2006). By excluding experiences of fathers from this review, the

researcher risks reinforcing this bias. However, two papers purporting to represent the views of both mothers and fathers failed to report how many fathers were included in their samples (Schofield et al., 2010; Zeman, 2004). Four others were heavily skewed towards representing the views of mothers (Newton, 2020; Srystad & Slettebo, 2019; Lewis & Brady, 2018; Otterlei & Engerbresten, 2021). Indeed, one paper included the perspective of one father but for ethical reasons gave him a female pseudonym and so it was not possible to differentiate between mothers' and father perspectives (Srystad & Slettebo, 2019). Only three studies focussed exclusively on the experiences of fathers (Baum & Negbi, 2013; Clifton, 2012; Warria, 2021). Had the review presented a synthesis of 'parents' experiences, based upon a sample predominantly comprised of mothers, it risked misrepresenting the experiences of fathers and omitting important differences between the two parent groups. For example, in Otterlei and Engebresten (2021) the authors note that while both mothers and fathers who lose custody report shame and embarrassment, for mothers this is linked to a specific kind of social stigma related to gendered expectations of parenting. Both mothers and fathers would be better served by separate review, though more primary research in respect of fathers' experiences would be required in the first instance.

Figure 1

PRISMA flow chart



Critical Appraisal

Quality assessment

In this review, studies were assessed for quality using the Critical Appraisal Skills Programme (CASP) tool (CASP, 2018). The CASP tool is a 10-item checklist which assists the reviewer to appraise the validity of results, the results themselves and how helpful the results are in a local context. The contribution of qualitative methods in the field health research is increasing, with a corresponding rise in efforts critically appraise its quality (Mays & Pope, 2000). However, there is no single framework and little consensus over how qualitative research should be reported (Tong et al., 2007), and debate continues as to how concepts such as validity and reliability can be applied and assessed (Hannes, 2011). As a result, there now exists multiple checklists for critically appraising qualitative research. Despite the lack of unifying approach, critical appraisal is important to ensure the findings of this synthesis are reliable and not distorted by the inclusion of poor-quality research (Dixon-Woods et al., 2004).

Rigour

All studies were independently rated by the lead researcher and a second reviewer to improve accuracy of ratings (Soilemezi & Linceviciute, 2018). Both raters employed the CASP checklist, results compared, and discrepancies resolved following discussion.

'Best Fit' Framework Synthesis

Framework synthesis is a pragmatic and blended approach to qualitive synthesis, drawing on both descriptive and interpretive methods, following a clearly articulated protocol (Carroll et al., 2011). It is primarily derived from framework analysis, a method for synthesising qualitative material in social policy research (Pope et al., 2000; Ritchie & Spencer, 2002). In this original context, demand for output is high and time limited. Framework synthesis

provides a highly structured yet flexible approach with a high degree of methodological transparency, which makes it clear to policy makers and practitioners how findings are obtained (Ritchie & Spencer, 2002; Barnett-Page & Thomas, 2009).

In framework synthesis, theories or conceptual models are identified prior to data analysis which form an a priori framework of themes against which data from included studies are coded. Typically, the researcher is required to develop their own framework, drawing on a range of sources. This process can be time and labour intensive (Carroll et al., 2011). Carroll and colleagues suggest a pragmatic alternative – the 'best fit' approach. Here, a single pre-existing related and relevant theory or conceptual model can be used to create the a priori framework of themes. Themes need not provide an exact match, but only a 'best fit' of the data being reviewed. In this way, themes are acting as a scaffold against which a framework can be tested, reinforced, and built upon (Carroll et al., 2011). Data that cannot be mapped against the framework is subject to further thematic analysis and newly derived themes incorporated into an expanded framework (Booth & Carroll, 2015).

'Best fit' framework synthesis was selected as the most appropriate means by which to analyse data in the current review following initial familiarisation with the pertinent literature and identification of a pre-existing conceptual framework. This conceptual framework sought to describe the immediate and enduring collateral consequences of court ordered child removal for custody losing parents (Broadhurst & Mason, 2017), an aim which was closely aligned with the aims of the current study. Using this method provided an opportunity to test whether this pre-existing framework was based on good quality empirical evidence and could be supported by the broader field of research (Booth et al., 2016), and given the time constraints on the current study, offered a pragmatic, methodologically rigorous alternative to a more time-consuming thematic analysis. See below under section

headed 'Data Synthesis' for further information on the conceptual framework utilised in the current study.

Epistemological Stance and Reflexivity

This review is interested in how individuals make sense of and describe their experiences and therefore aligns with a constructivist perspective. This perspective assumes that reality is subjective at the level of the individual, and how we understand and describe these experiences is socially constructed (Rogoff, 1990; Ernest, 1998). The researcher acknowledges that this applies to individual participant narratives, to each included study, and to the current review itself. Each involves some level of subjective interpretation – of experience or of data - and is therefore influenced by the context and time within which they were produced.

To ensure transparency in this review, the researcher critically considered factors influencing subjectivity throughout the research process. The purpose of such reflexive endeavour is not to eradicate possible influences, but rather to acknowledge and account for them, and provide context for the reader (Mays & Pope, 2000). To that end, the researcher identifies as a white, Scottish female of childbearing age with no children of their own. The researcher was a Trainee Clinical Psychologist with a special interest in working with Looked After and Accommodated Children and Young People derived from personal experience of being the child of a care experienced mother, and of working previously with young people ageing out of local authority care. They were also simultaneously conducting qualitative research exploring the experiences of motherhood and mental health for care experienced mothers. These experiences and interests generate points of proximity and distance between the research and the researched, which likely influenced how the data was synthesised in terms of themes identified as being of primary importance, the degree to which emphasis is

placed on the perceived harms perpetrated by CPS and of understanding the mothers' historical and current contexts.

Results

Study Characteristics

Fifteen studies fulfilled inclusion criteria for this review and are summarised in Table 1. All explored the experience, impact, or consequences of child custody loss. Ten studies explored the views of mothers only, four included the views of fathers, and one included the views of midwives and social workers. Studies reporting multiple perspectives were included only where mothers' perspectives were clearly distinguishable. Recruitment was largely purposive (n=13), through child protection services, voluntary agencies, support groups, and through social media advertising. Both Kenny et al. (2015) and Kenny et al. (2021) used a theoretical sampling approach.

All fifteen studies used participant interviews as their primary means of data collection, with Syrstad & Slettebo (2020) also utilising focus groups. Studies were based in UK (n=5), Canada (n=4), Australia (n=3), Norway (n=2) and the USA (n=1). The total sample size of mothers across included studies was 206.

Table 1.

Summary of included studies

	Author/ Year/ Citation	Location	Aim of Research	Sample	Methods and Analysis	Qualitative findings	Themes (**bold** denotes superordinate theme)
1	Bell et al., (2020)	UK	Obtain viewpoints of birth mothers about the value to a pilot intervention for supporting birth mothers and families following removal of a child	N = 10 (mothers) Experience of successive losses	Semi – structured interviews Voice centred relational method of analysis	Findings are presented as three 'example narratives' and suggest mothers felt let down by CPS systems wanted better communication, more respectful treatment, more support for both mothers and fathers, and felt abandoned after the removal of their child.	No themes explicitly labelled but the following idea were discussed within the text: - Relationships with fathers as crucial - Ambivalent relationships with professionals - Negotiating/ navigating life experiences and the professional 'system' - Positive independence - Asking for better communication - Reasons for interventions - The role of external forces - Complex structural/social issues - Grief and bereavement

2	Broadhurst & Mason (2020)	UK	To investigate the short and long term consequences of child removal from birth mothers' point of view.	n = 72 (mothers) Experienced two or more sets of care proceedings, or one previous experience of care proceedings and ongoing care proceedings for unborn child Ethnicity: - White – 62 - Black – 5 - Other - 5 Adulthood Experiences: - Domestic abuse – 63 - Mental health – 60 - Substance misuse – 43 - Lack of support network – 35 - Transience - 25 Childhood experiences: - Looked after – 33 - Domestic abuse – 32 - Significant loss – 40 - Physical abuse – 43 - Sexual abuse – 34 Age at first birth: - Under 16 – 9 - 16-19 – 48 - 20-25 – 13 - Over 25 – 2	Interviews with mothers Phenomenological analysis	Findings suggest that mothers experience a period of intense and immediate distress after child removal, and that over time their distress is compounded by the stigma they experience in various spheres of life, the loss of their role and identity as a 'mother' and loss welfare entitlements	**Immediate Psychosocial Crisis** - *No subthemes* **Cumulative and Enduring Collateral Consequences of Child Removal** - Role loss – In the context of fragile and restricted social statuses - Restrictions on intimate partner relationships and distorted family roles compound role loss - Social stigma and isolation within informal networks – Sheer isolation - Stigmatised identities and professional service use - Restrictions in welfare entitlements – Home and housing loss

3	Honey et al., (2018)	Australia	To investigate how mothers with severe mental illness experience mothering after the removal of their children by CPS	N = 8 (mothers) Children removed 1-3 Children restored 0-3 Age of children at removal birth – 12 years Time since removal 1 – 17 years	Narrative style semi-structured interviews Interpretative Phenomenological Analysis	Findings suggest mothers continue to view the role of 'mother' as the main focus of their lives, though acts of mothering were significantly changed. The way mothers could enact this role was limited by the demands of CPS, courts etc. What is expected of mothers is difficult to understand and doesn't often make sense to them.	**Constrained mothering** - Mothering continued - Mothering differently - Mothering constrained by external agents - External agents flawed and unpredictable
4	Janzen & Melrose (2016)	Canada	Exploring the grief of four crack cocaine recovering mothers who lost custody of their children.	N = 4 (mothers) Crack cocaine addiction Age 18-30 All reported coexisting mental health disorders, history of abuse and interpersonal violence -	Semi-structured interviews IPA	Findings suggest mothers felt a sense of betrayal and profound distress immediately after custody loss and often used substances to cope. Religion, residential recovery centre and hope of eventual reunification with children helped women reclaim their lives.	- Betrayal - Soul ache - Reclamation
5	Kenny et al., (2015)	Toronto, Canada	This study sought to explore the impact of child custody loss on drug using mothers, as well as assessing the potential	n = 19 (mothers) Self-identified as using illicit drugs in previous 6 months and who had lost custody of one or more children Age 18-62 years (median 39)	Thematic narrative analysis	Findings describe the traumatic experience of child removal, profound suffering in the immediate aftermath, attempts to block out or 'forget' loss of a child, the importance of remembering the lost child and mothers' attempts to survive.	**Trauma** - Separation - Suffering - Forgetting and remembrance - Survival

			impact of intersectional forms of violence and power inequalities that can both lead to child custody loss and mediate its consequences.	In receipt of government social assistance – 95% Homeless – 3 Ethnicity: - White – 11 - Black or Indigenous – 8 Childhood experiences: Looked after – 5 Drug predominantly used in previous 6 months: - Crack cocaine – 8 - Cannabis – 6 - Opioids – 6 - *with additional alcohol use – 5			
6	Kenny et al., (2021)	Canada	Exploring physical and mental health consequences of child removal for sex workers	N = 31 (mothers) Ethnicity: - Indigenous – 19 - Non-indigenous – 12 Age 27-56 years Termination of parental rights – 27 All reported living in poverty	Semi-structured interviews Thematic analysis	This study identified four trajectories through which events of child removal influenced women's health. Severe mental distress immediately followed child custody loss, with women often turning to substances as a means of coping. Increased poverty was often described involving housing loss and reliance on sex work for income. Both self and other imposed isolation due to	- Severe mental distress - Poverty - Social isolations and displacement - Caretaking and family regeneration

				Almost half reported unsuitable housing		shame and stigma cut women off from support networks. Connections with children and working towards reunification remained important, and acted as a protective factor for women.	
7	Lewis& Brady (2018)	England, UK	Exploring birth parents' accounts of inequality in adoption (from care)	N = 14 (12 mothers and 2 fathers)	Interviews with life history approach Thematic analysis	Findings suggest that parents experienced a range of adversities prior to the removal and adoption of their children, that these were often exacerbated by the loss of their children and endured over time. Parents struggled to access or make use of support.	**Parental Adversity** - Parenting under adversity: Before child(ren's) removal - Parenting under scrutiny: adversity post removal - Adversity addressed - Parenting after adoption: adversity continued - Parenting after adoption: adversity overcome
8	Marsh et al., (2019)	Australia	Study childbearing women's and professionals' experiences of assumption of care at birth (AoC) – how to the make sense of meanings and how did this	N = 3 (mothers) N = 7 (midwives) N = 5 (social workers) N = 5 (case managers from Department of Family and Community Services (FACS))	Interviews Narrative inquiry/ holistic form	This study described the intergenerational influences leading to AoC and psychosocial risk factors, lack of continuity of care for mothers and poor communication from FACS. It describes the distress of AoC, compounded by the need for postnatal care and physical changes in the body, feelings of guilt and shame, mothers' sense of the enduring power of	- The 'prelude': life before custody loss - The 'focal point': the Assumption of Care, living the experience - The' Coda': life after custody loss

			frame their lives.			FACS, and mothers repeat pregnancies and attempts to 'do better'.	
9	Memarnia et al., (2015)	England, UK	Aimed to explore separation, sense of identity and experience of contact and support during process of custody loss.	n = 7 (mothers) Ages 23-35 yrs Ethnicity: - White British – 6 - Asian – 1 Time since child removal 1-6yrs	Semi-structured interview Interpretative Phenomenological Analysis	Findings suggest that the mothers in this study felt a sense of isolation both before and after child custody loss, and that there was no one there to help them manage the difficulties that led to custody loss. Mothers described attempts to block out painful emotions. Mothers struggled to make sense of their identity as mothers living apart from their children, compounded by sporadic and infrequent contact with children.	- No one in my corner - Disconnecting from emotion - Renegotiating identity - Children are gone but still here
10	Newton (2020)	Australia	Exploring the experiences of Aboriginal Australian parents who have their children removed by CPS.	N = 7 (1 father, 6 mothers) Number of children removed 1-6 Number of children restored 0-6 Reasons for removal: Substance misuse – 6 Domestic violence – 3 Neglect – 5 Incarcerated parent – 4 families Parents in employment at time of interviews – 1	Interviews Thematic analysis	Findings suggest that parents experience a sense of powerlessness in the face of CPS interventions. Parents described feeling judged, vulnerable and unable to ask for help, which further compounded those difficulties which ultimately resulted in custody loss.	- Overview of families and circumstances - Circumstances leading to removal - Feelings of powerlessness following child removal - Impact of removal on attachment - Aboriginal specific issues

				Living in public housing – 4 (3 families)			
11	Nixon et al., (2012)	Canada	Explore the impact of child protective services on mothers because of concerns of domestic abuse	N = 9 (mothers) Ethnicity: - Caucasian – 7 - Aboriginal – 2 Age 21-43 years Marital status: - Married – 1 - Divorced – 1 - Separated – 2 - Common law relationships – 3 - Dating – 2 Number of children 1-5 Status of children: - At home with CPS involvement - 1 - Removed from home – 7 Time since children removed 1-8 months	Semi-structured interviews Grounded Theory	This study found that child custody loss for mothers who have experienced intimate partner violence can be experiences as both ambiguous and traumatic, with significant physical and mental heath impact, and that loss of the 'mother' role also meant the loss of their identity as a mother.	- Nature of the women's abuse by intimate partners - Women's involvement with CPS - Women's experiences with grief and loss when CPS removed their children - Loss of mothering rights and responsibilities - Loss of mothering identity - Health effects
12	Otterlei & Engebresten (2021)	Norway	Exploring how parents negotiate	N = 13 (10 mothers, 3 fathers) Removal more than 2 years ago	Semi-structured interviews	Findings suggest that participants experience child removal has stigmatising and	**Parents at war** - Facing a powerful system

			their loss after experiencing child removal by child welfare services (CWS)	31 children removed (2 returned home)	Analysed using principles of discursive analysis and positioning theory	their treatment by CPS dehumanising. Participants attempted to resist the label of failed parent by positioning themselves in opposition to CPS.	- Resisting fallible labels - Renegotiating the blame **Threatened identities** - The impact of loss - The impact of stigma - Valuing abnormal parental positions
13	Richardson & Brammer (2020)	UK	Exploring outcomes and experiences of mothers of children removed under a care order, with a focus on relationships with their own mothers	N = 9 (mothers) Ages 19-25 years Children aged 3 months – 14yrs 32 children in total 6 mothers were care experienced	Free association narrative interviews	Women describe their relationships with their own mothers, their childhood experiences and being taken into care, the impact this has had on their own mothering capacity and subsequently their own children. Women describe re-experiencing childhood experiences such as domestic abuse, substance misuse and mental health difficulties.	- Harm, Welfare and unreasonable parental care: an intersubjective approach to harm? - The way ahead: mother and child; Becoming reconciled with harmful experiences - The test of reasonable parental care
14	Syrstad & Slettebo (2019)	Norway	Exploring the challenges parents face when they lose care of their children and their experiences of family counselling as	N = 6 (5 mothers, 1 father) Ages 27-49 Time since child placed in care 1-8 years All parents dependent on social security Education:	Focus groups and semi-structured interviews Thematic analysis	Findings suggest that participants struggled to understand why their children were taken into care. They described feeling disempowered, under constant evaluation and unable to ask CPS for explanations. They described trying to appease CPS. The described feeling	- The struggle to understand why their children are placed in care - There is no point trying to go against the system - You are not a failure

			a support service in Norway	- Secondary school – 3 - High school – 3 Number of parents reunified with children – 1 Number of home owners - 1		judged as a failed parent by CPS, but as a person of value by the family counselling service (FCS).	
15	Wells (2011)	USA	This study aimed to illustrate how existing theoretical concepts might increase understanding of maternal identity in mothers who lose and regain custody of their children	n = 1 (mother) - African American - Single mother - Three children - 55 years old - Reunified with children 7 years previously - Substance misuse - Poverty - Homelessness Criminal Justice involvement	Semi-structured interview Structural narrative analysis	Describes custody loss and regain for one mother, how she constructed her identity as 'mother' in ways which reflect prevailing cultural ideals of motherhood, yet accommodate her failure to conform to these same ideals.	- 'Steadily moving' - 'Feeling lost' - 'Trying and Failing' - 'You going to do this' - 'Returning home' -

Quality Assessment

As the CASP tool does not propose its own scoring system (CASP, 2018), studies were assigned a global rating for quality based on a scoring system described by Cesario and colleagues (2001). For each criterion a score of 0-3 was given where 0 is 'not applicable/reported', 1 is 'poorly addressed', 2 is 'adequately addressed' and 3 is 'well addressed'. In addition, studies were given a total score out of a possible 30. A designation of QI indicates that 75% to 100% of criteria were met (global score of 22.5-30) and the study is of high quality; QII indicates that 50-74% of criteria were met (global score of 15-22.4) and the study is of adequate quality; and QIII indicates that less than 50% of criteria were met (global score of less than 15) and the study is of poor quality. See Table 2 for CASP ratings and quality designations.

All quality criteria on the CASP tool were independently rated by two raters. As data were ordinal, level of agreement between raters was calculated using Cohen's Weighted Kappa (k). Data were analysed using IBM SPSS Statistics (Version 24) predictive analytic software. An overall k value of 0.694 ($p<.000$) indicated a moderate level of agreement (McHugh, 2012). Interrater reliability was calculated for each study and Cohen's Weighted Kappa scores are provided in Table 2.

Six of the studies received a global quality rating of "high", while the remaining nine received a global quality rating of "adequate". No studies were rated as "poor", and no studies were excluded from subsequent analysis based on quality. For those studies rated as "high" quality, strengths included a clear rationale for method of data collection, for example, why semi-structured interviews selected over focus groups. High quality studies offered some critical reflection on the role of the researcher and their potential influence on data collection and analysis, and sufficient detail regarding ethical practice and participant welfare.

Conversely, for those studies rated as "adequate" quality, the aforementioned factors tended to be poorly reported or omitted altogether. Notably, six of the fifteen studies failed to provide any reflexive statement, meaning the reader cannot know what researcher factors may have influenced how data was collected or analysed.

Table 2.

Quality ratings table

	Study (Author/year)	**Quality Criteria**										**Total**	**Global Rating**	**K values***
		1	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10***			
1	*Bell et al., (2020)*	*1*	*3*	***1***	*2*	***1***	*1*	*2*	*1*	*1*	*2*	*15*	*QII*	*.744 (p<.001)*
2	*Broadhurst & Mason (2020)*	*3*	*3*	***2***	*3*	*3*	***1***	*3*	*3*	*3*	*3*	*27*	*QI*	*.444 (p<.035)*
3	*Honey et al., (2018)*	***3***	*3*	*3*	*2*	*3*	*1*	*2*	***2***	*3*	*3*	*25*	*QI*	*.697 (p<.007)*
4	*Janzen & Melrose (2016)*	***2***	*3*	*1*	*1*	***1***	*0*	*1*	*2*	*2*	*3*	*16*	*QII*	*.811 (p<.000)*
5	*Kenny et al., (2015)*	*3*	*3*	*3*	***2***	*2*	***1***	*1*	*2*	***2***	*2*	*21*	*QII*	*.674 (p<.001)*
6	*Kenny et al., (2021)*	***2***	*3*	*1*	*2*	*2*	***1***	***1***	*3*	*3*	***3***	*21*	*QII*	*.583 (p<.008)*
7	*Lewis& Brady (2018)*	*3*	*3*	***2***	*2*	***3***	*2*	*3*	*2*	*3*	*2*	*25*	*QI*	*.615 (p<0.35)*
8	*Marsh et al., (2019)*	*3*	*3*	*3*	*3*	*2*	*0*	***2***	*2*	*2*	*2*	*22*	*QII*	*.891 (p<.000)*
9	*Memarnia et al., (2015)*	*3*	*3*	*2*	*1*	*2*	*0*	*0*	*1*	*2*	*2*	*16*	*QII*	*1 (p<.000)*
10	*Newton (2020)*	*3*	*3*	*2*	***3***	*2*	*0*	***2***	*2*	*2*	*2*	*21*	*QII*	*.744 (p<.001)*
11	Nixon et al., (2012)	3	3	2	2	2	0	3	2	3	3	23	QI	*1 (p<.000)*

12	Otterlei & Engebresten (2021)	3	3	3	2	**2**	1	3	2	3	**2**	24	QI	.773 (p<.001)
13	Richardson & Brammer (2020)	2	3	2	2	**2**	**1**	**2**	**2**	**2**	2	20	QII	.216 (p<0.98)
14	Syrstad & Slettebo (2019)	3	3	3	2	3	**2**	2	**3**	3	2	26	QI	.571 (p<010)
15	Wells (2011)	2	3	3	**0**	3	**0**	1	2	**1**	2	17	QII	.444 (p<.008)

Note. Scores highlighted in bold indicate disagreement between raters. The scores reported above were agreed upon following discussion between raters.

* Kappa values: 0-.20 = None; .21-.39 = Minimal; .40-.59 = Weak; .60-.79 = Moderate; .80-.90 = Strong; Above .90 = Almost Perfect (McHugh, 2012)

Data Synthesis

As outlined above in the description of 'best fit' framework synthesis, the initial theoretical or conceptual framework must be relevant and related to the review topic, though need not be an exact match (Carroll et al., 2011). In paper 2 (Broadhurst & Mason, 2020) the authors present amendments to their own original conceptual framework which described collateral consequences of court ordered child removal for birth parents (Broadhurst & Mason, 2017). In their revised framework, the authors introduce a temporal element, differentiating between acute and long terms consequences of child removal, and focus solely on mothers.

The revised conceptual framework presents the consequences of child removal across two phases: an acute phase typified by immediate and overwhelming distress; and the cumulative and enduring consequences experienced over time. Superordinate and subordinate themes from this paper, which together describe Broadhurst and Mason's conceptual

framework, were 'deconstituted' into the table below (Table 3). This provided the a priori framework against which data from the remaining primary studies could be coded.

Table 3.

Broadhurst & Mason's (2020) conceptual framework

Superordinate themes	**Sub-themes**
Immediate psychosocial crisis	*No subthemes*
Cumulative and enduring consequences	Role loss – In the context of fragile and restricted social statuses
	Restrictions on intimate partner relationships and distorted family roles compound role loss
	Social stigma and isolation within informal networks – Sheer isolation Stigmatised identities and professional service use
	Restrictions in welfare entitlements – Home and housing loss

Data was defined as verbatim quotes from study participants and author summaries where findings could be clearly attributable to a participant or where there was an indication of prevalence of a concept (e.g. 80% of participants reported…). Data were extracted from 'Results' sections with the exception of Paper 1 (Bell et al., 2020) where the majority of participant quotes and exploration of possible themes were to be found in the 'Discussion' section, and Paper 13 (Richardson & Brammer, 2020) which did not clearly delineate between methods, results and discussion. Otherwise, data from 'Discussion' and 'Conclusion' sections were excluded from the extraction process as they were assumed to

focus on interpretation of previously presented findings (Carroll et al., 2011). Themes presented in the included studies were set aside and data analysed on a line-by-line basis using coding software Nvivo (QSR, 2014). Units of meaning, as defined by Burnard (1994) were coded against the six themes identified by the a priori framework. Data not adequately accounted for by these themes were subject to secondary thematic analysis, leading to the generation of novel themes (Braun & Clarke, 2006). Where large quantities of data were coded against a single a priori theme, secondary thematic analysis was again conducted to determine whether data could be better represented by multiple themes. The final result was an amended and expanded framework, represented in Table 4.

Themes derived from Framework Synthesis

When coding against the original framework, the superordinate theme *'Immediate psychosocial crisis'* attracted significantly more units of data than any other theme. To test whether this continued to represent a standalone theme or whether there was additional nuance within the data, it was subject to further thematic analysis. This identified two subthemes: *'Felt impact'* and *'Coping and its consequences'.* The differentiation here is between the overwhelming distress generated by custody loss, what mothers did to cope with their distress and the often very damaging consequences of their coping strategies.

The original subtheme *'Role loss – in the context of fragile and restricted social statuses'* also attracted a large proportion of the data and was subject to further thematic analysis. This identified two further themes: *'Renegotiating mothering roles and identities'* and *'Adverse life histories in context of child removal'.* The first theme reflects activities associated with the role of mother, and how women see themselves in relation to children no longer in their care. This was maintained as a subtheme within the original superordinate theme *'Cumulative and enduring consequences'.* The second theme was positioned as a new

superordinate theme, preceding the second superordinate theme of *'Immediate psychosocial crisis'* to maintain the temporal structure of the original Broadhurst and Mason (2020) framework. The original framework presents the experiences of child custody loss following CPS intervention as unfolding over time. This was supported by data from the included studies, with mothers often differentiating between preceding, short-term and long-term experiences. While the majority of included studies, as well as the Broadhurst and Mason (2020) framework, presented life histories preceding custody loss in terms of sample characteristics as opposed to explicit themes, women's narratives often portrayed historical context as inseparable from the circumstances of child removal, and reflection on personal histories often featured in mothers' attempts to make sense of custody loss. From a constructionist perspective, these social, economic and cultural histories provide vital context within which these women understand and describe their experiences, hence the repositioning of this new superordinate theme at the beginning of the revised model.

From data that did not fit the original framework, three novel subthemes were identified. All were assigned to the superordinate theme *'Cumulative and enduring consequences'.* The first, labelled *'Facing powerful systems'* reflects mothers' interactions with professional services and, often, child protective services. The original theme *'Restrictions in welfare entitlements – Home and housing loss'* was supported by only three studies. However, such penalties could be viewed as enactments of institutional power over mothers and therefore is subsumed within the novel theme of *'Facing powerful systems'*. The novel theme *'Renegotiating accountability'* reflects movement within mothers' narratives between positions of self-blame, blaming services and a tricky middle ground where mothers reflected on what could have been done differently to achieve a different outcome. The final novel theme *'Finding healing and meaning'* represents mothers' stories of resilience and, if not exactly recovery, how they made room for their grief and loss and found meaning in their

lives. The researcher had considered making this final subtheme a superordinate theme, in part because it is not entirely a consequence of child custody loss, but also to maintain the linearity of the original framework. The risk in positioning this theme prominently as a final superordinate theme in a linear model is that finding healing and meaning is assumed to be an inevitable next step in the narrative of child custody loss. This was palpably not the case for several mothers who spoke of severe and enduring consequence stretching decades beyond the loss of their child.

The original themes *'Social stigma and isolation within informal networks – Sheer isolation'*, *'Stigmatised identities and professional service use'*, and *'Restrictions on intimate partner relationships and distorted family roles compound role loss'* were relabelled more simply as *'Social stigma'*, *'Institutional stigma'*, *and 'Restrictions, change and loss within interpersonal relationships'* respectively to improve the immediate readability of the amended framework.

Table 4.

Updated framework

Superordinate themes	**Sub-themes**
****Adverse life histories and context of child removal***	
Immediate psychosocial crisis	**Felt impact* **Coping and its consequences*
Cumulative and enduring consequences	Role loss – In the context of fragile and restricted social statuses **Renegotiating mothering roles and identities* Restrictions on intimate partner relationships and distorted family roles compound role loss **Restrictions, change and loss within interpersonal relationships* Social stigma and isolation within informal networks – Sheer isolation

	**Stigmatised identities and professional service use*
	**Institutional stigma*
	**Facing Powerful Systems*
	+ Restrictions in welfare entitlements – Home and housing loss
	**Renegotiating Accountability*
	**Finding Healing and Meaning*

* Denotes novel theme or relabelled original theme

Superordinate theme: Adverse life histories and context of child removal

Broadhurst and Mason (2020) described the 'fragile and restricted social statuses' of women in their study and noted how this both limited their access to protective resources and shaped their experience of custody loss. They discussed this more specifically in the context of role loss, suggesting that for women whose lives have been marked by multiple adversities – physical and sexual abuse in childhood, experience of care, poverty, domestic abuse, substance misuse, mental health issues - the loss of a positive identity left them with nothing and nowhere to turn. Elevating this aspect of women's narratives to a superordinate theme reflects the prevalence of such histories across studies, their far-reaching impact, and the importance of locating women's experience of custody loss within these contexts.

> I was a ward of the state because my mum was an alcoholic and drunk all the time. Alcohol was always around and even as young teenagers we drank and the drinking just never stopped. Mum drank so we did too. My siblings still do and now they're alcoholics. . . I had no support from my daughter's father. It was like I was a single mum. I drank while I was pregnant and the father of my baby did too. All my family

> drank and we were often drunk together. I knew I had a problem, but so did all my family. When I'm drinking, my record is very bad. (Marsh et al., 2018, p4)

> I got adopted at the age of nine and I had 22 episodes of care before then . . . My biological mother committed suicide when she was 31. My mum suffered a lot of mental health issues. Her dad killed her mum and she was adopted by my nan. My mum suffered amnesia and she drank an awful lot . . . However we have dealt with that over the last couple of years with the keyworkers from the voluntary agency. For many years I have been on complete self-destruct because of that . . . I would like to have thought, growing up, I would have treated my children differently, but actually it's hard when you don't know what different is. I could not do it; I did not know how to do it. (Richardson & Brammer, 2020, p365)

These two excerpts demonstrate that, for many women, the adversity they faced in childhood is both profound and inextricably linked to losing custody of their own children. Behaviours that place children at risk of harm, such as alcohol use, can be so prevalent within families of origin that they can become normalised. Even when women recognise that they do not wish to recreate their own childhood experiences, in the absence of alternative models of parenting the task is extremely difficult.

Superordinate theme: Immediate psychosocial crisis

Broadhurst and Mason (2020) reported that *all* mothers participating in their study described immediate and acute devastation following child custody loss, often leading to exacerbation of pre-existing difficulties, such as mental health difficulties and substance use, and increased vulnerability. This was supported by data from included studies. Originally presented as a

stand-alone superordinate theme, analysis of the data from included studies supported division into two subthemes differentiating between the emotional impact of custody loss and attempts to manage distress.

Subordinate theme: Felt impact

Women commonly reported feelings of grief, sadness and shame of such overwhelming intensity that they thought of ending, or tried to end, their lives. The loss of their children was magnified by the accompanying loss of routines associated with childcare which provided structure to women's days, the loss of their role and identity of 'mother', and often frantic concern for the welfare of their children now in care.

> I went insane. I broke down, nearly died. I couldn't stay in my house. I couldn't be around their clothes . . . I found myself just wandering around looking for them. Even though, you know, they are not there. It's just— it's traumatizing. It's awful. [sobbing] . . . It's as if the three of them died. One day just died. That's the grief that I went through. That's the pain that I went through. But meanwhile they didn't [die]. Somebody's got them. Somebody's keeping them from me . . . So I had to go back to the women's shelter. If I wasn't at the women's shelter, I would have been at the psych. ward because I couldn't deal with it. It was too much. (Nixon et al., 2013, p180)

Few women across included studies used diagnostic labels to describe their distress. The excerpt above is unusual in that the narrator explicitly labels her experience as traumatic. Many mothers' accounts described symptoms indicative of trauma such as hyperarousal, hypervigilance for, and avoidance of, reminders of their loss which often triggered extreme distress (e.g. being in the home the home they shared with their child before they were removed), as well as states of dissociation and derealisation.

Several women described the apprehension of their child as like, or indeed worse than, a death.

> Like especially when I lost my first son, like he passed away when he was a month old in my arms. That's all I could think and it was worse than my son passing away because at least I knew he was gone. Knowing Jason was out there and I couldn't be with him was horrible [crying] Sorry . . . (Janzen & Melrose, 2016, p243)

> It is very like taboo ...I strongly feel that it is sorrow you are not allowed to have ... You have been a shit parent, so ... you do not have any right to grieve or to hurt. (Otterlei & Engerbresten, 2021, p11)

The second excerpt articulates the experience of 'disenfranchised grief' (Doka, 1989). Child custody loss is not afforded the same legitimacy and recognition as bereavement, and so women must negotiate their grief in the absence of the usual customs and rituals of death, such as a funeral and other culturally defined practices (Bertz & Thorngren, 2006).

Subordinate theme: Coping and its consequences

Almost universally women reported attempts to numb or avoid their pain through substance use. Some engaged in deliberate self-harm or made attempts on their lives. Women also reported entry or re-entry into sex work, returning to violent ex-partners, and avoiding physical reminders of their loss.

> The increase of using by myself. The increase of drug use. I would never double check whether if it really was that or this or that, I would just do it. You know because, oh there, that pain's surfacing. I need to do it now. So yeah there was lot of risk. (Kenny et al., 2021, p1910)

> Staying when other mums have their baby would have destroyed me. I could have

> stayed in the birthing room but I knew that he was next door in the nursery. If he couldn't be with me I just needed to get out of there and go home. I was in a state. I'd had a bleed and they tried to talk to me into staying but I signed myself out against medical advice. (Marsh et al., 2019, p7)

These excerpts start to uncover the cumulative risks faced by women as a consequence of their attempts to cope. Sharp increases in substance use and binging to alleviate immediate and intolerable distress, coupled with a disregard for their own safety, placed women at increased risk of overdose. In the second excerpt, the mother is unable to access vital health care as this would mean returning to the maternity facility where her new-born baby has just been apprehended. To finance their substance use, women reported turning or returning to sex work. Here too women described risk taking such as unprotected sex (Kenny et al., 2015). Circumstances such as sex work and returning to violent ex-partners placed women at increased risk of interpersonal violence. Financial hardship and an inability to return to homes where children once resided for some resulted in homelessness (Kenny et al., 2021).

Superordinate theme: Cumulative and enduring consequences

Consistent with Broadhurst and Mason's original framework is the superordinate theme of cumulative and enduring consequences. Following the initial period of psychosocial crisis, adversity rapidly accumulates and persists over time. Seven subthemes were identified which appeared consistent across included studies.

Subtheme: Renegotiating mothering roles and identities

Across 12 of the 15 included studies, women described the myriad ways in which they tried to accommodate losing custody of their children. This required psychological adjustment in terms of how they identified themselves in relation to their child, and how they physically enacted this new role.

> I don’t feel like a parent. I don’t feel like my kid’s mother any more. I really don’t . . . I feel more like a friend to her right now . . . because she isn’t in my life. (Nixon et al., 2013, p182)

> I feel like an aunt or something. (Nixon et al., 2013, p182)

> I don't know how to be anything else but someone's mum. (Honey et al., 2018, p420)

While the vast majority of women continued to identify as mothers, the excerpts above demonstrate that this was not universally the case. Women frequently reported both consciously and sub-consciously dissociating from the distress of custody loss, and so perhaps identifying as a friend or aunt as opposed to mother creates a manageable psychological distance from the experience. This may also represent an internalisation of culturally defined constructions of motherhood, with women who no longer perceive themselves to be fulfilling the expected role of mother redefining these relationships as something else.

> I was scared to have visits at DoCS [Department of Child Safety]. Every time I'd go to my kids' visit I'd be nervous because reading those reports was like saying well then how am I supposed to act? (Newton, 2020, p819)

For those women who continued to identify as mothers, the tasks of mothering changed dramatically, often with a view to maintaining or increasing contact with children and/or working towards reunification. These tasks included attending groups and classes to

improve parenting skills, attending court dates and other professional meetings, engaging in support for issues such as mental health difficulties and substance use, extracting themselves from abusive relationships and trying to improve personal circumstances by seeking employment or education. However, the above renegotiations of both identity and role were often complicated by ongoing contact with children no longer in their care. While contact was undoubtedly extremely important, it also served to remind women of their loss (Memarnia, 2015). Women reported feeling under intense professional scrutiny during contacts, which often took place in environments not conducive to easy social interactions. Having been deemed unfit to retain custody of their children, women were now unsure who to show affection or manage behaviour in ways that would be acceptable to professionals.

Subtheme: Restrictions, change and loss within interpersonal relationships

This original theme was supported by data from included studies. As Broadhurst and Mason (2020) describe, women's profound sense of loss was further exacerbated by the fragmentation and dissolution of interpersonal relationships as a consequence of formal restrictions. For women experiencing domestic abuse, this often involved CPS advising them to terminate relationships in order to protect both mother and child. For several women with children placed in kinship arrangements, frequently with maternal grandmothers, ongoing contact with children became a flashpoint for familial discord.

> My mum phoned the police on me. It would not have been as bad as it was if she had not been stood in the window yelling, you're not having your kids back, they don't even love you. She was antagonising the situation because the kids were with her at the time. And then she let me take the kids out completely slaughtered. Why would you do that? And then phone the police on me? Well I can go down and see them whenever I want. But it's got to the point now where I just don't want to go because

> she just causes trouble and I end up arguing. And she pushes my buttons to where I could fight with her. So, I have to get my youngest child and I have to walk out, and then the kids are like, look, you don't want me no more. And it's not that. If I stayed with that woman any longer, I physically will. I will punch her in the face. She is vile. (Richardson & Brammer, 2020, p367)

> Social workers ... said: 'we're not forcing you to but if you don't, then it will lead to this ...' so you feel like it's bully tactics. (Bell, 2021, p2029)

These two excerpts exemplify the kinds of pressures placed on women, and their intimate and familial relationships, as a consequence of CPS mandated formal restrictions. In the first excerpt, although the woman states she is free to visit her children at any time, her volatile relationship with her mother, with whom her children have been placed by CPS, makes contact extremely difficult. This excerpt demonstrates the potential for children to be weaponised between family members, causing harm to the children and limiting women's access to both her children and the support her family might have been able to offer her.

The second excerpt speaks to the issue of domestic violence as a factor in child custody loss and the restrictions placed on these relationships by CPS. While there is little doubt as to the potential for harm against mother and child as a consequence of domestic abuse, such partners may fulfil several important functions in the lives of these women. As Broadhurst and Mason (2020) point out, many of the women in this population were themselves in the care system as children, and so maintaining the family unit may be of particular importance to them. Some women questioned whether managing the risk of domestic abuse was truly within their individual field of agency, and looking back on their

experiences expressed regret that they had not been better informed regarding domestic abuse or supported to extricate themselves from such relationships (Kenny et al., 2015; Bell et al., 2021; Marsh et al., 2019).

Subtheme: Social stigma

Stigma revealed itself as a powerful force in women's lives. In the social realm, stigma that was both external and internalized served to restrict social networks, family and romantic lives, limited help seeking, and reduced women's life opportunities in terms of education and employment.

> You have failed as a mom ... one of the female things. It goes without saying that we should be good moms. (Otterlei & Engerbresten, 2021, p12)

> The biggest feeling I struggled with was guilt and shame that I'd had a child removed by FACS [Family and Community Services]. I couldn't go anywhere and the shops were especially hard, particularly where I used to work as they knew I was pregnant. There's shame in explaining what happened and where the baby is now. In the end, I would just say that he's not with me. It was easier for me to wait and get someone else to go for me. (Marsh et al, 2019, p7)

In these two excerpts both women illustrate how cultural expectations of motherhood may become internalised. Women's own perceptions that they have failed to meet these expectations generated a powerful sense of shame. Many women across included studies reported disguising their loss from others and isolating themselves from social networks for fear of how others would respond: ''Illegitimate . . . Like that you're not capable of anything.'' (Kenny et al., 2015, p1162)

Stigma and shame eroded women's' self-esteem and sense of worth such that they doubted their capabilities beyond the role of mother. This has a limiting effect on life opportunities such that women felt unable to pursue education or employment.

Subtheme: Institutional stigma

As Broadhurst and Mason (2020) report, women experience stigma across multiple settings. In their encounters with professional services concealment of custody loss is no longer an option and women spoke of feeling like a 'marked card'. This extended beyond custody loss with many women reporting that their own personal histories of substance use, experiences of domestic violence, and most frequently their own experience of local authority care, contributed towards their stigmatised identities.

> They [social services] were labelling me. It was like I was being stuck in a corner, I suppose, with a load of Post-Its coming off me, like you know, indication like, you know, abused . . . everyone looking at me and poking and prodding and having an opinion but there was no resolution . . . Because when I was a child, I was a victim of abuse and I didn't grow up deliberately parenting wrong or putting my kids at risk in a deliberate way. I did it because it was embedded in me to be normal. (Richardson & Brammer, 2020, p370)

> How long will they use my childhood against me? I lost because of my past. (Syrstad & Slettebo, 2020, p104)

In the two excerpts above both women reference their own childhood experiences of abuse and being in the care system. They illustrate how women feel judged for things that

were outside their control and perpetrated against them. As such histories are documented in permanent records, women described feeling unable to escape the associated stigma.

> The whole time I was pregnant I was really scared. I wanted to stop using but I was really frightened to get help because I thought they'd call FACS, which ultimately, that went against me anyway. (Marsh et al., 2019, p4)

Most women across included studies appeared highly sensitive to how they were perceived by professional services. As in the excerpt above, many were fearful of how services would respond to their requests for help and that ultimately it would be held against them. Someone women reported that their help seeking was the very thing that brought them to the attention of CPS and ultimately resulted in the removal of their children (Newton, 2020). A lack of trust in professional services and fear of institutional stigma served to further isolate women for support networks.

Subtheme: Facing powerful systems

This theme appeared consistently across all included studies with women describing feelings of powerlessness in the face of all-powerful systems. Women described professional services, and primarily CPS, as dismissive, inconsistent, invalidating, deceitful and dehumanising.

> I thought that CWS [Child Welfare Services] had to adhere to the same rules, but they do not. I have experienced that they have made their own rules, which work for them. (Otterlei & Engerbresten, 2021, p8).

> You may not agree with it but you just have to bow down, if you wanna keep your kids, that's what you gotta do. (Lewis & Brady, 2018, p10)

Women in the included studies provided examples of their attempts to understand

what was expected of them by CPS in order to retain custody of their children or have them returned to their care, asking CPS for clarification or even to put it in writing (Honey et al., 2018). They spoke of CPS demands as like ever shifting goalposts (Honey et al., 2018). While many described a sense of profound injustice and feelings of anger towards CPS, women reported feeling powerless to do anything about it as expressing dissatisfaction could be viewed as 'uncooperative' (Kenny et al., 2015). Instead, many described adopting a position of compliant submission and went to great lengths to 'prove' themselves worthy mothers (Richardson & Brammer, 2020).

> They didn't care, they didn't wanna help. To me it felt like it was just about getting him into care, they didn't care, sort of, how that impacted on me or anything. (Memarnia et al., 2015, p305)

For many women across the included studies, and for all participants in Memarnia et al. (2015), the pain of custody loss was compounded by a sense that their distress was irrelevant and that CPS representatives simply did not care about them. Indeed, child protection services are often focussed on managing risk to children with no statutory obligation to provide support to mothers. Some women described having to fight for support, such as access to mental health services, drug treatment programs and parenting classes (Wells, 2011; Lewis & Brady, 2018).

Subtheme: Renegotiating accountability

This novel theme reflects women's attempts to make sense of custody loss, to understand the reasons why it occurred, what part they or others may have played, and what could have been done differently to avoid the removal of their children.

> They expect you to understand, and then they come up with terms such as 'cognitive failure', 'lack of cognitive capability,' or 'taking turns.' It is tough to ask them to explain in this context. I would never do that. Then I go home and try to Google it to understand. Even then, I feel that I do not get good explanations. In the end, I still do not understand. (Syrstad & Slettebo, 2020, p104)

Like many of the women across included studies, the mother in this excerpt describes struggling to understand why her children were removed from her care. She references the use of complex terms and an assumed understanding which appears to have a silencing effect on her. There is a clear willingness to make sense of what happened which for this mother and many others, may not be adequately supported by professional services. Conversely, some expressed a clear wish not to understand, to avoid reflection and the distress associated with it (Syrstad & Slettebo, 2020).

> I got tired of feeling like I'm not adequate, I'm not capable of being a woman, combing hair, making breakfast, going to the grocery store with the list or the coupons, coming back home on time, doing the right thing, going to work. I felt like I couldn't get it into gear. Ah, but I was [ ]. That's the good part. I kept… I kept…something kept pushing me. I was very fearful. I thought I wanted this, sometimes I didn't want it. (Wells, 2011, p444)

> It had a lot to do with my childhood ...I can't do much about that. But I also feel that [CWS] is partly to blame too, that my childhood was like it was, so I felt very judged ... for things I was not responsible for or could not have done anything about. (Otterlei & Engerbresten, 2021, p10)

As in the excerpts above, many women appeared to struggle with concepts of blame, accountability and responsibility. Some saw themselves as failed mothers and others felt failed by services. Several women attempted to minimise the reasons for custody loss, perhaps to protect themselves from external judgement or from the distress associated with self-blame (Memarnia et al., 2015; Richardson & Bremmer, 2020).

> They could've helped with some sort of counselling or whatever for the drinking and obviously I was going through the violent relationship, but they just didn't wanna ... (Memarnia et al., 2015, p305)

Reflecting on what could have been done differently, women stated that more information about CPS concerns and what change they needed to see to avoid custody loss, with the addition of facilitated access to supports such as drug treatment programmes, psychological therapies, and help to recognise patterns on domestic abuse, may have increased their chances of retaining custody of their children.

Subtheme: Finding healing and meaning

Though the grief and distress associated with child custody loss endured over time, for a significant number of women across included studies, finding new meaning in their lives was part of a process of healing and recovery.

> "(I) realised I had nobody to live for and thinking stupid and I went to rehab and pulled my socks up and got them back" (Newton, 2020, p818).

Hope of eventual reunification with lost children was a powerful motivating force for many women. For some women this hope operated as a protective factor against suicide (Kenny, et al, 2015). For those seeking to re-establish parental rights, and for those hoping for reunification when their children aged out of the care system, this was the motivation to

engage in drug rehabilitation and parenting programmes, psychological therapies, to pursue education and employment, and to maintain a tenancy.

> I arrived one hour too early for the group that day. Waited. Did not know what to do. And when I entered the room, I immediately had a feeling of belonging. I was wanted. I was seen and heard. Somebody gave me a pat on the shoulder, and said I was brave. I no longer felt so alone. (Syrstad & Slettebo, 2020, p104)

> Esther (Indigenous, 51 years) put forward a vision for widespread cultural and land-based healing villages for Indigenous families to 'get rid of the trauma'. As she put it unambiguously: '[We need to] get our culture back, 'cause that's what's gonna heal us'. (Kenny et al., 2021, p1914)

The two excerpts above speak to the power of belonging in women's journeys towards healing and finding meaning - of being seen, heard, and cared for. This could be found in a variety of places, with many describing peer support as crucial in their recovery. A small minority said that they experienced this in the context of therapy (Lewis & Brady, 2018), while others found it in religion (Janzen), or the reclamation of cultural identities (Kenny et al., 2021). For some, being able to 'give back' or support others facing adversity provided a renewed sense of purpose (Janzen & Melrose, 2016).

Discussion

The aim of this systematic review was to identify, review and synthesise qualitative studies exploring the experiences of mothers who have lost custody of their child or children following CPS intervention. A best-fit framework synthesis drew upon a conceptual model

developed by Broadhurst and Mason (2020), which provided a preliminary framework against which included studies could be compared. Analysis of data broadly supported those themes outlined in the original framework and suggested the need for some expansion to describe the experiences of child custody loss more comprehensively.

Broadhurst and Mason (2020) presented a linear framework, describing how the consequences of child custody loss unfold over time. This linearity was supported by mothers' narratives in the included studies and is a useful way of organising the data. Broadhurst and Mason (2020) took the event of custody loss as their starting point and highlighted women's already fragile and restricted social statuses within the context of proceeding themes and in their description of sample characteristics. They described child custody loss as triggering an acute phase of psychosocial crisis which precipitated a range of chronic and accumulating difficulties. This model identifies women's loss of role, compounded by stigmatised identities, across multiple spheres including as mothers, within interpersonal relationships, and within more formal networks. This has a profound impact on their access to support and resources, amplifying their loss and vulnerability. These phases and processes were mirrored by narratives in included studies. Synthesis of multiple studies provided additional nuance to the description of women's experiences, and supported the inclusion of one new superordinate theme, 'Adverse life histories and context of child removal', as well as five subordinate themes: 'Felt impact'; 'Coping and its consequences'; 'Facing powerful systems'; 'Renegotiating accountability'; and 'Finding healing and meaning'. The following discussion will focus primarily on these amendments made to the original model.

The first modification in the revised conceptual model was the addition of a new superordinate theme: 'Adverse life histories and context of child removal'. Many of the studies included in this review chose to focus on specific groups of mothers, defined perhaps

by their mental health status (Honey et al., 2018), substance use (Janzen & Melrose, 2016), ethnicity (Newton, 2020), or involvement in the sex industry (Kenny et al, 2021). However, sample descriptions and self-reported histories revealed early experiences and life trajectories that were strikingly similar. What was apparent was that prior to CPS involvement, the identities of custody losing mothers are *already* marginalised. A broad spectrum of structural, institutional, and interpersonal forces such as intergenerational poverty, unemployment, sexism, racism and classism combine, limiting women's ability to care for their children and attracting increased scrutiny (Dewy et al., 2018). Evidence suggests that for those facing multiple and chronic disadvantage, further disadvantage rapidly accumulates (Arditti et al., 2010). As it accumulates, the negative impact also becomes amplified (Sampson & Laub, 2017). Indeed, attempts to identify specific risk factors associated with child custody loss demonstrate that no risk factors have significantly greater predictive value, the greatest predictor of custody loss being the presence of *multiple* risk factors (Larrieu et al., 2008).

The second amendment to the original model was the subdivision of the superordinate theme 'Immediate psychosocial crisis' into two novel subthemes: 'Felt impact' and 'Coping and its consequences'. In the immediate aftermath of custody loss, women described the felt impact as all-consuming, utter devastation and often compared their experience to that of bereavement. However, custody loss, unlike bereavement, does not attract the same recognition or legitimacy, leaving some women in a state of 'disenfranchised grief' (Doka, 1989). There are no customs or rites associated with this form of loss to facilitate grieving (Betz & Thorngren, 2006). Society may judge such women harshly, attributing personal fault or blame, leaving them with little access to social supports (Everitt, 2013). Women's grief is further complicated by the ambiguous nature of the loss (Boss & Yeats, 2014). Their child is gone but still alive, and for some, ongoing limited contact served as a further reminder of their loss (Memarnia, 2015; Scourfield, 2001). Boss and Yeats (2014) suggest that ambiguous

losses are harder to resolve, and more likely to lead to complicated grief, an abnormal grief process lasting in excess of 12 months characterised by intense longing for the loved one accompanied by anger, self-blame, diminished sense of identity, and a sense of emptiness, loneliness or detachment (DSM-5). In their study, Janzen and Melrose (2016) found that experiences of grief for custody losing mothers can persist up to a decade after the loss. Drawing on the child bereavement literature, when faced with a death of a child, some women report deriving comfort from photographs of their child, a lock of hair, footprints or other reminders (Woodger, 2000). In the absence of a funeral and other culturally defined practices, perhaps supporting these personal acts of remembrance could facilitate the grieving of custody losing mothers and moderate the intensity of their distress. Another suggestion is that women are offered a form of grief counselling, both in the immediate aftermath of custody loss and on an ongoing basis, in recognition of their loss (Janzen & Melrose, 2016; Novac et al., 2006).

As Broadhurst and Mason (2020) suggest, losing custody of a child becomes a gateway to additional and escalating adversity. This is further illustrated by novel subtheme 'coping and its consequences', which describes how prevalent coping strategies such as substance use, sex work or returning to violent partners increases women's vulnerability and risk of related harms. In their paper, Kenny and colleagues (2021) discuss this in terms of the stress process model (Pearlin, 1989), whereby a primary stressor (e.g. custody loss) generates both acute and chronic stress as a direct result of the primary stressor, as well as through the triggering of associated secondary stressors (e.g. new/increased substance use). As above, this model highlights how events such as child custody loss occur disproportionately in marginalised populations who already experience multiple disadvantages, and how such disadvantage influences how women cope.

The third novel subtheme derived from synthesis of included studies and included in the revised model, 'Facing powerful systems', describes women's experience of interactions with CPS and other professional organisations, which was often a source of distress, fear and anger, compounding the impact of custody loss. This theme was supported by data from all included studies and reflects a crucial aspect of women's experience. There is an inescapable imbalance of power between CPS workers who are in an evaluative role, and mothers who are being evaluated (Bundy-Fazioli et al., 2008). Merritt (2020) goes as far as to suggest that CPS interventions are inherently coercive as engagement with interventions is based on the threat, either explicit or implicit, of losing contact, or any chance of reunification, with children. Data from included studies suggests that mothers engage behavioural strategies to manage this power imbalance, often adopting a position of compliant submission with CPS workers. In a grounded theory study exploring how CPS involved parents perceive and react to CPS intervention, Dumbrill (2006) also found that when parents perceive CPS workers as wielding power over them, they predominantly respond by 'playing the game' with feigned co-operation. A minority opted to challenge CPS workers, and in the current review mothers reported that expressions of dissatisfaction or open hostility were perceived as leading to less favourable outcomes (Kenny et al., 2015). While some mothers may feel forced into a submissive position and experience this as dehumanising (Smithson & Gibson, 2016), others report that ostensibly co-operative strategies may give them greater influence over interventions (Moldestad & Skillbred, 2010). While examples of positive interactions with CPS were notably lacking in included studies, results from the Dumbrill (2006) study suggest that when CPS involved parents perceive power as being used 'with' them, they were more likely to experience interventions as helpful. Examples of this included CPS workers using their influence to advocate for parents, or calling to account representatives of other powerful systems such as schools, hospitals or landlords. When given opportunities to express their

views about what would help mitigate the effects of this power dynamic, custody losing parents are very clear about their need for unambiguous communication and transparency from services, empathy and understanding for their context and grief responses, and to be viewed as both parents and as human beings rather than just a risk to their children (Ross et al., 2017). While efforts are being made in this direction (Alpert, 2005), combining a supportive role with that of continuous evaluation of parenting safety remains a significant challenge (Kiraly & Humphreys, 2015). This is further compounded by extremely high levels of stress and burnout, high staff turnover and difficulties retaining appropriately skilled workers in child protection services (McFadden et al., 2015).

Closely linked to, and overlapping with, themes relating to facing powerful systems, identity and stigma, is the fourth novel subtheme 'Renegotiating accountability. This theme describes women's attempts to make sense of custody loss, how they view their own and other's roles as contributing to custody loss, and what they think could have been done differently. The task of sense making for custody losing mothers is enormous and has the potential to be highly distressing. For custody losing women, whose lives before motherhood are typically troubled and whose identities are already marginalised, motherhood is often viewed as a positive step which confers a meaningful and valued identity (Broadhurst & Mason, 2020). Having lost custody of a child, women are positioned as 'failed mothers' by CPS. Falling short of societal ideals of mothering attracts significant stigma within both formal and informal networks as described in subthemes 'social stigma' and 'institutional stigma'. Stigma isolates women from supportive networks and can generate distressing feelings of shame. From this position, women appear to construct narratives which provided some level of explanation for custody loss that could, crucially, be tolerated (Schofield et al., 2010). This often involved attempts to minimise reasons for custody loss, attributing blame to CPS workers, or portraying themselves as victims or innocent parties (Otterlei &

Engerbresten, 2021). This could be understood as an attempt to maintain the positive identity of 'good mother', resisting their perceived positioning as 'failed mother' by CPS, and protecting them from the unbearable pain of a 'spoiled identity' (Juhasz, 2018; Ellingsen 2007; Goffman, 1963). However, these strategies can also impact the likelihood of reunification as CPS workers can interpret such resistance as uncooperative and an unwillingness to change (Sykes, 2011). Jenkins (1991) observed that the more someone is asked to accept accountability, the more forcefully they will resist. Memarnia (2015) suggests that group based mentalisation-based therapies may provide a safer space within which mothers can explore their relationships with their children and factors contributing to custody loss.

The final amendment to the original Broadhurst and Mason (2020) framework was the inclusion of novel subtheme 'finding healing and meaning'. While not necessarily a predictable outcome of child custody loss, several women across included studies described a lessening of their grief and distress over time and finding new sources of meaning in their lives. Janzen & Melrose (2016) found that women were better able to discover new meaning once they could accept some level of accountability for custody loss. It has been noted previously that bereaved individuals make a renewed commitment to living their own lives, they will often focus their energies on helping others (Talbot, 1998). Similarly, women in the current review expressed a desire to help mothers in a similar position to themselves. While loss and grief have the potential to impact negatively on mental and physical health (Prigerson et al., 2008), there is increasing recognition that it can also lead to the phenomenon known as post-traumatic growth (Calhoun et al., 2010). Post-traumatic growth has been associated with new or renewed religious beliefs and practices, with increased religiosity being associated with greater post-traumatic growth (Calhoun et al., 2000). Several women in the current review reported that religion was an important factor in their recovery

from custody loss, which helped them construct meaning and perhaps conferred a greater sense of belonging.

The addition of one novel superordinate and five novel subordinate themes to the original Broadhurst and Mason (2020) framework, supported by this review, could be largely accounted for by differences in population and phenomenon of interest. First, Broadhurst and Mason (2020) are interested in a specific sub-group of custody losing mothers – those who have experienced two or more sets of care proceedings. The current systematic review broadened its criteria to include mothers who had experienced one or more care proceedings. Increasing not only the sample size but the relative level of heterogeneity in the sample may have given rise to the description of a broader range of experiences. This in turn could partially account for an increased number of themes arising from the data. Second, Broadhurst and Mason (2020) are primarily interested in *consequences* of child removal and mothers' vulnerability to subsequent care proceedings. The current review is more broadly interested in the *experience* of child custody loss. In particular, the novel subthemes 'Renegotiating Accountability' and 'Finding healing and meaning' reflect key aspects of mothers' experiences as opposed to consequences of child custody loss. Additionally, the novel subtheme 'Facing powerful systems' incorporates Broadhurst and Mason's (2020) original theme 'Restrictions in welfare entitlement – home and housing loss', which elevates the phenomenon from a consequence to one element of how institutional power is enacted and then experienced by mothers.

Strengths and Limitations

The main strengths of this study are its focus on studies with qualitative methodologies which foreground the voices of a group of women who exist at the intersection of multiple marginalised identities, who frequently report feeling shamed and

silenced by their communities and professional institutions. Amendments to the original Broadhurst and Mason (2020) framework moves understanding beyond that of consequences of child custody loss to how this is experienced by those affected. The selection of 'best fit' framework synthesis for the purposes of this review can also be viewed as a strength. This review has followed a clearly articulated protocol and has endeavoured to provide a high level of methodological transparency at every step. In doing so, it should be clear to policy makers and practitioners how findings were obtained (Ritchie & Spencer, 2002; Barnett-Page & Thomas, 2009).

There are difficulties inherent in using electronic database searches to identify qualitative literature, including the use of more abstract titles, variability in the structure and quality of abstracts (e.g. omission of research method), and differences in how databases index qualitative studies (Evans, 2002). Although efforts were made to avoid accidental omission of relevant studies (e.g. use of the SPIDER tool) it is possible that some were missed. A further six studies were identified by forward citation searching, demonstrating the limitations of systematic database searching for qualitative literature. Search terms were broad to ensure as many relevant studies as possible could be found. However, this resulted in a large number of results to be screened by hand, introducing additional room for human error.

In a qualitative synthesis the reviewer is making sense of researchers making sense of participants making sense. Second order interpretation of this kind risks obscuring the nuance of individual experience which is at the heart of qualitative research. It also limited in its ability to account for the context in which the research was conducted (e.g. Indigenous mothers in North America versus Caucasian mothers in the UK). Similarly, qualitative syntheses do not account for the theoretical, methodological or social factors which shape the research findings in each study. As such, additional layers of context are lost.

As mentioned above, the exclusion of fathers from this review could be considered a limitation, as it risks perpetuating the tendency within child welfare research and practice to neglect the role, contributions and experiences of fathers (Cameron et al., 2012; English et al., 2009; Dubowitz, 2006). In recent years there has certainly been a move towards increasing father involvement in child welfare work and to reduce gender-biased discourse and practice (Scourfield, 2014; Maxwell et al., 2012). However, in moving away from gender-bias, there is a danger that some gender-sensitivity may be lost. An important finding of this review is the gendered experience of identity loss and associated shame as it relates to cultural expectations of motherhood. Gender is an important aspect of social identity and, from a constructionist perspective, has a bearing on how people perceive and articulate their experience (Ernest, 1998). How fathers express distress, how they relate to CPS workers, who are predominantly female, and how this may alter how the CPS worker/client power dynamic is perceived and managed by both parties, could have a significant bearing on their experience of child custody loss (Baum, 2017). Therefore, fathers may be better served through further primary research exploring their experiences of child custody loss in the first instance, before any meaningful review or comparisons may be possible.

Summary and conclusion

This best-fit framework synthesis provides a more comprehensive understanding of women's experiences of child custody loss following CPS intervention. Mothers who lose custody of their children typically report facing multiple adversities in their own lives. The experience of custody loss acts as a gateway to further adversity, characterised by an initial psychosocial crisis. Adversity rapidly accumulates and amplifies, initially driven by how women cope with their distress. They face renegotiating their role and identity in relation to their children, in the context of restricted or severed interpersonal relationships, socially and institutionally stigmatised identities, and in the face of profoundly powerful systems. Making

sense of child custody loss is a process that threatens to overwhelm, and women can be observed engaging a range of strategies to construct an understanding that can be tolerated. For some, though not all, the profound sense of loss and grief will diminish over time, aided by religious or spiritual beliefs, giving back to communities and helping others, hope of reunifying with lost children, and connecting with other custody losing mothers. Results suggest that mothers would benefit from ongoing support beyond the point of custody loss. This support may be intensive at first, reflecting the intensity of distress and associated risks of self-harm, suicide, and substance or interpersonal related harms. Recognition and support for their grief may be of benefit, perhaps as formal grief counselling or by facilitating personal acts of remembrance. Making sense of custody loss is particularly challenging, and mothers may benefit from safe, non-judgemental spaces to explore this, to find new ways of defining their relationship with their children, as well as opportunities to connect with other custody losing mothers. While much of this is beyond the scope of CPS, facilitating access to supports could be viewed as a positive example of power being used 'with' mothers as opposed to 'over' them.

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Empirical Research Article

Mother and professional perspectives on how care experienced mothers perceive and manage the impact of motherhood on mental health: A Multi-perspectival Interpretative Phenomenological Analysis

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Empirical Study Abstract

Care leavers as a population have received relatively little attention in academic research, and as such there are significant gaps in our understanding regarding the interplay of childhood adversity, experience of care, motherhood and mental health. The current study aims to explore how care experienced women perceive and manage the impact of motherhood on their mental health. Using multi-perspectival Interpretative Phenomenological Analysis (IPA), it explores this phenomenon from two perspectives: that of care experienced mothers; and that of a group of professionals who provide support to care experienced mothers within the context of their professional role. Four superordinate themes emerged from analysis of nine participant interviews: *The value and fragile benefits of motherhood; When the past and present collide; The value and power of identities; and Engagement with services: the push and pull.* Results are discussed in relation to the current literature, clinical implications considered, and suggestions made for future research.

Introduction

Children and young people entering the care system are overwhelmingly removed from their family of origin to ensure their safety, meaning their childhoods are often marred by abuse, neglect and family difficulties (Barnes et al., 2017; Department for Education [DfE], 2021). Such adverse childhood experiences lead to an increased risk of poorer outcomes across virtually all domains (see Hughes et al., 2017 for a review and meta-analysis; Mendes & Moslehuddin, 2006). Care leavers are more likely to experience homelessness (Evans, 1996), unemployment (Broad, 1998), physical health problems (Zlotnick et al., 2012), mental health problems (Simkiss et al., 2013), engage in offending behaviour (Summerfield, 2011), use alcohol and drugs (Neale, 2002), and underachieve academically (Rees, 2013). Furthermore, and pertinent to the current study, they are also more likely to become young parents (Craine et al., 2014).

Research suggests that levels of parental involvement with children differs markedly between care experienced mothers and fathers (Roberts, 2021; Schelbe & Geiger, 2017), with care experienced mothers being twice as likely as their non-care experienced peers to be parenting alone (Botchway et al., 2014). Additionally, children of care experienced fathers are more likely to live with their biological mother, while non-resident children of care experienced mothers are more likely to reside in foster or adoptive placements (Courtney et al., 2011). The reasons for comparatively low levels of father involvement are many and complex involving structural barriers such as limited access to suitable accommodation, failure of services to recognise the contribution of fathers or even explicit discouragement of involvement by professionals (Chase et al., 2006; Tryer et al., 2005). Fathers also cite relationship breakdown, imprisonment, unemployment and drug misuse as barriers to their involvement (Chase et al., 2006). Given the increased likelihood that care leaver mothers will be actively parenting their children, understanding their experience of motherhood, the

potential impact on their mental health and meeting their support needs is a priority. This aligns with two of seven key aims outlined by the government's Care Leaver Strategy (Department for Education [DfE], 2013) which seek to address physical and mental health inequalities and the ongoing support needs of care leavers in the UK. Maternal mental health challenges also have implications for children and research has demonstrated an association between maternal mental health difficulties and adverse effects on child development (Kingston & Tough, 2014). Therefore, research on maternal mental health also speaks to the broader child health agenda (World Health Organisation [WHO], 2021).

For women with experience of care, vulnerability to mental health difficulties in motherhood appears to be increased. By the very nature of being care experienced, these mothers are less likely to enjoy the support of family (Botchway et al., 2014), which, combined with an increased likelihood of single parenthood, may increase mothers' sense of isolation. There is strong empirical evidence linking social isolation to poorer mental health (Rohde et al., 2016). Care experienced mothers are also likely to face greater economic and social disadvantage during their child's first year of life compared to their non-care experienced counterparts (Botchway et al., 2014), factors which are again strongly associated with poorer mental health (e.g. Marmot et al., 2008; WHO, 2013d). In terms of their mental health, data from the Millennium Cohort Study found that care experienced mothers were twice as likely to report symptoms of depression, with over half of those surveyed reporting a formal diagnosis compared to under a third of non-care experienced counterparts. They were also more likely to report higher levels of dissatisfaction with life with less control over how it might turn out (Botchway et al., 2014).

While the Millennium Cohort Study provides illustrative population level data, studies utilising qualitative methodologies can offer additional insights into the experience of motherhood for care leaver women. Review of the literature revealed that qualitative research

pertaining to the experiences of mothers with experience of care frequently focusses on those either still in care or those who became parents while in care and/or were transitioning out of care at the point of interview (e.g. Radey et al., 2016). This reflects an overall trend in the research on care experienced mothers which primarily focuses on teenage or 'young' mothers (Crous et al., 2021; Duncalf, 2010). Though none of the qualitative studies identified specifically addressed the mental health of care leaver mothers, these young women frequently spoke of the emotional impact of motherhood as part of their broader experience. For example, Chase and colleagues (2006) interviewed 63 care experienced parents, 47 of whom were mothers, to qualitatively explore a range of issues including experiences of support via a constant comparative method of analysis. They recruited a large representative sample with broad age range (15-23), ethnic diversity and range of care experiences. However, all participants became parents in their teens, and it was not clear how many were still in care when their children were born so caution must be exercised when considering the generalizability of findings. This study found that many of the mothers interviewed felt overwhelmed by the responsibility of new motherhood. Several mothers reported that the arrival of a child brought with it a desire to reconnect with birth families. However, the imagined practical and emotional support of birth families was not made available to them, triggering feelings of rejection. For those who reported episodes of post-natal depression, few reported seeking help for fear of custody loss. Those who did seek help reported feeling unheard or dismissed by professionals. Mothers reported a sense of increased scrutiny by social services because of their own history of care which eroded trust and generated feelings of anxiety, again about the potential for child removal. Despite the challenges outlined above, most women also described motherhood as a positive, calming experience which conferred a sense of maturity and improved social status. Mothers also said they felt a renewed sense of motivation, purpose and achievement in their new mothering role.

Two further studies employed Interpretative Phenomenological Analysis (IPA) to explore facets of care leaver women's lived experience of motherhood. Maxwell and colleagues (2011) conducted semi-structured interviews with six care leaver mothers, all of whom became mothers in their teens, about their experiences of motherhood, how they experienced themselves as mothers, their relationship with their child and their understanding of their child's experiences. Results suggested that mothers experienced a desire to be loved and needed by their child and fear that their child might reject them. Mothers described feeling overwhelmed and taken over by their child's dependency. A subsequent urge to reject their child elicited feelings of guilt and shame, perhaps replicating early relational experiences. For some, motherhood triggered fears about repeating the mistakes of their own mothers, which generated additional anxiety about potential social work involvement and custody loss. Some mothers also described external forces such as critical cultural narratives regarding young and care experienced mothers, as well as the intrusive involvement of services, as destabilising, with doubts about their ability to parent being internalised. Pryce and Samuels (2010) examined how childhood history and experiences of being mothered impacted the meaning attributed to motherhood for 15 mothers aging out of the care system. As part of their semi-structured interviews, participants were asked to define a range of concepts such as success, family, adulthood and maturity, as well as societal expectations of 'normal' and 'ideal' life stages. In contrast to the study by Maxwell and colleagues (2011) which utilised broad, open-ended questions typical of an IPA approach, findings from Pryce and Samuels must be interpretated in the context of having been 'led' to a degree by concepts introduced by the researchers. For example, the study reported that mothers experienced distress relating to the loss of imagined futures, perhaps in relation to future careers, or reality's failure to meet idealised expectations of motherhood, which may relate to the researcher-introduced concept of 'ideal' life stages. That being said, some findings were also

consistent with those of Chase and colleagues (2006) as for some participants, motherhood was viewed as an opportunity to forge a new identity and status, to gain independence and a sense of purpose. Additionally, several mothers reported that becoming a mother was their first experience of unconditionally loving and feeling unconditionally loved. Some mothers described their attempts to 'correct' their own difficult experiences of 'family' through the parenting of their child, and motherhood as the trigger for reflection on these difficult experiences which had the potential to elicit painful feeling of loss.

Similar findings to those outlined above have been replicated across a number of other qualitative studies, with motherhood often being presented by mothers as both challenging and positive. Rolfe (2008) characterised this as 'hardship and reward', with findings from interviews with mothers 33 marginalised mothers, 22 of whom had experience of care, suggesting that the positives of motherhood outweighed any difficulties. Again, participants described motherhood as their motivation for pursuing employment and healthier lifestyles. Similarly, Barn and Montivani (2007) reported on interviews with 9 care experienced mothers as part of a larger mixed-methods study with motherhood being described as a positive turning point in chaotic lives and a source of love, enjoyment, and focus. In their study representing the experiences of 33 care leaver parents (21 mothers), Schelbe and Geiger (2017) presented these experiences as 'balancing the joys and challenges of parenthood' and 'children as a source of motivation'.

Practitioners who provide support to care leaver mothers are well placed to contribute perspectives on the impact of motherhood on mental health and how women manage this, given that their roles will often involve identifying risks and challenges faced by mothers and their children, as well as an awareness of what strengths and supports lead to the most positive outcomes (Gordon et al., 2011). Their first-hand experience can make a meaningful and valuable contribution to research and to changes in policy and practice. For

example, Roberts and colleagues (2018) undertook qualitative exploration of 22 leaving care service workers perceptions of the needs, barriers and facilitators to, and availability of, local support to parents in and leaving care in Wales. Findings suggested that workers viewed parenthood as potentially transformative with the power to improve parents' mental health. However, they perceived this to be predicated on parents' willingness to acquiesce with the demands and expectations of services, and potentially hindered by structural and social barriers such as limited access to appropriate accommodation and informal supports.

Radey and colleagues (2016) presented perspectives of 15 care leaver parents (13 mothers) and 14 service providers. Through a series of small group interviews, both professionals and parents were asked about the day-to-day experiences, strengths and support needs of parents aging out of care, data were subject to thematic analysis and both perspectives integrated with areas of convergence and divergence presented in resulting themes. Both groups described parenting while aging out of care as overwhelming and stressful. While professionals doubted parents' ability to escape intergenerational cycles of abuse and dependency, parents expressed optimism about their ability to overcome challenging circumstances. Both groups viewed parenthood as increasing motivation and resilience. Once again, professionals expressed some pessimism relative to parents' optimism about sustaining these gains in the long term. This study had many strengths including clear definition of sample, research aims and interview questions, and methodological transparency. Inclusion of professional perspectives provided a deeper, more reliable account of the phenomenon of interest (Larkin et al., 2019).

In summary, care leavers as a population are vulnerable to poorer outcomes across virtually all domains and are more likely to become parents, particularly as teenagers. Mothers are more likely to be parenting apart from fathers and face a broad range of challenges associated with histories of disrupted attachments, childhood experiences of abuse

and neglect, limited support networks and myriad socioeconomic disadvantage. Though not inevitable, these factors can increase the risk of mental health difficulties. Qualitative exploration of care experienced mothers' experiences of motherhood reveals that while it is undoubtedly challenging, it also has some potential to shift life trajectories in a more positive direction. However, these studies frequently focus on teenage mothers, many of whom are still in care or are transitioning out of care, reflecting a general trend in the literature pertaining to care leavers mothers. Professionals with first-hand experience of supporting care leaver mothers are well placed to offer an additional perspective on the experience and impact of motherhood on mothers' mental health and their combined contributions can speak directly to current policy and practice.

The current study

The current study aims to explore how care leaver women perceive and manage the impact of motherhood on their mental health. What is currently known about this phenomenon is largely based on population-level data like the Millennium Cohort Study (Botchway et al., 2014) and incidental findings from qualitative studies exploring the experience of motherhood for care experienced mothers more generally. Qualitative studies have also tended to focus on mothers still in care, those transitioning out of care, and teenage mothers. The current study focuses exclusively on mothers who have already left care and specifically addresses their experience of mental health. Reducing inequalities in health outcomes and increasing access to ongoing support for care leavers are two of the key priorities as set out in the UK Government's Leaving Care Strategy, and understanding mothers' experiences of mental health in motherhood has an important contribution to make to this agenda.

As the current study is interested in the individual lived experience of care experienced mothers, how they create meaning from this experience and interpret events,

objects and people, Interpretative Phenomenological Analysis (IPA) was selected as the most suitable methodology. Employing a multi-perspectival design, it explores this phenomenon from two perspectives: that of care experienced mothers; and that of a group of professionals who provide support to care experienced mothers within the context of their professional role. The aim of including this second perspective is to provide a more detailed and multifaceted account of the phenomenon (Smith et al., 2009).

The central aim of this study is to answer the question "How do care experienced mothers perceive and manage the impact of motherhood on their mental health?" As this study is explorative in nature, no prior hypotheses or additional research questions are proposed. This is in keeping with the inductive nature of IPA (Reid et al., 2005).

Methods

Design

This qualitative, multi-perspectival study adopts the phenomenological principles of IPA (Smith et al., 2009). IPA provides a framework for the collection and analysis of data and is exploratory in nature. IPA is concerned with how participants understand or experience a particular phenomenon. It therefore aligns with a constructivist perspective. From this position it is assumed that reality is wholly subjective, that it is located at the level of the individual, and that how individuals make sense of their experiences is socially constructed, necessarily influenced by the social, economic and political context they exist within (Rogoff, 1990; Ernest, 1998). The multi-perspectival approach of this study sought to explore the phenomenon of interest from two perspectives: a group of care experienced mothers and a group of professionals whose role it is to support them, with the aim of providing a more detailed and multifaceted account of the phenomenon (Smith et al., 2009). Participants were interviewed by means of semi-structured interviews to generate rich, experiential data.

Sampling

This study reports on data from nine participants: five mothers and four professionals whose role it is to support them (see Tables 1 and 2 for demographic information). An additional two mothers and two professionals expressed an interest in participating. However, they did not respond to further communications indicating they no longer wished to participate.

IPA is concerned with the in-depth analysis of a phenomenon as opposed to generating a generalizable theory. While there are no specific rules regarding sample size in IPA, it will necessarily be influenced by the depth of analysis of individual cases, the richness of each case, how the researcher wants to represent convergence and divergence between cases, and practical concerns such as time restrictions and ease of recruitment (Pietkiewicz & Smith, 2012). Smith and colleagues (2009) suggest that for a professional IPA study, a sample size of between four and ten is sufficient. The aim is not to achieve saturation of themes, as representing the richness of individual accounts is the primary aim (Hale et al., 2007; van Manen et al., 2016). Rather, it provides for opportunities to explore similarities and differences between cases without being overwhelmed by data.

Mothers

To be eligible for inclusion mothers were required to be 'care experienced'. The researcher adopted a broad definition of the term to represent the range of care settings a person may have experienced. National Guidance from the Scottish Government defines this as "anyone who has been or is currently in care or from a looked-after background at any stage in their life, no matter how short, including adopted children who were previously looked after" (Learning Directorate, 2021, p. 2). Care experience could include foster, kinship, residential or secure care. Mothers were required to be over the age of 18 years and aged out of the care system. No upper age limit was set. Participants were required to have English as their first

language due to time and financial constraints on this study which precluded the use of translation services. Individuals with a formal diagnosis of moderate to severe intellectual disability or current psychotic illness were excluded from the study due to concerns regarding their ability to participate and to give informed consent. Mothers were required to have at least one biological child with their youngest child being at least six months old. This decision was based on Mercer's (2004) finding that it takes at least 4 months for mothers to achieve a sense of maternal identity, and that women both with and without histories of childhood abuse and neglect demonstrate increased bonding with their child over the first 6 months postpartum (Muzik et al., 2013).

The issue of child custody as an inclusion/exclusion criterion was applied on an individual basis. Four of five mothers participating in this study had full custody of all children with no periods of custody loss. One mother who wished to participate had lost a child to Sudden Infant Death Syndrome (SIDS), had one child in kinship care and had had two further children in temporary respite foster care. IPA demands that a sample is relatively homogenous to ensure that the phenomenon of interest has both personal relevance and significance to each participant (Pietkiewicz & Smith, 2012). On reflection it was felt that, as this mother had had care of her two youngest children for approximately 5 and 7 years respectively before temporary respite foster care was provided to help her manage her mental health during the COVID-19 lockdown, she was still in a position to offer insights into the phenomenon of interest in ways that were broadly analogous to the rest of the sample.

Professionals

Professionals were broadly defined as anyone who, in the course of a professional role, was currently or had previously worked in a supportive capacity with care experienced mothers. An initial attempt was made to recruit support workers through third sector organisations but

due to difficulties with recruitment, as outlined below, no specific professional background was stipulated.

Recruitment strategy

Participants in both the 'mothers' group and 'professional' group were recruited via multiple sources. An initial recruitment drive was made through a range of third sector organisations based in Scotland, namely through children's charities Barnardo's and Aberlour, and residential child-care provider Curo Salus. The researcher made initial contact with senior representatives within each organisation and provided detailed information about the study via email for dissemination within their respective organisations. Contact details were then provided for a range of professionals within each organisation who were either interested in participating themselves or were able to support the recruitment of service users falling within the 'mothers' group. Representatives from these organisations were responsible for approaching mothers in the first instance and contact details were shared with the researcher only with explicit consent of the mother. Contact was then established via email or telephone to provide opportunities to discuss the project, answer any queries, seek consent to participate and arrange an interview date. All participants were sent detailed information about the study via email and were invited to complete an online consent form (appendix J). Two professionals and one mother were successfully recruited in this way.

Further ethical consent was sought and granted to extend recruitment nationally via social media advertising. The researcher approached multiple open and closed groups on Facebook believed to be of interest to potential participants and sought consent from group administrators to share the recruitment flyer. The flyer was also published publicly on both Facebook and Twitter. One professional and three mothers were recruited in this way, with a further one professional and one mother being recruited via snowball sampling. Again,

detailed information about the study was shared via email and participants were invited to complete an online consent form.

Table 1

Demographic Information for Mothers

Pseudonym	Age	Nationality	Marital status	Employment status	Disclosed care history	Age when first child born	Age of children (in years)
Cristina	35-40	English	Married	Employed Student	Foster care	21	13 8
Aileen	25-30	English	Single	Employed Student	Adopted	23	5
Kerri	45-50	English	Living with partner	Self-employed	Residential care 4-5 months age 9 years	32	18
Kayleigh	35-40	Scottish	Single	Unemployed	Kinship and residential care from age 11-16 years	24	13 (kinship care) 11 8 (deceased) 6
Miranda	20-25	Scottish	Living with partner	Employed	Long term foster care to age 18 years	21	2

Table 2

Demographic Information for Professionals

Pseudonym	Professional group	Years of experience	Country of practice
Daphne	Third sector residential care	7	Scotland

	children's service – manager		
Sophie	Newly qualified Clinical Psychologist with background in support work	7	Scotland
Catriona	Senior support worker and qualified social worker	8	Scotland
Stella	Social worker	40	Scotland

N.B. One participant opted to select their own pseudonym with the remaining eight generated randomly using a random name generator website (https://randomwordgenerator.com/name.php)

Procedure

Data collection

Interviews were all conducted remotely either by telephone or via Microsoft Teams. Interviews with mothers lasted 90 minutes on average (range: 34.49 – 124.40 min) and with professionals 69 minutes on average (range: 44.56 - 91.41 min). Interviews were digitally recorded using an encrypted dictation device or via Microsoft Teams. Recordings were immediately uploaded onto the secure University of Edinburgh server and transcribed verbatim by the lead researcher. As soon as transcription was complete audio recordings were destroyed. All identifying information was anonymised. Locations, dates and names of third parties were removed and all participants names were replaced with pseudonyms. Copies of their anonymised transcripts were sent via email to participants to ensure accuracy and provide a further opportunity for participants to anonymise their data. One participant opted to redact elements of their transcript to ensure their anonymity.

Interview schedule development

A semi-structured interview was developed, in accordance with IPA guidelines, using open-ended questions designed to allow participants to talk freely and at length about the phenomenon of interest (Smith et al., 2009). An initial interview schedule was piloted with three individuals and following discussion and reflection with an expert by research it was felt that questions, though phrasing was open-ended, were too leading. Significant revision reduced the number of questions included in the interview schedule from eleven to six with additional prompts used to invite further exploration of participants' experiences (Appendix O). A further two pilot interviews were conducted with the new revised interview schedule. Feedback from participants suggested the revised schedule provided sufficient scope for deep exploration of personal experiences. Further discussion with the same expert by research and personal reflections captured in the lead researcher's reflective journal indicated no further amendments were necessary. Due to difficulties with recruitment to the study, the two latter pilot interviews were kept as part of the final sample.

All interviews began with a brief rapport building chat which was not recorded. Participants were reminded of what the interview would generally entail, their right to terminate or take a break at any time, and consent to record the session and how data would be used was discussed a final time. Once interviews were concluded, time was provided to reflect on participants' emotional wellbeing and they were reminded of the information sheet provided prior to interviews detailing various avenues of support should it be required. Again, this was not recorded. Time was also provided for participants to ask any additional questions about the study, and all were thanked for their contribution.

Ethics

This study received favourable opinion from the University of Edinburgh School of Health and Social Sciences Ethics Committee on 23rd July 2020 with additional amendments

receiving favourable opinion on 30th March 2022 (Appendix G-H). Additional ethical approval was also granted by Barnardo's on 7th June 2022 (Appendix I). Participant data was collected, stored and used in accordance with General Data Protection Regulation (GDPR).

Reflexivity

IPA acknowledges the influence of the researcher on the analysis, their personal beliefs, experiences and biases (Langdridge, 2007). IPA demands that the researcher consciously engage with these influences in a process termed 'reflexivity' (Berger, 2015). Again, this process is not prescriptive, but suggestions include conducting a 'bracketing interview' at one or more points during the study, keeping reflective journal, and making use of supervision structures to maintain self-awareness and reduce the potential impact of personal bias and assumption. This also allows the reader to situate the analysis further within the context of the researchers own social, cultural, political and economic influences.

A bracketing interview was conducted with an experienced IPA researcher prior to participant interviews. This interview revealed several factors with the potential to shape both the researcher's interpretative lens as well as how participants engaged with the researcher and interview process. The researcher acknowledged their position as a young, white, middle-class female of child-bearing age, and as a Trainee Clinical Psychologist. The researcher's professional, social and economic status may have influenced interviews with 'professionals' and 'mothers' in unique ways, perhaps altering how participants wished to be perceived (e.g. as a professional equal or as a client in a therapeutic relationship) or how comfortable participants felt discussing personal aspects of mental health, depending on their own experiences and perceptions of mental health professionals. The researcher is themselves the daughter of a care experienced mother, fell pregnant with their first child during the recruitment and data collection phase of the study, and is a 'professional' with experience of

supporting care experienced mothers. This may have influenced which parts of interviews the researcher interpreted as being most salient, perhaps because they identified strongly with them (e.g. the challenges of pregnancy). Ongoing use of academic supervision and a reflective journal were essential components of the research process to ensure researcher influence at all stages of the study were adequately accounted for.

Analysis

Data was analysed using IPA methodology. The primary goal of IPA is to reveal how participants create meaning from their experiences, how they interpret events, objects and people (Pietkiewicz & Smith, 2012). To that end, IPA employs the principles of phenomenology, hermeneutics and ideography. It is concerned with how people perceive and talk about their experiences. The analytical process is dynamic, with the researcher taking an active role, attempting to make sense of the participants' sense making (Smith & Osborne, 2008). This is the 'double hermeneutic'. IPA is ultimately concerned with experience at an individual level as opposed to the general, taking into account the unique social, political, cultural and economic contexts in which an individual exists (Sullivan & Forrester, 2019).

Smith and colleagues (2009) suggest that while there is no single prescriptive method for conducting analysis in IPA, methodologies are typically characterized by shared processes and principles. Analysis in IPA tends to move from the analysis at the individual level to the group level, and from description to interpretation, whilst remaining grounded in participants' lived experience and how they make sense of it.

Analysis at the multi-perspectival level follows a similar process of moving "outwards" from analysis at the individual level and attempts to convey a coherent narrative about how participant experiences relate to one another (Larkin et al., 2019). The multi-

perspectival analysis in the current study was informed by the procedure broadly outlined by Larkin and colleagues (2019).

Analysis began at the individual case level within a single group. The researcher first analysed all participant interviews in the 'mothers' group followed by all in the 'professionals' group. The final stage of analysis was between and across groups. Analysis at the individual case level followed the six steps outlined in Smith et al., (2009). Step one required immersion in the original data through a process of reading and re-reading interview transcripts. Step two involved making initial exploratory notes on the descriptive, linguistic and conceptual content of transcripts. That is, the experiences participants described, the language they used to describe them, and how they made sense of them. Step three was to develop emergent themes reflecting the participant's own words and the researcher's interpretation. Step four involved identifying connections and patterns across emergent themes, clustered into superordinate themes, which highlighted important elements of the participant's experience. To facilitate step four, the researcher found it helpful to write a brief reflective summary of each transcript which focussed on what seemed to be the essential aspects of participants' experiences. Returning to these reflective summaries at step four ensured the evolving analysis was grounded in participants' accounts. Step five was moving to the next case and step six was identifying patterns across cases. The researcher then repeated this process with the second group (i.e. professionals).

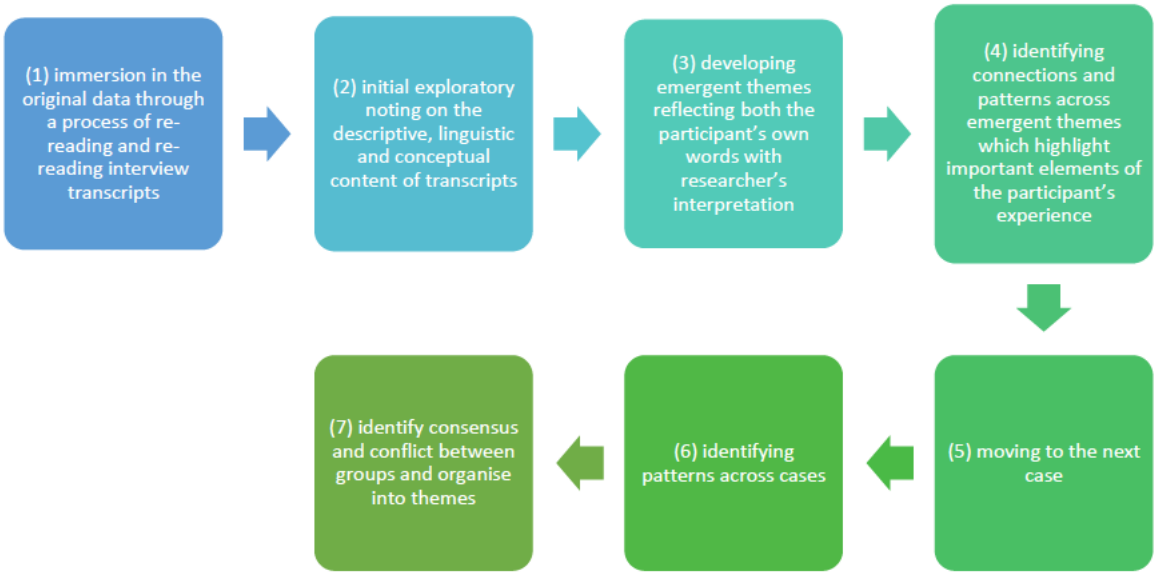
The final step of analysis involved synthesis of analyses from both groups. To achieve this, superordinate themes for both groups were considered together to identify areas of consensus or conceptual overlap where participants were explicitly expressing the same concerns or claims about the phenomenon of interest, as well as any conflicting perspectives. On reflection it was felt that synthesis at the level of group superordinate themes risked losing some idiographic detail and did not produce a coherent narrative which truly reflected

consensus and difference between groups. It was therefore necessary to consider emergent themes at the case level *alongside* group superordinate themes. This is consistent with the overarching aim of multi-perspectival IPA which "capitalises on multiple accounts while offering a plausible interpretative perspective on how the participants' lifeworlds interact and overlap" (Larkin et al., 2019, p. 191), and reflects the necessary flexibility and creativity espoused by Smith and colleagues (2009). All steps are outlined below in Figure 1.

This final analytical stage resulted in a set of superordinate and subordinate themes which reflected all participants' narratives. These preliminary results were shared with all participants by email and all were invited to offer their thoughts and reflections about the themes and whether they felt they reflected the essence of their experiences. Only two participants from the 'professionals' group and one participant from the 'mothers' group offered feedback but all stated they felt the final themes reflected their perspectives and the content of their interviews.

Figure 1

Steps Involved in Multi-perspectival Analysis



Results

The aim of this study was to explore how care experienced mothers perceive and manage the impact of motherhood on mental health from two perspectives: mothers and the professionals who support them. Interviews from both participant groups were analysed and themes synthesised. Four superordinate themes emerged: *The value and fragile benefits of motherhood; When the past and present collide; The value and power of identities; and Engagement with services: the push and pull.* Within these a further six subordinate themes emerged (see Table 3). As recommended by Smith (2011) for samples of 8 or above, each theme is illustrated with extracts from at least three participants. These extracts aim to convey

essential aspects of participants' experiences as well as how they converged or diverged from one another. Following each quote, participant pseudonyms are preceded by either an 'M' or 'P', meaning they are attributable to a mother or professional respectively.

Table 3

Superordinate and subordinate themes

Superordinate Themes	**Subordinate themes**
The value and fragile benefits of motherhood	
When the past and present collide	*Motherhood as a source of guilt and anxiety* *Compensating for the past*
The value and power of identities	*Developing valued identities* *Ascribed identities and their consequences*
Engagement with services: the push and pull	*The struggle for power and control* *Imperfect professionals and systems*

Superordinate theme: The value and fragile benefits of motherhood

Mother and professional narratives conveyed a sense that while motherhood for care experienced women could be immensely challenging and pose a threat to mental health, it was also perceived as valuable and conferred many benefits. Both participant groups reported that most pregnancies were unplanned and, with only a few exceptions, came as a welcome surprise: "He wasn't planned. But we wouldn't change it now, right enough!" (M: Miranda, 20); and "I think, the initial pregnancy, it wasn't planned. Em, I think they were quite delighted." (P: Daphne, 288-289). In the excerpt below, Aileen recounted her joy on

discovering that she was pregnant and seemed to express a willingness to endure a difficult pregnancy for the reward of motherhood:

> I was like "oh my gosh!". And obviously it was like, really joyful and it was nice to know that it could happen. And obviously I wanted to keep him… But, em, it was horrible in some ways because pregnancies are difficult, but it was nice because I got him at the end of it. (M: Aileen, 15-18)

Motherhood appeared to be the incentive some mothers needed to overcome practical issues as "having a baby kinda brings that massive, you know, get that house, get that prepared" (P: Stella, 200-201), but also valuable enough to warrant sometimes significant sacrifices: "I just thought "No, I'm keeping this baby" and basically said to my husband "It's up to you how much you want to be involved." (M: Cristina, 17-18). The perception of motherhood as something worth sacrificing for was a significant shift for Cristina who "had such a negative experience of having a mum it was never something that I aspired to be" (M: Cristina, 231-232). Aileen, too, had been "totally against" it as the mere thought had been "too complex" but "when it happened it was kind of like, oh god. I can't, this can't not happen." (M: Aileen, 26-27). These two mothers had established a belief, because of poor gynaecological health and an historical termination, that motherhood was an impossibility for them. There was a sense that the prospective loss of a possible future followed by an unexpected pregnancy prompted a more conscious re-evaluation of motherhood and what it could be, rather than what it had been for them.

The early post-partum period appeared to bring with it a new set of challenges with the "enormity of the responsibility" (M: Cristina, 430-431) of looking after a new baby posing a potential threat to mothers' mental health. Aileen's description of the early days of motherhood as "quite a dark time" (M: Aileen, 90) suggested an experience which was

perhaps overwhelming or frightening. Professional Stella appeared to perceive this time as somewhat perilous for care experienced mothers' mental health, when things could "change very quickly" and she must "anticipate there might be a crisis" (P: Stella, 326). However, new motherhood also brought with it novel experiences such as breastfeeding which could be a "lovely bonding experience" (M: Kerri, 227). Children rapidly became a source of pride and joy which for some was protective against mental health difficulties and for others aided their recovery:

> She always makes me wee things, like, and is always saying nice wee things to me. I think they really are… they make my day every day. That's what I get up for in the morning every day. So I don't know where I'd be without them. That's what I've said, I wouldn't be here anyway. I've always said that. That's what keeps me going in life, definitely. (M: Kayleigh, 589-592).

In Kayleigh's experience, positive interactions with her children seemed to help boost her self-esteem. The excerpt above suggested that even when her mental health has been poor, the pleasure she experienced in the company of her children was the motivation she needed to tolerate it and face each day. However, Kayleigh also seemed to imply that her children were her *only* motivation, and without them her mental health, and perhaps even her life, would be at risk. Like Kayleigh, professional Sophie reflected on the protective power of motherhood against suicide:

> I had sort of asked a couple of times and she was like, "Nope. I categorically I will not. There is no chance that I will hurt myself because I can't do that to the kids because again, they might end up in care and then they might end up with horrible foster parents and I don't want that legacy, sort of thing, to happen." (P: Sophie, 512-515)

In this excerpt, Sophie was paraphrasing a mother she supported. There was a sense that this mother had presented with mental health difficulties significant enough to warrant Sophie's ongoing concerns about risk of suicide, indicated by her repeated questioning. Despite this, the mother was unambiguous about her lack of suicidal intent. Her fear that her own care history would be re-experienced by her children was a powerful protective factor, but the protective element conferred by her children seemed to go beyond this. A 'legacy' of giving her children up to the care system also implied that the action might be worthy of judgement and may say something fundamentally shameful about her. There was a sense that this shame may also be a powerful deterrent when contemplating suicide.

For many, motherhood provided a sense of focus that had previously been lacking in their lives. The everyday tasks of motherhood for some provided a welcome distraction from other life stressors as well as an orientation towards the future and working purposefully towards goals. Professional Sophie observed:

> Umm, I guess motherhood had quite a defining role for her, in terms of sort of shifting her from being, yeah, like a young woman who's a little bit lost but trying to figure out what she was doing to being someone who had a lot more purpose. And what I think was interesting, maybe in contrast, the first person who sort of had lived entirely for her children. (P: Sophie, 1105-1108)

In this excerpt, Sophie first appeared to be contrasting versions of a woman pre and post motherhood. There is a sense that from Sophie's perspective motherhood had been instrumental in shifting this woman between opposing positions, moving from an ill-defined to a defined role, and from being lost to being orientated. She also contrasted being a young woman with being 'someone'. Sophie seemed to imply that motherhood was the agent through which this woman had acquired maturity and status. The final contrast Sophie made

was between two women who experienced the role of mother quite differently. The implication is that for one, motherhood had the power to positively define in ways that were life-expanding, while for the other the definition may have been limiting. As for Kayleigh above, there was a sense that the benefits conferred by motherhood are fragile when they are entirely dependent on children to the exclusion of, or in the absence of, all else.

Superordinate theme: When the past and present collide

This superordinate theme reflects mothers' and professionals' perceptions of how mothers' own childhood experiences impacted on how they viewed themselves as parents, their concern about how others might perceive them as parents, and the sometimes-painful emotions this elicited. It also reflects some of the strategies mothers engaged in to cope with this.

Subtheme: A source of guilt and anxiety

Several mother and professional narratives suggested that the experience of motherhood for care leaver women was often associated with feelings of guilt and anxiety, and that these feelings were frequently borne of mothers' own adverse childhood experiences. Mothers often appeared anxious about their own capacity to parent, as well about as how others might perceive their capacity to parent. Where mothers perceived themselves to be falling short of their own or others standard for 'good enough' parenting, they often expressed feelings of guilt. Mother Aileen offered the following reflection:

> Yeah, I think I was reflecting a little bit about motherhood in general and especially, like, this week is a great example of like, I've come away (on holiday) on my own, which as a mum, all the guilt about, of course, we have all the guilt. But sometimes you gotta do these things. But I think I question my choices like 10 times more because I, I'm like, am I like my birth mum? (M: Aileen, 584-587)

Aileen's broader narrative was permeated with references to her 'mother guilt' which was often related to the challenge of balancing her own needs with those of her son. In this excerpt, Aileen seemed to imply that guilt is a normal, predictable aspect of motherhood. However, she also appeared to suggest that she was more vulnerable to feelings of guilt because of worries related to being like her own abusive mother. There was a sense that Aileen tried to manage her discomfort through increased self-monitoring which might stifle her decision making, but there were also times when she was able to overcome this and make choices which prioritised her own emotional wellbeing.

References to the experience of 'mother guilt' appeared in several mothers' narratives and as mentioned above, was often related to their anxieties about being a 'good enough' mother. Like Aileen, professional Catriona reflected on the struggle some mothers experience identifying what 'good enough' parenting looks like, as "without, you know, the things that we take for granted, you know, the kinda cues that they would have picked up on as a child themselves, if they've not had that experience then it's really, really difficult for them" (P: Catriona, 70-72). Professional Sophie also noted that in the absence of positive role models, some mothers had "a really strong sense of what they didn't want to be, but less what they did want to be necessarily other than a good parent." (P: Sophie, 1062-1063). In an effort to manage their anxieties about their parenting capacity, there was a sense that some strived instead to be the 'perfect' mother, a coping strategy explored in more detail in the theme below. Aileen, for example, explained that she would "try and like do the most fun things with him all the time because I wanna, I want him to have all these fun, fun experiences." (M: Aileen, 836-837). When they perceived themselves to be falling short of this impossible ideal, the guilt some mothers experienced led them to be particularly hard on themselves: "She was like "I've, I've been like my birth mom. I've just fucked stuff up for this child so badly." (P: Sophie paraphrasing a mother, 289-290)

For Kerri and Kayleigh, mental health difficulties which they associated with their adverse childhood experiences were an additional source of guilt and anxiety in terms of their parenting, as they worried about what impact they might have on their children.

> And it's more to do with decision making and you know, that, that, that eh, that eh, that freeze response which happens when you're sexually abused. And I know this isn't anything to do with this study but its, that's where the anxiety comes from. But I do, I do think, going on to some of your other questions, I do think I've passed some of my anxiety on to [my son], and I have incredible guilt with regards to that. (M: Kerri, 321-325)

And:

> So I don't want them to look back and think, oh, my mum was- do you know what I mean? That we were in care, and oh, my mum's mental health was bad, and addiction and- I don't want them ever thinking like that or knowing that stuff either. (M: Kayleigh, 609-612)

For Kerri, her feelings of guilt were associated with the fear that she may have transmitted her mental health difficulties on to her son. Kerri's lengthy hesitation at the start of this quote suggested that the emotion she was verbalising was difficult to express in a way that hints this may have been a source of shame for her. Kayleigh appeared to be experiencing some anxiety about how her children might one day perceive her because of her mental health difficulties and her historical use of substances to cope, that they will make a judgement about her as a mother. Again, there was a suggestion that what Kayleigh may have been experiencing was a sense of shame. Indeed, when mothers related their experience of guilt, this was often linked to fears of negative evaluation by others and global negative

evaluations of self, the very definition of shame: "Like, do they think I'm a shit mum?" (M: Aileen, 871).

In the following excerpt, professional Catriona also highlighted one mothers' tendency to fear the negative evaluation of others, to negatively evaluate herself, and the adverse impact this had on her mental health.

> She's very self-aware that she will spiral and overthink and really, really worry herself. But it could be little, little things that for us seem really little, but for her are huge. So it could be that the children, for example, transitioning into primary school. For her, she'll worry about bullying, em, I don't know, playtime - what they were doing. And I think that there's two parts to that I think, and I think it is her own childhood and her own experiences that she's been subjected to, but also that worry that she's not being a good enough mum to, to the kids that are in her care. And she is one that's very fearful of services and picking up the phone. (P: Catriona, 184-191)

Here, Catriona contrasted the experience of 'us' as professionals and 'she' the care experienced mother and seemed to suggest that, because of this mothers' adverse childhood experiences, she was more likely to experience anxiety related to her children's welfare. Despite the mother's own awareness of this, it seemed that she remained easily overwhelmed by it. Catriona interpreted this mother's anxiety as being additionally related to how she perceived herself as a mother. Again, this global evaluation of self as not being good enough hinted at an underlying sense of shame.

Subtheme: Compensation for the past

As highlighted above, becoming a mother often triggered difficult emotions such as anxiety as mothers worried about being a 'good enough' parent and being like their own abusive mothers/caregivers. Both mothers and professionals reflected on some mothers' attempts to

mitigate some of these feelings by trying to repair, or compensate for, their own negative childhood experiences in the way they parented their children. Below, the contrasting experiences of mothers Cristina, Aileen and Kerri highlight the range of parenting behaviours observed within the sample, and how the relative intensity of mothers' anxieties about their parenting and repeating the past appeared to influence the extent to which they engaged in compensatory parenting behaviours. In the excerpt below, Cristina reflected on her experience of supporting her son through assessment for autism and how her own childhood experiences influenced her priorities and behaviour as a mother.

> Em, and especially with my youngest, with him having his autism assessment. That has been a real fight and I've had to really advocate for him at school. And I know that a lot of that is borne from my parents not supporting me and not advocating for me when I, you know, had difficulties. Em, yeah, and making sure that his voice is heard throughout everything, that you know, any intervention that the school does. I'm very focussed on making sure that [son's] views are central. Cause I didn't have that. (M: Cristina, 491-496)

Cristina was the only mother in the sample who did not express feelings of anxiety and guilt in relation to her parenting, perhaps suggesting she viewed herself more positively as a mother. Indeed, the excerpt above suggested that for Cristina, her adverse childhood experiences provided her with additional insight as a parent from which she appeared to derive a sense of determination and strength. This was reflected in Cristina's positioning of herself as a fighter in a battle with her son's school to ensure that his views and wishes were reflected in planned interventions. In contrast to the mothers below, Cristina's style of parenting appeared to be helpfully informed by her childhood experiences rather than an attempt to compensate for them.

For other mothers in the sample, it seemed harder for them to distinguish between parenting that was informed by their own adverse childhood experiences and parenting that tried to compensate for them. In the excerpt below, Aileen reflected on advice she received from a professional about the dangers of compensation:

> I remember someone from the perinatal team saying to me, try not to have, compensate, because you'll smother him. Because you're so conscious of not feeling loved, that you'll smother him. And I was like, I won't do that. And I'm like, yeah, I say like, "I love you, [son]. I love you so much. I love you the most ever. Do you know that I love you?" And he's like, "Yeah. Shut up, mom." I'm like, "I love you." Em, and I do that all the time. But I feel guilty for doing it. Like I'm harming him. (M: Aileen, 831-835)

In Aileen's experience, an awareness of the temptation to engage in more overtly compensatory parenting behaviours and the potential for adverse impacts on her child did not appear to be enough to prevent her from practising them. She seemed to imply that the pain of feeling unloved as a child was so great that she felt compelled to behave in ways she also feared may harm her son, resulting in feelings of guilt. Kerri, too, was determined that her son would be 'loved and protected to, to, to the end of my, you know, whatever extreme I had' (M: Kerri, 401-402). Kerri contrasted the experience of being parented herself with her own compensatory parenting as being 'sort of one extreme to the other, isn't it' (M: Kerri, 405). Like those who strived to be a 'perfect' mother to manage anxieties about their parenting, mothers who engaged in the more extreme forms of compensatory behaviour also seemed to be using it as a means of coping with their own distress. Both Aileen and Kerri feared the impact this kind of parenting would have on their child, as Kerri reflected: "maybe I didn't allow him to develop some of his own abilities" (M: Kerri, 403-404), and for both

resulted in feelings of guilt: “Guilt is my, is my, is my, you know, constant companion.” (M: Kerri, 414).

Within the sample, mothers and professionals appeared to describe a range of compensatory parenting behaviours, from the perhaps overprotective parenting described above by Kerri, to the more permissive: “em, spoiling we would say” (P: Catriona, 410).

> And whether that’s then getting into debt, they will make sure that the kids have the best because it's either what they didn't have, or they don't want to let their kids down. So, I think that can be a real challenge for, em, both mothers, making sure that they have the best, best clothing, the best toys. Em, or just scared to say no to them. They don't want that rejection from children. (P: Catriona, 410-414)

Catriona noted that, in her experience, many care experienced mothers feared being rejected by their child and that by implementing rules and boundaries, they would risk losing their child’s love. This seemed to trigger a vicious cycle whereby any attempt on the mothers’ part to reintroduce rules and boundaries triggered a more intense response from their child and caused mothers to question their parenting capacity: “And I guess that kind of then reinforces a lot of self-doubt in mum's” (P: Catriona, 466). Professional Sophie also observed one mothers’ reluctance to set boundaries and limits: “Uh, “I don't want to be strict like my foster parents were. I don't want my kids to feel unwanted” (P: Sophie paraphrasing a mother, 156-157) and when upset by her children’s behaviour “she shouted, and she was mortified that she shouted. She was so ashamed. And she's like, “I should never… You should never shout at children.”” (P: Sophie, 596-597). The implication was that some care experienced mothers may fear feeling the pain of rejection they experienced themselves as a child, but also that they may misinterpret their own behaviour as abusive, generating painful feelings of

shame. As professional Catriona reflected, "For them, there's a similarity there that can be quite triggering" (P: Catriona, 451).

Superordinate Theme: The value and power of identities

This superordinate theme refers to the concept of 'identity' which emerged frequently across all participant narratives, both in terms of being a mother and a care experienced person. Identities were described as sometimes hard to define, hard to resist when they are ascribed by others, and powerful in their ability to both limit and expand women's access to support, opportunities and to make informed choices. This in turn had implications for how they experienced and managed their mental health.

Subtheme: Developing valued identities

Mothers in the sample appeared to experience varying degrees of uncertainty about their identity before becoming a mother. The acquisition of this new identity often helped them make sense of themselves and their histories, and as described above, conferred a renewed sense of purpose. Mothers varied in how strongly or wholly they identified as a mother, and in how experiences of care had been integrated into a wider sense of self. The opportunity to make sense of the past and define who they were appeared to impact positively on mothers' mental health. In the excerpt below Kayleigh articulated her experience of identity formation as a new and unfolding process supported by the identity of 'mother'.

> Like, even now, I feel like I'm still, I'm just learning who I am if you know what I mean? I'm still, I don't know. When I was with my ex as well, I felt as if, well… when I became a mum, I had been on drugs and I didn't really know who I was. And then I became a mum, and then domestic abuse. And then I couldn't be who I was for years with him, because I didn't even know who I was. Cause I had to like his music,

> and I had to eat what he ate, and I had to like all of that stuff. And I remember leaving him and thinking, I don't even know, like, what I like to eat. (M: Kayleigh, 598-602)

For Kayleigh, the formation of her identity seemed to have been variously put on hold and interrupted by her experiences both in and following care. As mentioned above, for several mothers in the current study, the transition to motherhood was an opportunity to review and make sense of care histories, and to integrate them into their ongoing sense of self. Though Kayleigh became a mother many years ago, her experience of domestic abuse seemed to stifle those processes. Kayleigh appeared to represent herself strongly as a mother throughout her interview, though she maintained in the quote above that she didn't know who she was. This seeming contradiction was perhaps indicative of her continued uncertainty about her identity. The excerpt above suggests that Kayleigh was ready to begin making sense of her past and start her journey of self-discovery. She further reflected:

> But I feel like I'm still just getting to know me. I don't know. But, em, I know that now I've got a right, like a proper, I've got a better way of thinking now than I did before. Definitely. I can, I think about things before I do them now. (M: Kayleigh, 605-607)

In this second excerpt, Kayleigh seemed to imply that getting to know herself and beginning to develop an identity was associated with improvements in how she coped with challenges. It seemed that knowing herself provided her greater access to her own mind, such that she was better able to make rational decisions rather than reacting to things more impulsively.

In the following excerpt, professional Catriona reflected more specifically on how the identity of 'mother' was experienced by a young woman she supported:

> So, it almost like, every bit of her energy was thrown into being a mother. And like, she took on that identity and quite proudly took on that identity. So, we know, you know, for any mother, it's not easy raising children, but she, she's really seemed to thrive and settle in that role compared to any other sort of roles or jobs or experiences that she, that she had had. (P: Catriona, 314-317)

In this excerpt there was a sense that the mother Catriona described had access to multiple identities, and that she had exercised a choice in selecting the identity of 'mother' above any other. It seemed to have a stabilising effect on her, both in terms of her day-to-day life as well as solidifying her sense of self. Again, Catriona highlighted the challenges inherent in being a mother, but this mothers' pride in her status as 'mother' appeared to confer additional energy and drive which made meeting those challenges possible.

For mother Aileen who frequently experienced concern about being, or being publicly perceived to a be, a "shit mum" (M: Aileen, 865), possessing an identity based not just on being a mother but also as a professional appeared to be protective for her. Aileen was one of few women who participated in the study who also embraced the identity of 'care experienced' and appeared to feel that this reflected positively on her. This seemed to help confirm her value as a person when her identity as a 'good enough' mother was threatened.

> A lot of Heads of service round the country came out and said that care experienced people are like one of the, you know, it's like precious assets they can get because, you know, there's a different level of understanding there and it's not, it's not somebody that you should be negative towards. And there has been a shift in that way, like I, um, I've done. I went from being a young person who was, like, would hide my care experience to being someone as an adult who utilises that appropriately. (M: Aileen, 313-318)

For Aileen, the identity of 'care experienced' had been a source of shame and something to be disguised from others. Now she seemed to experience it as valued aspect of her identity. She experienced this shift occurring not just in herself but within the professional realm of social work and subscribing to an identity which was evaluated positively by others appeared to contribute positively to her self-esteem. Aileen and Cristina, both trainee social workers, seemed to reformulate their care experience as something which set them apart in positive ways, which conferred a different, unique or even special level of understanding about what it takes to be both a good mother and effective in their professional roles: "Being in care, it's a very niche experience to have, but there's things that it opens your eyes to, can make you, you know, a much more understanding person." (M: Cristina, 316-318). In the context of their professional roles, both mothers prized being able to use their care experience to 'give back' to the care experienced community and live a life consistent with their personal values, again contributing positively to their self-esteem: "that's quite a strong value that I have in me, kind of striving for social justice for people" (M: Cristina, 145-146).

Subtheme: Ascribed identities and their consequences

This subordinate theme encapsulates participants' experiences of labelling both in reference to mothers with care experience and mothers who might struggle with their mental health, and a sense that professionals and systems ascribed them identities which could be immensely silencing and limiting.

In the excerpt below, Miranda made the critical point that not all journeys through care are equal.

> I was taken into foster care with my brother and sister. She took all three of us. So, I was quite lucky in that sense, where we were together. We were in the same house

> until we were like, 18. Em, but we had, I had a special [maternity] team that deals with people who have been in care before, but it's also the same level as like, junkies. Like addicts. They get the same support. So, I did feel kinda like, I think, labelled in a way. If that makes any sense? (M: Miranda, 52-57)

For Miranda, being in care was a relatively stable, positive experience. However, to her, this did not seem to be reflected in the care she was provided by maternity services. The allocation of a 'special team' seemed to set her apart from other mothers, and Miranda's use of the derogatory term "junkies" implied that she felt as though she was being criticised and ascribed negative attributes she did not recognise as being part of her. Miranda went on to explain that before her own pregnancy she had been a temporary carer for her sister's two infant children, an arrangement approved by social services. She recalled that this information was dismissed by her midwife who said, "it's your own child now, and you know, it's different." (M: Miranda, 244). Miranda appeared to experience a sense of regret that she had not advocated more strongly for herself: "I just feel like I wish that I had said that really, that I knew what I was doing and whatever else." (M: Miranda, 241). Miranda's experience seemed to imply that, within maternity services, the label of 'care experienced' superseded all other relevant information about her, that it defined her entirely as a mother, and significantly restricted her ability to make choices about her care. Miranda's allocation to this service appeared to 'other' her more publicly too. She reflected on her experience within a mother and baby group, where she felt compelled to explain why she was able to see her midwife when others were not: "It just felt, it wasn't very nice, you know, having to explain, like, why. Cause it does feel like, that's coming into like, labels again." (132-133). Again, it seemed that being ascribed this label set her apart from others in ways that she did not recognise and did not want.

Several mothers spoke of the power of labelling in mental health services too. Aileen highlighted the dangers of ascribing young care experienced mothers diagnostic labels such as 'Personality Disorder', one which was "queried when I was a teenager, thankfully never came to fruition" (M: Aileen, 1407).

> But 15-year-olds who are in care were who've had traumatic experiences, or adverse life, childhood experiences which have impacted the development of their personality. And then you're labelling them, which we know there's an aspect there of self-fulfilling prophecy. And you're labelling them to… Maybe they feel quite comfortable with that label because that gives them identity in some ways that they haven't had before and then actually we're giving them a life of that, you know? We're not offering them the opportunity to live a life without that label." (M: Aileen, 1428-1434)

Reflecting on her own near-diagnosis of personality disorder as a teenager, it appeared that Aileen felt as though she had narrowly escaped an alternative, less positive fate which would have been defined by the label. Aileen seemed to imply a sense of permanency, that once applied the label could not be taken back. This ran contrary to her views on managing the impact of childhood trauma: "you just need to give people enough space to deal with that without the label" (M: Aileen, 1149-1150). Instead, there was a sense of hopelessness associated with a label of personality disorder, that it defined a person's whole identity and robbed them of opportunities to recover, or to see themselves in any other way. Aileen referred to medical professionals who "love to throw personality disorder diagnoses at teenagers and young mums" (M: Aileen, 1406-1407), suggesting she perceived a degree of flippancy, irresponsibility, and perhaps even lack of professionalism in how or why the label is applied, and that young mothers are disproportionately targeted.

Cristina, too, spoke of her experience of mental health labelling as inaccurate and diminishing:

> I really didn't like the fact that doctors were calling it post-natal depression. And I was like, this isn't, you know. In my mind that, that's very different to being confronted with childhood trauma. So, I didn't, I didn't like the way that they kind of spoke about it (…) And actually, I've just realised, and that's the trigger, that I wasn't being listened to. Yeah, they weren't understanding my viewpoints. Em, they probably just thought, she's had a baby, we see this often, you know, symptoms of depression. (M: Cristina, 72-74, 439-441)

As for Miranda above, there was a sense that, within a professional system, Cristina had been reduced to a simplistic label which failed to recognise and validate her specific adverse childhood experiences. Despite Cristina's attempt to disagree with the diagnosis, there remained an impression that she felt silenced it, and that the diagnosing professionals' interpretation of her symptoms was privileged over her own. Cristina had clearly sought help for mental health difficulties, but rather than feeling supported, inaccurate diagnosis appeared to generate additional distress for her.

Professionals in the sample also reflected on the labelling of care experienced mothers. Below, Sophie described her hesitancy to share information regarding experience of care within a health care setting:

> I'm just thinking so, in [location], all the notes are online and I don't know if I was seeing someone who was care experienced if I would necessarily include that in the notes. I would consider that very private information, potentially, depending on depending on the issue that was happening. But it's something that I would actually

> probably be sort of quite thoughtful about whether I was including it in my generic notes that everybody can see or not. (P: Sophie, 1545-1545)

Above, Sophie seemed to suggest that experience of care is privileged information, that it is not necessarily of any relevance depending on the healthcare being accessed, and should only be thoughtfully disclosed. However, Sophie's hesitancy to commit care experience to a mothers' generic notes also suggested that she did not entirely trust that other professionals would be able to judge the relevance for themselves. Sophie explicitly expressed her concern that the information "may affect some of the treatment that you get to some extent." (P: Sophie, 1567). This also seemed to suggest that Sophie harboured concern about other professionals' ability to suspend their judgement about care experienced mothers in ways that might negative affect their care.

Superordinate Theme: Engagement with services: the push and pull

This final superordinate theme overlaps with all other preceding themes and relates directly to mothers' interactions with professional services. Mothers and professionals participating in this study spoke about the operation of power dynamics which could be challenging for both to navigate, and all participants volunteered examples of health and social care professionals and systems failing to meet mothers' mental health and parenting needs. Imperfectly functioning systems and challenging power dynamics had the ability to significantly impact on mothers' mental health and their level of engagement with services.

Subtheme: The struggle for power and control

This subordinate theme reflects mothers' experiences dealing with professional systems, as well as professionals' experiences working within the systems that support mothers. Both groups spoke about the balance of power primarily resting with professionals, and mothers' experience of this as controlling. For some mothers this was particularly distressing as it

replicated childhood experiences of feeling overpowered and controlled by others. Power dynamics also impacted on mothers' access to appropriate care and the care professionals felt able to provide. Miranda reflected on her experience of trying to access talking therapies for post-natal depression:

> Yeah, I did like, voice that to them, that I would prefer that. I agreed to take the medication as long as, like, I was referred to that. But then I ended up taking the medication and I was quite settled. Em, it just made me feel a wee bit, like, for a while like numb. Like I didn't have any emotions. Em, but then it started to work so I didn't really push it. But I still heard nothing as I say. Now he's two [laughs]. So, it's quite bad to be honest. That's a year and 9 months. (M: Miranda, 320-324)

Despite Miranda's clearly articulated preference for talking therapies over pharmacotherapy, the impression she gave was that it needed to be bargained for, that she had to submit to the preferences of medical professionals in order to access the care that she needed. Professional Stella reflected that for some mothers, these interactions with professional systems in adulthood could be "triggering of 'I've been here before'" (P: Stella, 403). For mother Kerri, concerns about being overpowered or controlled by professionals and systems disincentivised accessing health care: "I don't think I actually went to one of the clinics until he was, maybe not a year, maybe 8 months/ 9 months old" (M: Kerri, 836-838).

While some mothers like Miranda appeared more inclined to submit to or acquiesce to powerful professionals and systems, others like Cristina below were more willing to challenge them:

> And I guess now looking back at it I made a mental note not to speak about my care experience. I didn't mention it, ever, to any other professional during that pregnancy. The second time round when I had my second son (…) and, you know, I'd had my

> counselling and, you know, I was feeling comfortable in who I was, I remember sitting there like waiting for the question and then very confidently, like, looking at her and going yeah, I was. And you know, what you gonna do? Are you gonna refer me? Are you gonna judge me? (M: Cristina, 116-121)

For Cristina, disclosing her care leaver status to her midwife appeared to be experienced as relinquishing power and control as, armed with that information, the midwife had the power to refer her to social services, potentially threatening Cristina's position as a mother. Challenging perceived authority was not something that came naturally to her but something she implied was a skill to be learned: "She [counsellor] was very good at, you know, kind of teaching me about – like I always remember her saying "hold your power"" (M: Cristina, 257-258). Despite Cristina's increased confidence, challenging power appeared to remain fraught with risk, required careful consideration, and was predicated on her feeling safe enough to do so: "I think if I felt safe, I would think of how to word it and speak out" (M: Cristina, 418). For mothers in the sample, trying to maintain some sense of agency and control in their interactions with services took many forms, from complete avoidance: "I wasn't talking to anybody. I was just living in this wee cave" (M: Kayleigh, 479); to limited engagement: "I wanted to have a home birth because I didn't want, you know, it was that whole lack of control" (M: Kerri, 801-802); to direct challenge: "And yeah, I put a complaint in" (M: Aileen, 440). How power was enacted by professionals and services, and experienced by mothers, appeared to have a significant impact on mothers' willingness and/or ability to access appropriate care, with the potential to put both their mental and physical health at risk.

Professional Stella provided some detailed reflections on her experience of power dynamics operating within professional systems, and between systems and mothers:

> It's not nice because you can't, in the meeting you can sort of, you can offer a view and an opinion, but you're normally, you know, in my experience I would normally have had a manager there who'd, and it's that managerial perspective, you know. People kind of come in and it depends who's chairing the meeting, how the meeting goes as well. You know, and that, you know, it's just kinda not nice. And then at the end of a meeting there's always the kinda task about who's gonna do what, when it's got to be done by, and how often, you know, that's required. And these mums are kind of sitting in these meetings, you know, and you, you're dealing with the kinda disappointment, and the shock sometimes about how do you regroup? How to you kinda regain trust again? (P: Stella, 153-160)

In this excerpt, Stella highlighted how power dynamics between professionals could also have an adverse impact on mothers. In the context of multi-disciplinary meetings where mothers were present, Stella implied that agendas and outcomes could be monopolised by individuals based on their seniority within professional hierarchies or perhaps even their personality. These power dynamics appeared not only to silence the mother but also the professional whose own perspective was superseded by that of her manager. Stella had previously reflected that meetings such as this could be immensely pressured and intense for professionals and 'traumatising' for mothers and could erode any sense of trust previously established between the two.

Subtheme: Imperfect professionals and systems

This subordinate theme reflects participants' experiences of professionals and systems failing to meet the parenting and mental health needs of care experienced mothers. Individual professional error or lack of competence, as well as inflexible systems, were perceived to be

significant barriers to mothers' needs being met. In the excerpt below, mother Kayleigh reflected on her variable experiences with individual social workers:

> And em, everybody had complained. It wasn't just me. Like, she wasn't getting in touch with people and she wasn't arranging meetings, and ignoring phone calls and like, making up like lies as well. And I'd, em, just had enough. So now I've got an amazing social worker. She's lovely. She's so nice, so things are on the right track now. (M: Kayleigh, 624-627)

Here, Kayleigh highlighted how difficult it was for her to challenge what she perceived to be bad practice. Kayleigh asserted that it wasn't 'just her' who complained which suggested that she felt the need to make her claims more credible and, had it been just her, perhaps she would not have been believed. At the end of Kayleigh's excerpt, she seemed to attribute improvement in her functioning to the quality of her social worker. This suggested a degree of fragility in her functioning, such that she was vulnerable to further deterioration dependent on the quality of her care.

Like Kayleigh, Aileen too related an experience of what she perceived to be unprofessional practice:

> He was like, "You, you were in care weren't you? So like, ah, you know we maybe need to think of a safeguarding referral for this child" and I was like you wouldn't do, you wouldn't do a safeguarding referral for a prebirth just because I've been in care. That's not appropriate (…) And he was like, why not? And I'm like, why? I'm a service user. Why am I telling you this? But also, why the fuck would you think you need to do, automatically do a pre-birth because I've been care? It was almost like an argument. I was like you weirdo. But, but he was a mental health worker. He wasn't a social worker. (M: Aileen, 375-386)

In this excerpt Aileen seemed to be communicating several things. In relation to the professional's behaviour, her experience of their interaction as argumentative suggested that both parties were defending a position and that the professional showed little willingness to view things for Aileen's perspective. Making the distinction between his role as a mental health worker and not a social worker suggested that Aileen perhaps viewed his behaviour as overstepping the limits of his own competency or remit. Aileen clearly felt as though this professional was making assumptions about her ability to care for her child based on her experience of care. Her use of the term 'weirdo' to describe him, a term suggestive of strangeness or abnormality, perhaps suggested that this is how she felt as a result of his judgement. Perhaps it also reflected Aileen's sense of incredulity at his suggestion of making a safeguarding referral, that this action would stray so far from her expectation of good professional practice as to be considered 'weird'. For Aileen to be able to safely navigate interactions with professional services and access the health care she required, it appeared necessary for her to be well informed about their procedures. Aileen linked this to her own experience of being in care and at the mercy of professional systems: "I've always took pride and like knowing the law and stuff and my, my rights around stuff because when I was a kid I felt like I had no rights" (M: Aileen, 397-398).

Professionals Sophie and Stella reflected on their own ability to meet the needs of care experienced mothers, and the limitations placed on their practice by imperfect and inflexible systems:

> And she'd say, you know, "We're not here to talk about me. I know. You know, you're, you're not my therapist, you're his therapist." I think because of the age of the child anyways, in CAMHS, like, with an 8-year-old, you don't necessarily do a huge amount of work always with an 8-year-old anyway. I think if they'd been teenagers, it would have been quite different but so it felt like there was sort of scope there to do

> that and to do a little bit of like a scaffolding (…) up in anticipation of, "As the kids grow older, what will things be like?" (P: Sophie, 230-238)

Here, Sophie related her experience of trying to meet the needs of a care experienced mother and her child within the context of a mental health service which separated the care of adults and children. Sophie explained that had the mother accessed adult mental health services "they'd probably say, "well, the kid's stuff you, you'll need to manage with CAMHS if you're struggling with that" (P: Sophie, 113-114). For Sophie, operating within this system that separated the mental health needs of a mother and her child rather than viewing them as interconnected seemed to limit the support she felt she could offer, and she appeared to feel the need to justify her practice. This excerpt suggested that both mother and professional had to repeatedly articulate a boundary between the mother's 'stuff' and the child's 'stuff', and there was a sense that both women felt restricted by it.

In the excerpt below, professional Stella reflected on her experience of gaps in the provision of services which she felt left care experienced mothers particularly vulnerable:

> Then she went back to her own place that we'd helped set up and within a short space of time between the professionals going in, health visitor, em, myself, the other social worker going in, you know, routines, you know, baby being distressed, being really tired, fatigue, and there not being the support from family. So, professionals tended to visit during the day really. She was on her own at night. (P: Stella, 345-349)

Stella observed that despite having a number of professionals involved in her care, the mental health of this young mother and her ability to care for her child deteriorated rapidly. Stella identified the physical and mental toll of being solely responsible for a new born baby as important factors. However, she also seemed to make a distinction between being alone and being lonely. For this young mother being alone during the night also "reinforced all

sorts of negative, you know, about not having family and needing family there, you know" (P: Stella, 368-369). Stella seemed to imply that for this mother, it was not just the absence of family support at night, but what that meant to her or said about her that had such a significant impact on her mental health. Limited by the structures of their service, Stella and her colleagues, though aware of the need for additional support at night, were unable to provide it.

Discussion

The aim of this study was to explore how women with experience of care perceive and manage the impact of motherhood on their mental health. This multi-perspectival study sought perspectives of both care leaver mothers and professionals who had experience supporting care leaver mothers within the context of their professional roles. Across nine participants' interviews four superordinate themes emerged: *The value and benefits of motherhood; When the past and present collide; The value and power of identities*; and *Engagement with services: the push and pull*.

Findings from the current study which make up the superordinate theme '*The value and benefits of motherhood*' suggest that, from the perspectives of both participating mothers and professionals, becoming and being a mother for care leaver women was an experience which could present challenges to mental health, yet also be valuable and rewarding. This seems to echo the experiences of women more generally who report that this is a time often characterised by significant disruption, emotional and physical exhaustion, and oscillation between happiness and fulfilment, loneliness and loss (Barclay et al., 1997; Miller, 2007; Nelson, 2003; Shelton & Jonson, 2006). The current findings support those of multiple other studies exploring the experiences of motherhood for women both in and following care,

with women frequently expressing feelings of joy, love and connectedness towards their children which provided a sense of future orientation and motivation to find work and make healthier lifestyle choices (Aparicio et al., 2015: Barn & Mantovani, 2007; Bermea et al., 2019; Chase et al., 2006; Haight et al., 2009). While previous research has suggested that both professionals and mothers can experience doubt about mothers ability to parent and fear the inevitability of 'cycles of care' repeating (Dominelli et al., 2005; Haight et al., 2009; Rutman et al., 2002), the findings of this and several other studies suggest that motherhood for some care leavers in fact has the potential to be calming, grounding and a positive turning point in their lives (Chase et al., 2006; Rutman et al., 2002).

Participant interviews revealed anxiety and guilt as emotions commonly associated with motherhood which impacted negatively on mental health as illustrated under superordinate and subtheme '*When the past and present collide: Motherhood as a source of guilt and anxiety'*. Mothers expressed anxiety about their parenting capacity, and how their ability to parent might be perceived by others. This was often related to fears of having their children removed from their care, or of replicating the abusive/neglectful caregiving they experienced themselves in childhood. Similar fears have been expressed by mothers in and following care across multiple studies (Dominelli et al., 2005; Haight et al., 2009; Maxwell et al., 2011; Pryce & Samuels, 2010; Rutman et al., 2002). Where mothers perceived their parenting competency to be 'falling short' in some way, they expressed feelings of guilt. The concept of 'maternal guilt' is a common finding in research beyond that focussing on the care experienced (Sutherland, 2010). It is often considered a 'natural', inevitable feature of motherhood, and is frequently associated with mothers' own internalised expectations as well as implicit and explicit messaging from those around them (Seagram & Daniluk, 2002). These expectations may be informed by the dominant cultural ideal of mothering, termed the "intensive mother" (Hays, 1996), who is "ever bountiful, ever giving" and "self-sacrificing"

(Bassin, Honey & Kaplan, 1994, pg. 2). Findings from the current study also suggest that restricted access to positive parenting role models can make it difficult for care experienced mothers to know what 'good enough' parenting looks like. The intensive mothering ideal and restricted access to positive role models, combined with mothers' fears of 'cycles of care', may account for the high levels of anxiety regarding parenting which emerged in the current study, as well as some mothers' tendency towards perfectionism as a means of coping with their anxiety. It may also account for the frequency with which mothers appeared to experience guilt for failing to live up to this ideal. Indeed, several studies have demonstrated that striving to be a perfect mother can increase maternal guilt and stress (Rotkirch & Janhunen, 2010; Henderson et al., 2016).

While most mothers associated negative evaluations of their parenting with feelings of guilt, several mothers appeared to experience significant discomfort expressing these feelings and rather than relating them to specific behaviours, were more inclined to relate them to evaluations of their whole self. This is more indicative of shame. Indeed, research suggests that it can be difficult for some people to distinguish between feelings of guilt and shame (Kim et al., 2011). Making the distinction is important because of the disparate ways in which they influence maternal behaviours which ultimately seek to mitigate the associated discomfort. Where guilt is associated with constructive, reparative behaviours, shame is more associated with avoidance and withdrawal (Smith et al., 2002; Tangney & Dearing, 2002). In their process model of help-seeking in mental health, Saunders and Bowersox (2007) demonstrated how shame can increase denial and minimisation of difficulties and act as a barrier to help-seeking. A further study found that maternal feelings of shame significantly predicted symptoms of post-natal depression and less positive attitudes towards help seeking while guilt did not (Dunford & Granger, 2017). Taken together, these findings suggest that for care leaver mothers experiencing feelings of shame regarding their parenting, who may

also fear the increased scrutiny and perceived threat of child removal associated with approaching services for support, shame may further disincentivise help seeking and negatively impact mental health. While management of maternal shame is relatively underexplored, there is some evidence to suggest that supporting mothers to develop greater self-compassion may be helpful in reducing shame and incidence of post-natal depression (Cohen, 2010). Perez-Blasco, Vigeur and Rodrigo (2013), for example, trialled an eight-week perinatal mindfulness-based intervention and found that reducing shame through increased self-compassion can significantly reduce stress, anxiety and psychological distress.

As illustrated under superordinate and subtheme *'When the past and present collide: Compensating for the past'*, several mother and professional interviews revealed some mothers' tendency to 'overcompensate' in the way they parented their children as a strategy for managing difficult emotions associated with motherhood. The phenomenon of over-compensatory parenting behaviours in mothers has been identified in other qualitative studies pertaining to both care experienced and incarcerated mothers, but has rarely been explored in any depth (Pryce & Samuels, 2010; Shamai & Kochal, 2008). Some mothers in the current study appeared able to identify and meet their child's needs proportionately, and one mother felt that her own negative experiences of being parented had simply taught her how to be more sensitive to those needs. This mother tended to view her own parenting more positively and experienced less anxiety and guilt. For others, becoming a mother appeared to trigger intense fears of being abandoned or rejected by their child, or of replicating their own experiences of abusive parenting. To manage their own distress, these mothers appeared to engage in more extreme forms of compensation, or overcompensation, resulting in parenting that could be overprotective or overly permissive. As one professional highlighted, boundary and limit setting could be a particular challenge for the care experienced women she encountered. DiLillo and Damashek (2003) suggested that for mothers who felt powerless as

children as abusive adults wielded power over them, there may be strong desire to protect their children from similar experiences. For them setting limits and boundaries may be misinterpreted as an abuse of power over their child and therefore avoided. These findings suggest that compensatory parenting behaviours may not be unique to care experienced mothers per se, but are linked to experiences of abuse and neglect which brought many into care in the first place. The aforementioned fear of 'cycles of care' repeating could potentially intensify their need to parent differently, or better, than their own mothers/caregivers. Some mothers may therefore benefit from additional support to understand the emotional world of their child and to learn alternative ways to manage the distress being a mother may elicit. Parenting groups such as the Mellow Bumps programme may be particularly suited to a care experienced population as it has an established evidence base for use with more vulnerable mothers and facilitates reflection on how a mother's past may influence her current parenting style (Puckering et al., 1994).

Mellow Bumps is a group intervention designed to reduce anxiety and promote wellbeing in vulnerable pregnant women using both psychological and practical strategies (Breustedt & Puckering, 2013). A rigorous and comprehensive Process Evaluation involving 108 mothers across 28 groups revealed that engagement with the reflective component of the programme was variable and was largely dependent on the coherence of the group, with relative rapport being negatively affected by poor attendance and lack of homogeneity within groups (Buston et al., 2019). In terms of implications for ongoing practice and research, an important first step in assessing the suitability of Mellow Bumps may be consulting with care experienced mothers to consider how such a group might be offered. For example, would some mothers welcome groups where all attendees share similar experiences of care? As one mother in the current study highlighted, not all care experiences are the same and not all mothers welcome interventions based on this definition and may find it stigmatising. As care

experienced mothers as a population are a highly heterogeneous group, consideration would need to be given to how homogeneity would be defined.

Identity was a concept which emerged frequently across mother and professional interviews and was captured under subtheme *'Developing valued identities'*, the first of two subthemes emerging under superordinate theme *'The value and power of identities'*. The identity of 'mother' appeared to help women make sense of themselves and provided a new sense of purpose. The identity of mother has also been framed as an opportunity to cast off previously unwanted identities, such as that of care experienced, and to acquire a more conventional identity which confers a new social status (Luyten et al., 2017; Pryce & Samuels, 2010). While both mothers and professionals in the current study echoed this experience, there was also a sense that mothers' positive sense of self, and therefore their mental health, was extremely vulnerable when their identity was linked wholly to being a mother. This suggests that while the identity of mother can provide a useful scaffold in the development of identity, supporting care experienced mothers to look more actively beyond motherhood as the only thing that positively defines them may promote more resilient mental health. Mothers' own narratives indicate that learning to see the value in their experience of care can promote more positive views of self. This was most evident in the narratives of two mothers who, at the point of interview, were training to be social workers. Not only were they able to use their experience in their work, they were also exposed to others who valued their experience and contribution too. This provided opportunities to internalise more positive views of self. Indeed, the specific value of care leavers experience to employers, and of employment to care leavers, are explicitly recognised by the Care Leaver Covenant which actively promotes careers in social care with the tagline *#wecanbeheroes* (Care Leaver Covenant, n.d.). Research has also shown that, for care leavers, job roles which position them as role models or 'experts by experience', as well as being instrumental in bringing about

positive change for others, can prompt positive inner change (Luyten et al., 2017), and a new peer group of colleagues can support the development of insight and reflection (Parkin & McKeganey, 2000).

In the second subtheme '*Ascribed identities and their consequences*', findings from both participant groups suggested that mothers frequently experienced being ascribed identities by others, particularly in healthcare settings, in ways that were felt to be both silencing and limiting. As mothers with care experience these identities were often highly stigmatised. Narratives suggested that assumptions made by health care professionals, when embedded in institutional practices, had the potential to limit mothers' ability to make informed choices about their care leading to inappropriate intervention. Similarly, research has suggested that other minority and marginalised groups (e.g. ethnic and racial minorities) also experience stigmatisation in health care settings which results in inappropriate treatments and adverse experiences meaning they are less likely to seek help and are more likely to terminate treatment early as a result (Atdjian & Vega, 2005). Three mothers highlighted the particular experience of having their mental health difficulties inappropriately or inaccurately labelled in ways that felt dismissive of their, often traumatic, early life experiences. A recent systematic review of service user, clinical and carer perspectives on mental health diagnosis found that while accurate diagnosis was associated with relief and validation and provided a framework within which experiences could be interpreted, misdiagnosis was associated with increased distress, decreased confidence in services and, again, inappropriate treatment (Perkins et al., 2018).

Within the final superordinate and subthemes *'Engagement with services: the push and pull: The struggle for power and control'* and *'Imperfect professionals and systems'*, both participant groups highlighted the potential for interactions with services to negatively influence how mothers managed the challenges of parenting and impact on mental health.

Specifically, they both reflected on the influence of power dynamics between mothers and professionals, and the imperfections of systems and professional practice as factors which limited mothers access to care and limited professionals' ability to provide care. Participants from both groups reflected that some mothers' perceptions of professionals and systems as wielding power over them, and their exposure to unprofessional practice, could be particularly distressing as they echoed childhood experiences of feeling overpowered and controlled by abusive parents, caregivers and systems. These findings reflect those of previous studies showing that care leavers can find it difficult to trust systems, adults and carers because of negative historical experiences (Knight et al., 2006). Butterworth and colleagues (2017) also found that young people transitioning out of care fear how professionals may use their power against them. Their participants spoke of the lack of collaboration they experienced in their interactions with professionals, how they felt powerless to influence their own care, felt disregarded, and as though their own concerns about their safety were routinely dismissed.

Health and social care professionals and systems are increasingly recognising the challenge of access and engagement for those who have a history of adverse experiences which may have been traumatic, which includes those with experience of care. By way of response there has been a move towards developing services and practices that are 'trauma informed'. The aim of a trauma informed approach is to raise awareness of the impact of trauma in all its forms, educate individuals and organisations to be able to recognise the signs, symptoms and widespread impact of trauma, and ultimately prevent re(traumatisation) of services users (Office for Health Improvement and Disparities, 2022). However, the Early Intervention Foundation and The Independent Review of Children's Social Care both noted that while many services claim to be 'trauma informed', children in care and adult care leavers continue to report that this is not their experience (Early Intervention Foundation,

2022a; MacAlister, 2022). These findings appear to be supported by the experiences of participants in the current study.

The Independent Review of Children's Social Care highlighted examples of good practice in meeting the mental health care needs of care leavers, such as the Pathways Leaving Care Service in Middlesborough who have embedded a therapeutic practitioner within their service who can offer evidence based psychological therapies and support access to more specialist services such as the perinatal mental health team. While the review argues that this eliminates the threat to mental health of the 'care cliff' - the cessation of support at age 18 - as Leaving Care services are offered until age 25, three of the five mothers participating in the current study gave birth after the age of 25 and were therefore wholly dependent on universal services to meet their mental health care or parenting support needs. As highlighted above, older care leaver mothers, and indeed older care leavers in general, have received minimal attention in academic research and little provision in policy. The Independent Review of Children's Social Care acknowledged that better data on the health outcomes of care leavers is required to better inform future policy and practice (MacAlister, 2022). They recommend that both the Office for National Statistics and the NHS initiate routine collection of data moving forward. This will inevitably include NHS mental health and maternity services. Mothers in the current study emphasised the importance of having collaborative relationships with professionals and being able to make informed decisions about their care, as well as being able to use their experiences to 'give back' to the care leaver community. These mothers have potentially valuable contributions to make in the co-production of research, policy and practice (McKirdy, 2015). Involving care leaver mothers at this early stage of data collection may have implications for which outcomes are prioritised. Increasing the visible presence of a typically stigmatised and marginalised population within the spheres of policy production, research and practice may also present

important opportunities to challenge stigma and further empower care leaver mothers (McKidy, 2015).

Strengths, limitations and future research

This study offers insight into how care experienced mothers perceive and manage the impact of motherhood on their mental health from two perspectives: that of mothers; and that of a group of professionals who support them. To date, much of the relevant literature, policy and practice has tended to focus on mothers in or recently transitioned out of care (Crous et al., 2021; Duncalf, 2010). A strength of this study is that is focusses only on mothers who have already left care. A further unanticipated strength is that it gives voice to a sample of predominantly older care experienced mothers who have often been overlooked. By employing a multi-perspectival design, Larkin and colleagues (2019) argued that the potential reach and impact of results can be extended. Evidencing experiential insight from multiple perspectives may provide a more persuasive argument as to the generalizability of findings (Larkin et al., 2019). Illuminating areas of consensus and conflict between the perspectives of service providers and service users may also have greater utility in terms of informing professional practice (Larkin et al., 2019). Those who participated in this study also reported that the experience was generally positive. Professionals said that they valued the opportunity to reflect on their practice and felt that these reflections offered them new insights into the experiences of care leaver mothers. Mothers said that they welcomed the opportunity to 'give back' or do something positive for the care experienced community. Some also said that they found interviews to be therapeutic and valued the chance to talk about their experiences.

A significant limitation of the current study is the level of homogeneity within the sample. With regards to the 'mothers' group, the age range of both mothers and their children was broad with maternal age ranging from early 20s to early 50s, and children's ages ranging

from 2-18 years. In terms of the 'professionals' group, several professions were represented. The purpose of homogeneity in IPA is to ensure that all included participants can speak to a phenomenon of interest, and to a large extent this was achieved. While IPA is less concerned with empirical generalizability (Pietkiewicz & Smith, 2012), reduced homogeneity may affect the degree to which results are perceived by readers to be valid. Smith and Osborn (2008) caution that a degree of pragmatism may be required as a sample will always be in part dictated by who is willing to participate. Indeed, significant efforts were made to achieve a more homogenous sample but recruitment was hampered by many obstacles, some of which were anticipated and some of which were not. For example, care leavers as a population are often considered 'hard to reach' (Palmer et al., 2022). Predicting challenges with recruitment, efforts were made to engage the support of multiple third sector organisations across the UK. Despite willingness on behalf of the organisations who engaged with the study, only one participant in the 'mothers' group was recruited in this way. Perhaps even more surprisingly, only two participants in the 'professionals' group were recruited through third sector organisations. Discussions with representatives from these organisations suggested that unprecedented demand for services post pandemic had an impact on the amount of time professionals may have had available. Two recruitment sites noted a welcome increase in interest from other researchers in care leavers as a population. This may have created a degree of research fatigue in both mothers and professionals associated with these sites. This study may also have suffered from a degree of volunteer bias, whereby only those who were particularly motivated to engage did so (Thompson, 1999). While IPA does not claim to be representative of a wider population, the potential for volunteer bias in the current study means that a range of equally valuable perspectives on the phenomenon of interest may have been missed. Further, due to restraints on time, triangulation with a second researcher was not carried out which may reduce the credibility and transferability of findings (Alase, 2017).

The exclusion of fathers from this study could be considered a limitation as it risks further excluding a group who already report feeling 'unimportant' in the eyes of professional services (Tryer et al., 2005), and whose role, contributions and experiences are routinely neglected in child welfare research and practice (Cameron et al., 2012; English et al., 2009; Dubowitz et al., 2006). A review of those studies exploring the experiences of care leaver fathers revealed some elements of their experience, such as anxieties about paternity, are gender specific (Tryer et al., 2005). Findings from the current study also suggest that aspects of mothers' experiences were influenced by gender-based culturally defined expectations of motherhood which contributed to the experience of 'mother guilt'. Several studies have reported that care experienced mothers are more likely to raise their children as a single parent (Schelbe & Geiger, 2017; Roberts, 2021; Botchway et al., 2014) which may alter the impact of motherhood on mental health, as well as the impact of fatherhood on mental health for those fathers parenting from a distance or who are entirely excluded from the role. As ongoing custody of a child/children was an essential inclusion criterion for this study, it is likely that reduced father involvement would have limited recruitment potential. For these reasons, the current study opted to prioritise gender-sensitivity over the risks of gender-bias.

Many of the limitations identified above provide opportunities for future research. Exploring care leaver fathers' perceptions of the impact of fatherhood on their mental health would certainly go some way to addressing the issue of gender-bias and underrepresentation of fathers in research and help tease apart potentially gender-specific elements of their experience. Similarly, focussing on the experiences of older care leavers more deliberately may also help illuminate the specific support needs of this group, should there be any. This may be particularly pertinent to those over the age of 25 as this marks the end of statutory support for care leavers in the UK, often referred to as the 'care cliff' (Palmer et al., 2022). Grounded theory as an alternative methodological approach may be useful in deepening

understanding of the processes involved in managing maternal guilt, anxiety and shame as well as to further explore identity formation in care experienced mothers.

Conclusion

This study explored how care leaver mothers perceive and manage the impact of motherhood on their mental health from two perspectives: that of mothers themselves and from the perspective or a group of professionals who support care leaver mothers. The findings of this study suggest that both mothers and the professionals who support them perceived motherhood to be challenging, with elements of the experience impacting negatively on mental health. However, this was often outweighed by the value attributed to the role and identity of 'mother' and the potential benefits this could bestow. Both groups observed that mothers' histories of care, and the experiences which brought them into care, often gave rise to painful emotions such as guilt, anxiety and potentially shame in relation to the role of mother, and that to cope with this, mothers might engage in compensatory parenting strategies. How mothers ultimately coped with motherhood and any possible impact on their mental health was influenced significantly by the nature of interactions with professionals and services. Both groups highlighted the power dynamics between mothers and professionals, or within professional systems, as well as inflexible systems and imperfect individual professional practices as particularly areas of difficulty which had the potential to limit mothers' access to appropriate support. Research suggests that some interventions, such as those seeking to developing mindfulness skills or increase self-compassion, may have some utility in reducing maternal shame, anxiety and post-natal depression. Parenting interventions such as Mellow Bumps may help care experienced mothers reflect on how their experiences of being parented influence their own parenting style and potentially reduce the likelihood of engagement in unhelpful over-compensatory parenting behaviours. However, relatively little is known about care leaver mothers as a population in general, let alone about

their ongoing mental health, and so an important first step in addressing this gap will be the routine collection of data, in work co-produced with care leaver mothers, to better understand their mental health care needs.

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Any correspondence, queries or additional requests for information on the manuscript submission process should be sent to the *Journal of Social Work* editorial office as follows:

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Appendix B: Systematic Review: Critical Appraisal Skills Programme (CASP) Quality Checklist

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Paper for appraisal and reference: .....

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal

Comments:

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:

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4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

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6. Has the relationship between researcher and participants been adequately considered?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location • How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained • If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study) • If approval has been sought from the ethics committee

Comments:

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8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

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Section C: Will the results help locally?	
10. How valuable is the research?	HINT: Consider • If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:

Appendix C: Systematic Review: Representation of themes across studies

		Paper	Bell (2020)	Honey (2018)	Janzen (2016)	Kenny (2015)	Kenny (2019)	Lewis (2018)	Marsh (2019)	Memarnia (2015)	Newton (2020	Nixon (2012)	Otterlei (2021)	Richardson (2020)	Syrstad (2019)	Wells (2011)
Superordinate Themes	Subordinate Themes															
Adverse life histories and context of child removal			x	-	-	-	x	x	x	x	-	-	x	x	x	x
Immediate psychosocial crisis	Felt impact		x	-	x	x	x	x	x	x	-	x	-	x	-	x
	Coping and its consequences		-	-	x	x	x	x	x	x	-	x	-	-	-	x
Cumulative and enduring consequences	Renegotiating mothering roles and identities		X	X	X	X	-	-	X	X	x	X	X	X	X	x
	Restrictions, change and loss within interpersonal relationships		X	X	-	X	-	X	-	-	X	-	-	X	-	x
	Social stigma		X	-	X	X	X	-	X	X	-	-	X	-	X	x
	Institutional stigma		X	X	-	X	X	X	X	-	X	-	X	X	X	-
	Facing Powerful Systems		x	x	x	X	x	x	x	x	x	x	x	x	x	x
	Renegotiating Accountability		x	-	x	x	x	x	x	x	x	-	x	x	x	x
	Finding Healing and Meaning		x	-	x	x	x	x	x	x	x	-	x	x	x	x

Appendix D: Systematic Review: Additional quotes supporting themes

Themes		Additional supporting quotes
Adverse life histories and context of child removal		• "But of course when you've got an influx of so many problems you know, you've got the health, you've got my housekeeping, not brilliant (laughs), you've got domestic violence, you've got you know gangs and crime (pause) that is a great number of things to deal with in one context." (Lewis & Brady, 2018, p. 257) • "It is not my fault that my parents got divorced. It is not my fault that he chose to be unfaithful to me while we were married .. . I ended up being punished." (Otterlei & Engebresten, 2021, p. 10) • She then goes on to describe her illegal drug use as beginning when her first child was born, and the life she had with her husband as "crazy"—characterized by multiple moves and breakups with her husband. Though the narrator's first child lived with her "most of the time", she described a pattern in which she left her daughter with her mother or her mother took her daughter into her care, when things were particularly unstable, and the effect of this instability on her child. She notes her own confusion as to whether she wanted "to be a mom or …a teenager", her "sense of abandonment", "loneliness", and feeling of "pretence", when her child was not with her. (Wells, 2011, p. 444)
Immediate psychosocial crisis	Felt impact	• "Knowing my daughter is happy and well is the only reason why I haven't killed myself, but there are many times when I've thought about committing suicide ...." (Bell et al., 2021, p. 2031) • "And in the end, due to my children going, I suffered a complete breakdown where I lost all sense of what was real, similar to how I was when I was a child." (Richardson & Crammer, 2020, p. 365) • ''I felt like for a long time like everything beautiful in me had been taken out. . . I felt like an empty husk.'' (Kenny et al., 2015, p. 1160)
	Coping and its consequences	• "Ultimately that's our coping skill. That's our friend. Because, yeah I lost my best friend. When anything was going wrong, who was there for me? By continuing [with cocaine], by going down the road after my kids [were] gone, like with Clara being apprehended, I didn't pick up the phone and call my treatment centre. I picked up the phone and called my drug dealer." (Janzen & Melrose, 2016, p. 241) • "I really felt that void at a certain period of my alcoholism. I don't care how much I would drink, I didn't feel comfortable inside that I knew my child was at my mom and she had the full responsibility …of nurturing her and making her happy." (Wells, 2011, p. 443) • "At the beginning I lost the plot, I was selfharming, I was overdosing, couldn't cope with it all ..." (Memarnia, 2015, p. 306)

Cumulative and enduring consequences	Renegotiating mothering roles and identities	• "I understand that I'm always gonna be their parent ... mother but having them not in my life is ... Especially the two that are up for adoption, not having them in my life but knowing they're out there and they're being raised by someone else. I see myself as a part-time mum. When I've got contact with them, that's when I'm a mum, but other than that I'm just me now. And I'm just trying to work out who me is. All I've known from the age of 17 upwards is being a parent. Erm, so, to have them suddenly removed .. . I just didn't know who I was anymore. And I couldn't work out who I was." (Memarnia, 2015, p. 307) • "You lose a part of yourself, I feel. You can't ... be the mom you want to be. You have to .. . be mom from afar .. . You miss out on a lot." (Otterlei & Engebresten, 2021, p. 11) • "We write every year . . . I struggle because you're not allowed to be mum. You've got to be flat. I call it my robotic letter. It's got to be emotionless . . . You cannot say how much you love them or miss them . . . What I do every now and again, every other year, I'll write a loving letter and they'll just put it in the system for me . . . Because I don't want them to go to their file and always find half-hearted letters, I want them to go there and know that I fought for them and I love them and I miss them." (Richardson & Brammer, 2020, p. 365)
	Restrictions, change and loss within interpersonal relationships	• "Rather than social services saying either get out of this relationship or lose your kid, it's not that easy, because they don't know they could be in charge of the finances. So if you've been in that relationship, say, for 10 years and they've had control of that money you don't know any more, it goes out your memory. It's like, 'oh how do I do this now' . . . you've gotta reprogramme yourself, and with them relationships it's hard." (Lewis et al., 2018, p. • "My mum phoned the police on me. It would not have been as bad as it was if she had not been stood in the window yelling, you're not having your kids back, they don't even love you." (Richardson & Brammer, 2020, p. 367) • "[My daughter] does not really know me, she got taken from the hospital and that was the only bonding I had with her besides when DoCS would bring her over, three days a week I had with her before I went off to rehab to fight for both the kids because the judge said I had to do twelve months rehab … if I have a visit with her and my mum well she knows who I am, but if I'm around my uncle and his wife she sort of pushes me away." (Newton, 2020, p. 817)
	Social stigma	• "I find society views mothers that use as write offs, that there's no going back or coming back from it . . . society is so judgemental when it comes to . . . even if they find out you've been clean for 10 years. It doesn't matter. You still have, you're tainted or something." (Janzen & Melrose, 2016, p 241-242) • "I was afraid that people would look down on me and judge me ... I have friends with children, and I was afraid that they would not let me be around them." (Otterlei & Engerbresten, 2021, p. 12) • "Only minimal people knew. I just felt so much shame and guilt and it was like . . . ' Oh my god, I've really f——d up!' I had no one to talk to. I didn't know who would understand. I hated going out of the house and I didn't for about two months." (Marsh et al., 2018, p. 7)

Institutional stigma	• "The place where I was … there's a lot of Aboriginals and the majority of them have got their kids taken from down there it's like yeah they are picking on that certain little area and the certain culture" (Newton, 2020, p. 820) • "They find out you're, you're an addict, sex worker, and you're shit to them. So, they don't care how they help you. If you don't know what you're doing, they're gonna screw you and they're gonna say 'we're not gonna help you.'" (Kenny et al., 2019, p. 1912) • "I would like to see moms have greater access to each other because I think the way the system is set up from many different perspectives in the system it is really individualized so you're meant to feel like you're the only one this has ever happened to and there is something wrong with you and what you did and women really internalize all of that crap." (Kenny et al., 2015, p. 1162) • "I think that particular case manager, she just, she judges you on what she knows from the past but not that you can progress forward." (Honey et al., 2018, p. 423)
Facing Powerful Systems	• "I wanted to get violent," recalled Cristine. "I really felt I guess betrayed a little bit, misled for sure, and . . . but at the end of the day there was nothing I could do." (Janzen & Melrose, 2016, p. 242) • "My plan is to apply for custody of my youngest child . . . It is doing my head in . . . We have got another review in 4 months but I want things to start now because the longer I wait, it sounds selfish, the more settled they are going to be . . . I am trying to find things now like parenting classes to prove that I have changed and that I do want my child." (Richardson & Brammer, 2020, p. 365) • "There is no point in trying to do something against this system. To gain more contact with your children, you must collaborate with the system." (Srystad & Slettebo, 2020, p. 104)
Renegotiating Accountability	• "I knew I needed help, I knew I wasn't a very good mum." (Bell et al., 2021, p. 2027) • "To dare to look at yourself in the mirror and say: I have betrayed my children. To dare to acknowledge your role as a mother who has betrayed, that requires much assistance. This is about rebuilding dignity, power and identity." (Syrstad & Slettebo, 2020, p. 103) • "Vicky is referring to her now adult children, who were removed nearly 2 decades ago, and in hindsight, she believes it was rejecting this offer of support that led to her children being removed, commenting 'if I'd done it earlier, I mightn't have got my children taken off me'" (Newton, 2020, p. 818)
Finding Healing and Meaning	• "I hated every minute of therapy if I'm honest, every day I hated it. But in hindsight now it's over and done with I, I realise I did get something from it, cos I see how angry my mum and my sister and everyone else still is, and I'm not in that same place." (Lewis & Brady, 2018, p. 257) • "If I hadn't of got into the further education or finding a career then god knows where I'd be. I'd probably be on the streets begging for money, taking drugs and stuff like that. Only I could make that decision that I wanted to change my life and I knew that." (Memarnia, 2015, p. 308) • "Now they're safe and I believe I can now handle myself. I'm emotionally stable and feel empowered to become a good mum. I've learnt coping skills and to be able to trust. I am more

confident to speak about what happened and how I've changed. Speaking to other women, in the same situation I was in, I try to motivate them to get support" (Marsh et al., 2018, p.7)

Appendix E: Systematic Review: Example of thematic analysis – Data that didn't fit original framework

New Theme	
Renegotiating Accountability	***Codes contributing to theme***
	Don't understand why child removed x 6 Reflecting on reasons for removal/ taking responsibility x 22 More information/support might have avoided removal x 14 Minimising reasons for removal x 4 Reflecting on reasons for removal/ using avoidance as protection Continuity of professionals important to mothers x2 Acceptance of child removal
Facing Powerful Systems	
	No control/ powerless x 4 CPS dismiss positives Honesty not rewarded Desperate measures to keep custody Ambivalent relationships with CPS CPS – want better communication CPS – not clear what they want CPS – feeling invisible/ dehumanised CPS – feeling betrayed/deceived CPS – deceitful CPS – incompetent/ deceitful CPS – deceitful Professionals deceitful/ feeling betrayed CPS as deceitful CPS – anger x 3 CPS – trying to prove self CPS – harmful, not helpful CPS – not recognising positive change CPS – must be compliant/submissive to get children back x 4 CPS – Trying to guess what they want Catch 22 – unable to meet all CPS expectations CPS – dismissive/ disrespectful CPS – feeling set up to fail Had to fight for support Fighting for the right support CPS – make their own rules CPS – condescending Professional services disorganised CPS – withholding information x 2 CPS – refused contact on meaningful occasions

	CPS – communication unclear/ mixed messages
	CPS – refusing to clarify expectations
	Professional agencies acting inappropriately
	CPS – dismissive
	CPS – disregarding feelings
	CPS – won't willing to listen
	CPS – superior
	CPS – lacking knowledge/ understanding x 3
	CPS – sharing limited information
	CPS – incompetent
	CPS – overstepping limits of competency
	CPS – hard to meet their expectations
	CPS – everything we do is wrong
	Expectations unfair
	CPS – lack of clarity in decision making
	CPS – inhumane
	CPS – emotions invalidated
	CPS – disregard mother's distress
	CPS – short-sighted policies
	Fear of future pregnancies and risk of removal
	Previous removal impacting on experience of subsequent pregnancy
	Aborted pregnancy rather than suffer removal
	CPS – dismissive of mothers and emotions insignificant x 2
	CPS – won't listen to story
	CPS – powerful
	CPS – no transparency
	Lack of transparency
	Removal sudden/ unexpected
	Lost opportunity for contact before removal
	Professional kindness
	CPS – lacking sensitivity
	No support
	Frustration with CPS decision making
	Parenting under scrutiny
	Lost confidence in ability to parent
	Asking child to collude to prove self to CPS
	Feeling as though Aboriginal culture not respected
	Cultural needs not prioritised
	Lost confidence in ability to parent x 2
	CPS – don't value ethnic minorities
	Women feeling unsupported by services
	Lack of support
	CPS working against mother
	Feeling helpless
	Feeling under intense scrutiny
	Removal unexpected
	Fighting for reunification
Finding Healing and Meaning	
	Importance of maintaining connection to children

	Importance of information about child
	Traditions important for maintaining hope
	Traditions important for healing
	Making up for the past with grandchildren
	Self talk helping recovery
	Moving forward positively in life
	Positive views of self x 4
	Support that helped recovery – feeling loved
	Support that helped – faith/religion x 2
	Hope of reunification x 8
	Giving back/helping others aided recovery x 3
	Reconciling historical adversities to move forward x 5
	Peer support aiding recovery x 5
	Therapy aiding recovery x 2
	Counselling and DV support aided recovery
	Finding strength
	Time important for recovery
	Activism aided recovery
	Education and employment aided recovery
Remaining codes not attributed to theme	
	Fathers important/ need help too
	Fathers important/ need help too
	Internalised gender roles
	Self blame
	Sense of personal agency
	Continue to want best for children
	Shame
	Comparing self to own mother
	Ambivalence about being a mother
	Expectations different for mothers and fathers
	Comparing self to own mother
	CPS contact initiated by mother
	Suffering endures in the long term
	Guilt endures in the long term
	Dissociating from emotions

Appendix F: Journal of Personality and Social Psychology author guidelines

General Submission Guidelines

The editorial team of *Journal of Personality and Social Psychology* is committed to both transparency and rigor in conducting and reporting research. We believe that science advances throughs a cyclical and recursive process that includes both (i) a theory-building, exploratory/descriptive phase and (ii) a theory-testing, confirmatory phase. We therefore support and encourage research that is informed by both phases. Guided by this overarching philosophy, we set out some concrete submission standards.

Open Science

Once a paper is published, APA requires authors to share their data with qualified researchers for the purpose of verifying published findings through reanalysis using identical or alternate statistical methods. To facilitate transparent and open research practices, *Journal of Personality and Social Psychology* further encourages researchers to make data, analytic methods, and research materials reported in the published article available to all researchers for the purpose of reproducing the findings and replicating the results by specifying where or how other researchers can access this material.

At submission, authors must complete the Open Practices Disclosure Form (PDF, 922KB). The completed form must be included as Supplemental Material. The disclosures include:

Availability of Data. Authors must indicate whether the data from each study included in the manuscript will be made available or provide a reason for not sharing the data in the author note.

Availability of Analytic Methods and Code. Authors must indicate whether the analytic methods and code for each study included in the manuscript will be made available or provide a reason for not sharing this information in the author note.

Availability of Research Material. Authors must indicate whether the research materials for each study included in the manuscript will be made available or provide a reason for not sharing the material in the author note.

Please fill in the information for each study reported in the manuscript. Study numbers are pre-filled on the form, but you may change these as necessary to match labels used in the manuscript. If you have more than nine studies, please use multiple forms.

Upon acceptance of the manuscript for publication, authors must provide a single link to a trusted open-access repository within the author note containing all data and materials that they have agreed to provide. If an author has multiple studies, the repository landing page should clearly identify how to access the specific type of information for each study and the links.

- Download a quick guide on how to organize this information (PDF, 310KB)

Disclosure of Prior Uses of Data. Upon submission of a manuscript, the authors must disclose any prior uses in published, accepted, or under review papers of data reported in the manuscript. The cover letter should include a complete reference list of these articles as well as a description of the extent and nature of any overlap between the present submission and the previous work.

Citation Standards

Upon submission, all data sets, materials and program code created by others must be appropriately cited in the text and listed in the reference section. Such materials should be recognized as original intellectual contributions and afforded recognition through citation.

Where possible, references for data sets and program code should include a persistent identifier assigned by digital archives, such as a Digital Object Identifier (DOI).

Data set citation example:
Campbell, Angus, and Robert L. Kahn. American National Election
Study, 1948. ICPSR07218v3.
Ann Arbor, MI: Interuniversity

Consortium for Political and Social Research [distributor], 1999.
http://doi.org/10.3886/ICPSR07218.v3

Design and Analysis Transparency

Please refer to the specific section editorials and the Journal Article Reporting Standards (JARS) (PDF, 220KB) for instructions on information to include in method and results sections. It is particularly important to provide justifiable power considerations and specific details related to sample characteristics.

Preregistration

Preregistration of studies and specific hypotheses can be a useful tool for making strong theoretical claims. Likewise, preregistration of analysis plans can be useful for distinguishing confirmatory and exploratory analyses.

At the same time, we recognize that there may be good reasons to change a study or analysis plan after it has been preregistered, and thus encourage authors to do so when appropriate so long as all changes are clearly and transparently disclosed in the manuscript.

The journal also acknowledges that preregistration may not always be appropriate, especially in the exploratory phases of a research project. If authors choose to preregister their research and analyses plans, all documents should be succinct, specific, and targeted, as well as anonymized to maintain double-blind peer review.

Whether or not a study is preregistered, *Journal of Personality and Social Psychology* stresses the importance of transparency in reporting and expects researchers to fully disclose in their manuscript all decisions that were data-dependent (e.g., deciding when to stop data collection, what observations to exclude, what covariates to include, and what analyses to conduct after rather than before seeing the data).

Replication

Journal of Personality and Social Psychology acknowledges the significance of replication in building a cumulative knowledge base in our field. We therefore encourage submissions that attempt to replicate important findings, especially research previously published in *Journal of Personality and Social Psychology*.

Major criteria for publication of replication papers include (i) theoretical significance of the finding being replicated, (ii) statistical power of the study that is carried out, and (iii) the number and power of previous replications of the same finding.

Other factors that would weigh in favor of a replication submission include: pre-registration of hypotheses, design, and analysis; submissions by researchers other than the authors of the original findings; and attempts to replicate more than one study of a multi-study original publication.

Journal of Personality and Social Psychology will also consider replications submitted as registered reports. Such submissions will consist of a detailed research proposal, including an Abstract, Introduction, Hypotheses, Method, Planned Analyses, and Implications of the Expected Results.

We recommend that authors initially contact the editor before submitting a pre-registered report. The proposed research will be reviewed and, if approved, should then be carried out in accordance with the proposed plan.

To the extent that the study is judged to have been competently performed, the paper will be accepted (pending any necessary revisions) regardless of the outcome of the study.

Please note in the Manuscript Submission Portal that the submission is a replication article.

Replication manuscripts, if accepted, will be published online only and will be listed in the Table of Contents in the print journal.

Papers that make a substantial novel conceptual contribution and also incorporate replications of previous findings continue to be welcome as regular submissions.

Section Submission Guidelines

Submit manuscripts to the appropriate section editor. Section editors reserve the right to redirect papers as appropriate. When papers are judged as better suited for another section, editors ordinarily will return papers to authors and suggest resubmission to the more appropriate section.

Rejection by one section editor is considered rejection by all; therefore a manuscript rejected by one section editor should not be submitted to another.
All three sections of *Journal of Personality and Social Psychology* are now using a software system to screen submitted content for similarity with other published content.
The system compares the initial version of each submitted manuscript against a database of 40+ million scholarly documents, as well as content appearing on the open web.
This allows APA to check submissions for potential overlap with material previously published in scholarly journals (e.g., lifted or republished material).

Attitudes and Social Cognition

To submit to the Editorial Office of Shinobu Kitayama, please submit manuscripts electronically through the Manuscript Submission Portal in Word Document format (.doc).
Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*). APA Style and Grammar Guidelines for the 7th edition are available.
SUBMIT MANUSCRIPT TO ATTITUDES AND SOCIAL COGNITION SECTION
Shinobu Kitayama, PhD
University of Michigan
6118 Institute for Social Research
426 Thompson Street
Ann Arbor, MI 48106-1248
General correspondence may be directed to the Editor's Office.
Journal of Personality and Social Psychology: Attitudes and Social Cognition now also welcomes innovative, theory-driven submissions that utilize novel methods under the Innovations in Social Psychology category.
For all research articles, authors must include the following information:

- a broad discussion on how the authors sought to maximize power in terms of, for example, sample size, improvement of measures, manipulation checks, and other elements as applicable. A relevant segment of the paper must be highlighted in yellow;
- a discussion on the diversity and inclusiveness (or lack thereof) of the sample. A relevant segment must be highlighted in light blue; and
- a discussion on how the reported study or set of studies contributes to cumulative theoretical knowledge in psychology. A relevant segment must be highlighted in light green.

Authors are also required to embed Tables and Figures within the manuscript, instead of providing these after the references.
A more detailed explanation of these requirements can be found in Dr. Kitayama's editorial (PDF, 30KB).

Interpersonal Relations and Group Processes

To submit to the Editorial Office of Colin Wayne Leach, PhD, please submit manuscripts electronically through the Manuscript Submission Portal in Microsoft Word (.docx) or LaTex (.tex) as a zip file with an accompanied Portable Document Format (.pdf) of the manuscript file.
Starting June 15, 2020, all new manuscripts submitted should be prepared according to the 7th edition of the *Publication Manual of the American Psychological Association*. APA Style and Grammar Guidelines for the 7th edition are available.
SUBMIT MANUSCRIPT TO INTERPERSONAL RELATIONS AND GROUP PROCESSES SECTION
Colin Wayne Leach
Barnard College
Columbia University
3009 Broadway
New York, NY 10027
Authors are also required to embed Tables and Figures within the manuscript, instead of providing these after the references.

General correspondence may be directed to the Editor's Office.

Personality Processes and Individual Differences

To submit to the Editorial Office of Richard Lucas, PhD, please submit manuscripts electronically through the Manuscript Submission Portal in Word Document format (.doc).

Starting June 15, 2020, all new manuscripts submitted should be prepared according to the 7th edition of the *Publication Manual of the American Psychological Association*. APA Style and Grammar Guidelines for the 7th edition are available.

SUBMIT MANUSCRIPT TO PERSONALITY PROCESSES AND INDIVIDUAL DIFFERENCES SECTION

Richard Lucas
Department of Psychology
Michigan State University
East Lansing, MI 48824

General correspondence may be directed to the Editor's Office.

Journal of Personality and Social Psychology: Personality Processes and Individual Differences now requires that a cover letter be submitted with all new submissions.

The cover letters should:

- Include the author's postal address, e-mail address, telephone number, and fax number for future correspondence
- State that the manuscript is original, not previously published, and not under concurrent consideration elsewhere
- Indicate whether a previous version of the submitted manuscript was previously rejected from any section of *Journal of Personality and Social Psychology*; and if so, identify the action editor handling the previous submission, provide the prior manuscript #, and describe how the present article differs from the previously rejected one
- State that the data were collected in a manner consistent with ethical standards for the treatment of human subjects
- Inform the journal editor of the existence of any published work using the same data (in whole or in part) as was used in the present manuscript; if such publications exist, describe the extent and nature of any overlap between the present submission and the previously published work
- Mention any supplemental material being submitting for the online version of the article

Authors are also required to embed Tables and Figures within the manuscript, instead of providing these after the references.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*).

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Cumulative line numbers must be included with all submissions.

Masked Review Policy

The journal has adopted a policy of masked review for all submissions. The cover letter should include all authors' names and institutional affiliations. The first page of text should omit this information but should include the title of the manuscript and the date it is submitted. Every effort should be made to see that the manuscript itself contains no clues to the authors' identity.

Word Limits

Although papers should be written as succinctly as possible, there is no formal word limit on submissions.

Abstract and Keywords
All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References
List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.
Examples of basic reference formats:
Journal Article
McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126
Authored Book
Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000
Chapter in an Edited Book
Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012
Tables
Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.
Figures
Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.
The minimum line weight for line art is 0.5 point for optimal printing.
For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.
When possible, please place symbol legends below the figure instead of to the side.
APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.
The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.
For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- $900 for one figure
- An additional $600 for the second figure
- An additional $450 for each subsequent figure

Display Equations
We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.
To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType

by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.
Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Materials

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Submitting Supplemental Materials

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See also APA Journals® Internet Posting Guidelines.
APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Disclosure of Interests Form (PDF, 38KB)

In light of changing patterns of scientific knowledge dissemination, APA requires authors to provide information on prior dissemination of the data and narrative interpretations of the data/research appearing in the manuscript (e.g., if some or all were presented at a conference or meeting, posted on a listserv, shared on a website, including academic social networks like ResearchGate, etc.). This information (2–4 sentences) must be provided as part of the Author Note.
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  Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

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It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).
In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).
APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.
Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other Information
Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

Appendix G: Empirical Article: Confirmation of University of Edinburgh School of Health in Social Care ethical approval

Ethics Approval Letter CLIN789

SCHOOL *of* HEALTH IN SOCIAL SCIENCE

The University of
Edinburgh
Medical School
Doorway 6, Teviot Place

Dear Brodie McGougan

Application for Ethical Approval

Reference: CLIN789

Project Title: Motherhood, mental health and wellbeing in care leavers

Thank you for submitting the above research project for review by the School of Health in Social Science Research Ethics Committee (REC). I can confirm that the submission has been independently reviewed and was approved on 23rd July 2020.

The standard conditions of this approval are:

I. Conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal required by the REC.

II. Advise the REC (by email to ethics.hiss@ed.ac.uk) of any complaints or other issues in relation to the project which may warrant review of the ethical approval of the project.

III. Make submission for approval of amendments to the approved project before implementing such changes.

IV. Advise in writing if the project has been discontinued.

The School's Research Ethics Policy and further information and resources are available on the School's website.

You may now commence your project; we wish you the best of luck.

Yours sincerely,

Sanni Ahonen

Administrative Secretary

School of Health in Social Science

Appendix H: Ethical approval for amendments to project

CONCLUSION TO ETHICAL REVIEW OF AMENDMENT
The applicant's response to our request for further clarification or amendments has now satisfied the requirements for ethical practice and the application has therefore has favourable opinion. Signature: Position: Ethics and Integrity Lead Date: 30.3.22

Appendix I: Empirical Article: Ethical Approval from Barnardo's Research and Ethics Committee

Barnardo's Research Ethics Committee (BREC)

Response to Applicant

This form provides feedback from Barnardo's Research Ethics Committee (BREC) against the criteria described in the BREC Guidance document. It informs you whether or not your application has been approved by BREC.

If you wish to discuss any aspects of the feedback given, or to arrange for re-submission of your application, please contact the Lead Reviewer that sent you this form.

Title of research
Impact of motherhood on mental health and wellbeing of previously looked after mothers – review of updated application May 2022.

1. Purpose and value of research
1.1 Research aims and objectives
☒ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
1.2 Research questions
☒ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
1.3 Value of research
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.

1.4 Dissemination of findings
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.

2. Research methodology

2.1 Sample and recruitment
☒ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions

2.2 Data collection and fieldwork
☒ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions

2.3 Interpretation of data
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.

3. Responsibilities towards participants

3.1 Competency of researcher(s)
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.

3.2 Voluntary, informed consent of participants
☒ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)

Comments/suggestions
3.3 Consent of parents/carers
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
N/A
3.4 Participant comfort
☒ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
3.5 Safeguarding children, young people, and vulnerable adults
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.
3.6 Confidentiality
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.
3.7 Recording and storing data, in line with the Data Protection Act 2018 and UK/EU GDPR
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.
3.8 Anonymity of findings
☒ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions

3.9 Concluding relationships with participants
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome
3.10 Recognition of participants' time and effort
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.
3.11 Complaints procedures
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.

4. Researcher welfare
4.1 Researcher's physical welfare
☒ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
4.2 Researcher's emotional welfare
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions

5. Roles and responsibilities
5.1 Agreement with gatekeepers
☐ This section has been completed satisfactorily

☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.
5.2 Agreement with Barnardo's service(s)
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
Services have not provided any agreement to participate in this research at the time of this application.
5.3 Agreement/contract with sponsors/funders
☐ This section has been completed satisfactorily ☐ This section needs more attention (see comments/suggestions below)
Comments/suggestions
See previous BREC review outcome.

6. Fieldwork tools and attachments
6.1 Fieldwork tools and attachments
☒ Fieldwork tools/attachments are satisfactory ☐ Fieldwork tools need more attention (see comments/suggestions below)
Comments/suggestions
Consider whether mothers should be informed on information sheet that their Project Worker may also participate in the discussions.

Review outcome
LEAD REVIEWER'S RESPONSE (ON BEHALF OF COMMITTEE)
Your application has been approved ☒ I am satisfied that this research conforms to Barnardo's ethical research guidelines, and you may proceed with your research ☐ I am satisfied that this research conforms to Barnardo's ethical research guidelines. We request that comments above are addressed before proceeding with your research, but you do not need to re-submit your application **Your application has been declined**

☐ Your submission requires amendments before it conforms to Barnardo's ethical research guidelines. Your research should not proceed at this time. Please refer to the comments given above if you wish to re-submit your application	
Name	Jill Cushing
Position	Chair of BREC
Date	07/06/2022

Appendix J: Empirical Article: Participant Consent Form (reproduced online)

THE UNIVERSITY *of* EDINBURGH
School of Health in Social Science

Motherhood and mental health in care leavers
Version 2
10/Jan/2022

Consent form

Motherhood and mental health in care leavers

Please initial the boxes, then sign and date the form at the end.

I confirm that I have read and/or had explained to me the research information leaflet (version 2, 10/01/22)	
I confirm that I understand the information contained in the research information leaflet and have had the opportunity to ask questions and had these questions answered satisfactorily.	
I understand that taking part in the research project is voluntary and I can change my mind and withdraw my participation at any time, without giving any reason.	
I agree to my interview being audio recorded and transcribed by Brodie McGougan, researcher. I understand that the anonymised transcripts will be shared with two research supervisors at Edinburgh University.	
I understand that all information that could identify me will be removed when my interview is transcribed.	
I am aware that my responses will only be used for the purposes of this study, as described in the information leaflet (version 2, 10/01/22)	
I agree that direct quotations from the interview can be included in the final research report.	
I understand that relevant sections of data collected during the study may be looked at by individuals from the sponsor (the University of Edinburgh) where it is relevant to my taking part in this research. I give permission for those individuals to have access to my records.	

I agree to take part in the above study. ☐

Name of Person Giving Consent _____

Signature _____

Date _____

Name of Person Taking Consent _____

Signature _____

Date _____

1x original – into Site File; 1x copy – to Participant;

Appendix K: Empirical Article: Participant Information Sheet (Mothers - brief)

THE UNIVERSITY *of* EDINBURGH
School of Health in Social Science

Motherhood and mental health in care leavers
Version 2
10/Jan/2022

Brief Information sheet

Motherhood and mental health in care leavers

Who am I?

My name is Brodie McGougan. I am a student at the University of Edinburgh. This study is part of my thesis project. I am studying for a Doctorate in Clinical Psychology.

What will I ask?

I'd like to know what being a mother has been like for you and other mums who spent time in care. I will also ask some questions about your mental health.

Why do I want to know?

I hope that services offering support to care experienced mums can better understand what it is like and design services that better suit your needs.

Why have I been invited to take part?

You have been invited to take part as you are a mother who has some experience of being in care. I would really like to hear about your experiences of becoming a mother and the impact it might have had on you.

What do I have to do if I decide to take part?

I will ask some questions about your experiences of being a mum as well as some questions about your mental health. I only have a few questions but they are open ended so that you can tell me as much or as little as you want to about what is important to you. This will be by telephone. We can talk for a few minutes or for a few hours. This depends on how much you would like to say.

Will anything bad happen?

This is unlikely! But you might get upset by things we talk about. You can stop at any point and you don't have to tell me why. We can take breaks or we can stop completely. We can talk together

about what might help you feel better in the moment and I will give you contact details for other services that can offer you support.

Will anything good happen?

I hope that you will enjoy telling me your story. I also hope that it will help other people understand what it is like becoming and being a mum for women who have some experience of being in care. You will receive a one-off gift of £10 as a 'thank you' for your time.

Should I take part?

It is up to you! You do not have to take part. Even if you do decide to take part, you can change your mind at any time, and you do not need to give me a reason why. Your decision will not affect your care in any way. In the final report of this study I will write about the number of people who dropped out. However, if you do decide to drop out, I will not mention you by name. If we have started our interview you can tell me whether I can use this or whether you would prefer it is destroyed and not used for the study.

What if something goes wrong?

This is unlikely! But if you want to make a complaint, I will explain how you can do this. I will send you an information sheet before we start with details of how to make a complaint too.

Will the things I say be kept confidential?

Yes, unless I am worried about your safety or the safety or someone else. If I have this kind of worry, I may speak to social services, the NHS or the police. I will talk to you about this first and I will tell you what I am going to do. If I have no worries about safety, I will only share information with my supervisor from the university.

When we talk on the phone, I will record our conversation (with your consent). I will then write it out and delete the recording straight away. Our written conversations will be stored securely on the University of Edinburgh online servers. Only I will have the password to access this.

When I write up this study, I will use quotes from participants as examples of important things that were said during interviews. I will use a fake name whenever I include a quote so that people will not know who said it. If I have any concerns that you could still be identified by a quote, it will not be included in the study. Your safety and confidentiality are extremely important.

Where will the study go?

The study will be published online by the University of Edinburgh and possibly by a scientific magazine. I will also send a copy to you by email.

Who knows about the study?

I have permission from the University of Edinburgh to conduct this study.

Who can I contact if I have more questions?

Me: Brodie McGougan – b.mcgougan@sms.ed.ac.uk

Timothy Bird, Postgraduate Research Director at the University of Edinburgh:
or 0131 650 3893

To make a complaint please contact:

Research Governance Team: cahss.res.ethics@ed.ac.uk

Appendix L: Empirical Article: Participant Information Sheet (Professionals - brief)

THE UNIVERSITY of EDINBURGH
School of Health in Social Science

Motherhood and mental health in care leavers
Version 2
10/Jan/2022

Brief Information sheet

Motherhood and mental health in care leavers

Who am I?

My name is Brodie McGougan. I am a student at the University of Edinburgh. This study is part of my thesis project. I am studying for a Doctorate in Clinical Psychology.

What will I ask?

I'd like to hear about your experiences of supporting care experienced mothers. Questions will relate to your impressions of what motherhood is like for these women, the impact on their mental health, and how they cope.

Why do I want to know?

As part of this project I will be interviewing both professionals like yourself and care experienced mothers, about the experience of beomcing a mum, the impact on mental health and subsequent coping. I hope to compare these interviews and highlight areas of difference and/or similarities between how mothers describe their own experiences and how they are perceived by those who support them. The ultimate aim is to better understand this phenomenon to inform the development of support services for this population.

Why have I been invited to take part?

You have been invited to take part as you are a professional who has some experience of supporting care experienced mothers.

What do I have to do if I decide to take part?

We will schedule a time that is convenient for you to complete an interview. I will ask a few broad, open-ended questions so that you have an opportunity to tell me as much or as little as you want about what seems important to you. As mentioned above, questions will relate to your impressions

of what motherhood is like for care experienced women, the impact on their mental health, and how they cope.

Interviews will be conducted by telephone and will be recorded with your consent. I will ask you to sign an online consent form before our interview begins. Interviews will be transcribed and audio-recordings destroyed immediately thereafter. Interviews could last from a few minutes to a couple of hours. This is entirely dependent on how much you would like to say.

Will anything bad happen?

This is unlikely! There is a chance that the topics of motherhood and mental health can bring up painful memories or feelings for you. This could relate to mothers you have supported, or may relate to things that have happened in your own life. Please know that you can stop at any point and you do not have to tell me why. We can take breaks or we can stop completely. We can talk together about what might help you feel better in the moment and I will give you contact details for other services that can offer you support.

Will anything good happen?

I hope that you will enjoy this opportunity to reflect on some of your professional experiences. I hope that you will come away from the interview feeling as though you have contributed to something important and that your insights are valuable. I would also like to offer you a one-off £10 gift voucher as a 'thank you' for your time.

Should I take part?

It is up to you! You do not have to take part. Even if you do decide to take part, you can change your mind at any time, and you do not need to give me a reason why. Your decision will not affect your employment status in any way. In the final report of this study I will write about the number of people who dropped out but will make no reference to you personally. If we have started our interview you can tell me whether I can use this or whether you would prefer it is destroyed and not used for the study.

What if something goes wrong?

This is unlikely! But if you want to make a complaint, I will explain how you can do this. Details are provided at the bottom of this information sheet about who to contact should you wish to make a complaint.

Will the things I say be kept confidential?

Yes, unless I have concerns about risk to yourself or to others. If I have concerns about risk I will first discuss it with you. If it is necessary for me to share my concerns with another agency (e.g. social services or emergency services) I will inform you of my intended actions. If I have no worries about safety, I will only share information with my supervisor from the university.

As stated above, audio recordings will be transcribed and deleted immediately thereafter. Transcriptions will be stored securely on the University of Edinburgh servers. This will be password protected and only I will have the password to access it. I may discuss my research findings with my academic supervisor. These conversations will be kept confidential with the exception of where there are concerns about risk.

When I write up this study, I will quote directly from participant interviews to illustrate recurring themes within the interviews. I will use a fake name whenever I include a quote so that it cannot be

directly attributed to you. If I have any concerns that you could still be identified by a quote, it will not be included in the study. Your safety and confidentiality are extremely important.

Where will the study go?

The study will be published online by the University of Edinburgh and possibly by a scientific magazine. I will also send a copy to you by email.

Who knows about the study?

I have permission from the University of Edinburgh to conduct this study.

Who can I contact if I have more questions?

Me: Brodie McGougan –

Timothy Bird, Postgraduate Research Director at the University of Edinburgh:
or 0131 650 3893

To make a complaint please contact:

Research Governance Team: cahss.res.ethics@ed.ac.uk

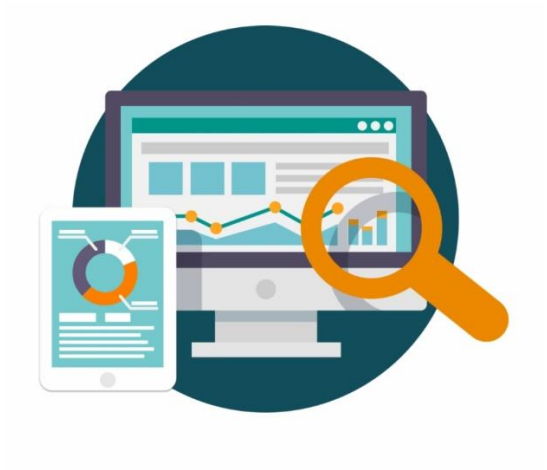
Appendix M: Empirical Article: Participant Picture Information Sheet (mothers)

THE UNIVERSITY of EDINBURGH
School of Health in Social Science

Motherhood and mental health in care leavers
Version 2
10/Jan/2022

Brief information sheet in pictures

Motherhood and mental health in care leavers



I am doing some research.

You are being asked to if you would like to help.

I want to speak to mums who were 'looked after' when they were a child.

I want to find out if being a mum has changed how you think and feel.

I will ask you some questions about being a mum and about your mental health (how you think and feel).

This might take1-2 hours.

You will get a £10 gift for taking part.

You can stop at any time.

You don't have to tell anyone why.

This won't affect your care.

Your information is kept safe online with the University of Edinburgh.

Only I will have the password to access it.

I will not use your real name in my study.

I will share information with my supervisor from the university.

If I am worried about you, your child or someone you know, I might have to tell a social worker, a doctor, the police and/or a support worker.

The study will be published online by the University of Edinburgh.

I will share it with:

- You
- some scientific magazines so that other people can read it
- The service who contacted you about the study

If you have any questions you can ask:

- Me (Brodie McGougan): b.mcgougan@sms.ed.ac.uk
- Timothy Bird at the University of Edinburgh: timothy.bird@ed.ac.uk or 0131 650 3893

If you want to make a complaint you can contact:

- Research Governance Team: cahss.res.ethics@ed.ac.uk

Appendix N: Empirical Study: Participant Information Sheet (Mothers - long)

THE UNIVERSITY *of* EDINBURGH
School of Health in Social Science

Motherhood and mental health in care leavers
Version 2
10/Jan/2022

(NON-MEDICAL RESEARCH)

PARTICIPANT INFORMATION SHEET (mothers)

Motherhood and mental health in care leavers

You are being invited to take part in research on the impact of motherhood on the mental health of care leaver mothers. Brodie McGougan, a student at the University of Edinburgh, is leading this research. Before you decide to take part, it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to develop further understanding about the experience of motherhood for women who were previously looked after children, as well as the impact on their mental health.

People who were previously looked after by a local authority and who have had children of their own, as well as professionals who have a role in supporting them, will be asked to talk about motherhood experiences and the perceived impact on mental health.

The information from this study can help clinicians and service providers understand the impact of motherhood on care leaver mothers from mothers' perspectives, reflect on how this may converge or diverge from the perceptions of professionals involved in providing support, and consider how support is best delivered.

WHY HAVE I BEEN INVITED TO TAKE PART?

You have been invited to take part as you are a mother who has some experience of being in care.

DO I HAVE TO TAKE PART?

No – it is entirely up to you. If you do decide to take part, you are still free to withdraw at any time and without giving a reason. Deciding not to take part or withdrawing from the study will not affect the service you receive. Please note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to your withdrawal and so you are advised to contact the research team at the earliest opportunity should you wish to withdraw from the study.

If you do decide to take part, please keep this Information Sheet. You will be asked to sign an Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate.

WHAT WILL HAPPEN IF I DECIDE TO TAKE PART?

You will be asked some questions about your experiences of becoming and being a mother and about your mental health. The interview will be conducted by telephone. We would like to audio record your responses (and will require your consent for this). You should find a comfortable place to be during this call where you will not be interrupted and where no one will overhear you. The interview should take around one to two hours to complete.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

By sharing your experiences with us, you will be helping Brodie McGougan and the University of Edinburgh to better understand the impact motherhood can have on the mental health of care experienced mothers. You will also receive a one-off gift of £10 (voucher) as a thank you for taking the time to participate.

ARE THERE ANY RISKS OR DISADVANTAGES ASSOCIATED WITH TAKING PART?

The disadvantages or risks of you taking part are minimal. However, it is important to acknowledge that not all aspects of becoming a mother, or indeed mental health, are positive. You may find that talking about your experiences of being a mother brings up distressing thoughts or memories. Likewise, discussing mental health issues can give rise to strong emotions. You do not have to tell the researcher anything you do not want to. You can end the interview at any point without giving a reason. You can also take breaks if you need to. If you have any concerns about this or have any other questions about taking part in the study, the researcher is more than happy to talk to you before you make any decision.

If you become distressed during the interview process you can be offered a range of supports. We can take some time together to focus on relaxing and calming strategies to reduce your distress. I will also provide you with information about a range of services you can access if you feel you would like to talk to someone following our interview. This will include phone, text and email support services, NHS mental health services and non-NHS services who may be able to support you.

If I continue to have concerns about your levels or distress, or your ability to keep yourself or others safe, either from yourself or from others, I will share this information with other services as the situation dictates. This might include health services, the police or social services. I will always discuss this with you first.

WILL MY TAKING PART BE KEPT CONFIDENTIAL?

Your data will be processed in accordance with Data Protection Law. All information collected about you will be kept strictly confidential. When your data is stored or referred to in the study a fake name will be used. You can choose this name if you wish. Your own name will not be recorded along with your data or referred to in the study. If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed. Your data will only be viewed by the researcher/research team. All electronic data will be stored securely on University of Edinburgh servers. I will not keep any paper documents. Your completed consent form will be kept separately from your interview responses in order to minimise risk of you being identified.

The University of Edinburgh is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Edinburgh will keep identifiable information about you for 5 years after the study has finished.

For general information about how we use your data go to:
https://www.ed.ac.uk/records-management/privacy-notice-research

WHAT WILL HAPPEN WITH THE RESULTS OF THIS STUDY?

The results of this study may be summarised in published articles, reports and presentations. You will not be identifiable from any published results. Quotes or key findings will always be made anonymous in any formal outputs unless we have your prior and explicit written permission to attribute them to you by name. A summary of the findings from the study will be made available to participants who indicate they would like to receive this. This summary will be sent to participants by post / email.

WHO IS ORGANISING AND FUNDING THE RESEARCH?

This study has been organised by Brodie McGougan, doctoral student of Clinical Psychology and sponsored by the University of Edinburgh.

WHO HAS REVIEWED THE STUDY?

The study proposal has been reviewed by the Ethics Committee and the School of Health in Social Science Ethics Committee.

WHO CAN I CONTACT?

If you have any further questions about the study, please contact the lead researcher, Brodie McGougan at

If you would like to discuss this study with someone independent of the study, please feel free to contact Timothy Bird Postgraduate Research Director at the University of Edinburgh: timothy.bird@ed.ac.uk or 0131 650 3893

If you wish to make a complaint about the study, please contact:
Research Governance Team: cahss.res.ethics@ed.ac.uk

Appendix O: Empirical Study: Participant Information Sheet (Professionals - long)

THE UNIVERSITY of EDINBURGH
School of Health in Social Science

Motherhood and mental health in care leavers
Version 2
10/Jan/2022

(NON-MEDICAL RESEARCH)

PARTICIPANT INFORMATION SHEET (professionals)

Motherhood and mental health in care leavers

You are being invited to take part in research on the impact of motherhood on the mental health of care leaver mothers. Brodie McGougan, a student at the University of Edinburgh, is leading this research. Before you decide to take part, it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to develop further understanding about the experience of motherhood for women who were previously looked after children, as well as the impact on their mental health.

People who were previously looked after by a local authority and who have had children of their own, as well as professionals who have a role in supporting them, will be asked to talk about motherhood experiences and the perceived impact on mental health.

The information from this study can help clinicians and service providers understand the impact of motherhood on care leaver mothers from mothers' perspectives, reflect on how this may converge or diverge from the perceptions of professionals involved in providing support, and consider how support is best delivered.

WHY HAVE I BEEN INVITED TO TAKE PART?

You have been invited to take part as you are a professional who has some experience of providing support to care experienced mothers.

DO I HAVE TO TAKE PART?

No – it is entirely up to you. If you do decide to take part, you are still free to withdraw at any time and without giving a reason. Deciding not to take part or withdrawing from the study will not affect your employment status. Please note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) prior to your withdrawal and so you are advised to contact the research team at the earliest opportunity should you wish to withdraw from the study.

If you do decide to take part, please keep this Information Sheet. You will be asked to sign an Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate.

WHAT WILL HAPPEN IF I DECIDE TO TAKE PART?

You will be asked some questions about your impressions of what motherhood is like for care experienced women, the impact on their mental health, and how they cope. The interview will be conducted by telephone. We would like to audio record your responses (and will require your consent for this). You should find a comfortable place to be during this call where you will not be interrupted and where no one will overhear you. The interview should take around one to two hours to complete.

WHAT ARE THE POSSIBLE BENEFITS OF TAKING PART?

By sharing your experiences with us, you will be helping Brodie McGougan and the University of Edinburgh to better understand the impact motherhood can have on the mental health of care experienced mothers. You will also receive a one-off gift of £10 (voucher) as a thank you for taking the time to participate.

ARE THERE ANY RISKS OR DISADVANTAGES ASSOCIATED WITH TAKING PART?

The disadvantages or risks of you taking part are minimal. However, it is important to acknowledge that not all aspects of becoming a mother, or indeed mental health, are positive. You may find that talking about others' experiences of being a mother brings up distressing thoughts or memories. Likewise, discussing mental health issues can give rise to strong emotions. You do not have to tell the researcher anything you do not want to. You can end the interview at any point without giving a reason. You can also take breaks if you need to. If you have any concerns about this or have any other questions about taking part in the study, the researcher is more than happy to talk to you before you make any decision.

If you become distressed during the interview process you can be offered a range of supports. We can take some time together to focus on relaxing and calming strategies to reduce your distress. I will also provide you with information about a range of services you can access if you feel you would like to talk to someone following our interview. This will include phone, text and email support services, NHS mental health services and non-NHS services who may be able to support you.

If I continue to have concerns about your levels or distress, or your ability to keep yourself or others safe, either from yourself or from others, I will share this information with other services as the situation dictates. This might include health services, the police or social services. I will always discuss this with you first.

WILL MY TAKING PART BE KEPT CONFIDENTIAL?

Your data will be processed in accordance with Data Protection Law. All information collected about you will be kept strictly confidential. When your data is stored or referred to in the study a fake name will be used. You can choose this name if you wish. Your own name will not be recorded along with your data or referred to in the study. If you consent to being audio recorded, all recordings will be destroyed once they have been transcribed. Your data will only be viewed by the researcher/research team. All electronic data will be stored securely on University of Edinburgh servers. I will not keep any paper documents. Your completed consent form will be kept separately from your interview responses in order to minimise risk of you being identified.

The University of Edinburgh is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Edinburgh will keep identifiable information about you for 5 years after the study has finished.

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https://www.ed.ac.uk/records-management/privacy-notice-research

WHAT WILL HAPPEN WITH THE RESULTS OF THIS STUDY?

The results of this study may be summarised in published articles, reports and presentations. You will not be identifiable from any published results. Quotes or key findings will always be made anonymous in any formal outputs unless we have your prior and explicit written permission to attribute them to you by name. A summary of the findings from the study will be made available to participants who indicate they would like to receive this. This summary will be sent to participants by post / email.

WHO IS ORGANISING AND FUNDING THE RESEARCH?

This study has been organised by Brodie McGougan, doctoral student of Clinical Psychology and sponsored by the University of Edinburgh.

WHO HAS REVIEWED THE STUDY?

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WHO CAN I CONTACT?

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If you would like to discuss this study with someone independent of the study, please feel free to contact Timothy Bird Postgraduate Research Director at the University of Edinburgh: or 0131 650 3893

If you wish to make a complaint about the study, please contact:
Research Governance Team: cahss.res.ethics@ed.ac.uk

Appendix P: Empirical Study: Support Information Sheet

THE UNIVERSITY of EDINBURGH
School of Health in Social Science

Motherhood and mental health in care leavers
Version 2
10/Jan/2022

Supports

If you feel you need help urgently and do not feel able to keep yourself safe contact emergency services on 999 immediately.

NHS 24 – providing urgent health advice out of hours, when your GP Practice or Dentist is closed.

Phone: 111 (free, 24 hours a day, every day)

Website: www.nhs24.scot

NHS Inform – website which provides a co-ordinated, single source of quality assured health and care information for the people of Scotland.

Website: www.nhsinform.scot

NHS Mental Health Services

If you would like to access your local NHS Mental Health Services, the easiest way to do so is through your GP. You may be referred to Psychiatry, Psychology or local projects such as counselling or therapy groups. Psychiatrists are medical doctors who support people with their mental health using medications. They are often supported by specialist mental health nurses in the community. Psychologists primarily offer talking therapies and do not prescribe medications. Ask your GP about what other services may be available in your area. Waiting lists for NHS Mental Health Services can often be quite long. You may wish to ask your GP how long you can expect to wait, and make use of self-help materials such as those available on Moodjuice (details below), or contact other support services such as those listed here, until you are offered an appointment.

Samaritans – to talk about anything that is upsetting you.

Phone: 116 123 (free, open 24 hours a day, every day)

Email: jo@samaritans.org (response time is 24 hours)

Breathing Space - A confidential phoneline for anyone in Scotland over the age of 16, feeling low, anxious or depressed

Phone: 0800 83 85 87 (free, Monday to Thursday 6pm to 2am, Friday 6pm – Monday 6am)

Cruise Bereavement Care – offering support, advice and information to children, young people and adults when someone dies.

Phone: 0808 808 1677 (free, Monday & Friday 9:30am - 5pm excluding bank holidays, Tuesday, Wednesday & Thursday 9:30am – 8pm)

Website: www.cruise.org.uk

Rape Crisis Scotland – if you have been raped or sexually abused or are supporting someone else who has, you can contact Rape Crisis for help and information.

Phone: 08088 01 03 02 (free, 6pm to midnight every day)

Email: support@rapecrisis.org.uk

Website: www.rapecrisisscotland.org.uk

Women's Aid Scotland – support for victims of domestic abuse and forced marriage in Scotland, whether the abuse is ongoing or happened in the past.

Phone: 0800 027 1234

Email: helpline@sdafmh.org.uk

Website: www.womensaid.scot (webchat available)

Moodjuice – an online resource of self-help materials for a range of emotional problems e.g. depression, anxiety, obsessive compulsive disorder, relationships, trauma and abuse, anger, self-esteem, eating disorders.

Website: www.moodjuice.scot.nhs.uk

ParentLine Scotland – For anyone caring for or concerned about a child.

Phone: 0800 028 22 33 (free, Monday – Friday 9am-9pm, Saturday & Sunday 9am - noon)

Website: www.parentlinescotland.org.uk

Home-Start – help families with young children deal with the challenges they face. They support parents as they learn to cope, improve their confidence and build better lives for their children from birth to starting school. Families struggling with post-natal depression, isolation, physical health problems, bereavement and many other issues receive the support of a volunteer who will spend around two hours a week in a family's home supporting them in the ways they need.

Website: www.home-start.org.uk

Gingerbread – for one parent families. A leading national charity working to help lone parents and their children.

Phone: 0808 802 0925

Website: www.gingerbread.org.uk

YoungMinds – Parents' information service giving advice to parents or carers who may be concerned about the mental health or emotional wellbeing or a child or young person.

Phone: 0808 802 5544

Website: www.youngminds.org.uk

Step Change Debt Charity – provides free, expert debt advice.

Phone: 0800 138 11 11 (free, Monday to Friday 8am - 8pm, Saturday 8am - 4pm)

Website: www. Stepchange.org (webchat available)

Email: via online form on the website

Shelter Scotland – housing and homelessness advice.

Phone: 0808 800 44 44

Website: www.shelter.org.uk

Citizens Advice Scotland – providing free advice on a range of issues including benefits, work, debt and money, consumer issues, housing, family issues, the law and court issues, immigration, health and more.

Phone: check the website for your local branch including contact details

Website: www.citizensadvice.org.uk/scotland

Scottish Welfare Fund – helps families and people in Scotland on low incomes through Crisis Grants and Community Care Grants. A Crisis Grant can help you if you're in crisis because of a disaster (like fire or flood), or an emergency (like losing your money or an unexpected expense). A Community Care Grant can help you or someone you care for to live, or to carry on living, a settled life in the community.

Website: www.mygov.scot/scottish-welfare-fund (select your local council for additional contact details)

Who Cares? Scotland – a national voluntary organisation, working with care experiences young people and care leavers across Scotland. Their advocacy service helps children and young people claim their rights.

Phone: 0141 226 4441 (charged at local rate)

Email: hello@whocaresscotland.org

Website: www.whocaresscotland.org

Appendix Q: Empirical Study: Interview Schedule

Motherhood and mental health in care leavers
Version 2
10/Jan/2022

Motherhood, mental health and wellbeing in care leavers

Interview schedule

MOTHERS interview schedule:

Pre-amble

Thank you for agreeing to this interview. Today I'm going to ask you just a small handful of questions. They are broad open-ended questions so that you can talk freely about what is most important to you. My questions are more of a guide for us. I will ask you some questions about being a mum and what this has been like for you. I will also ask some questions about your mental health. Sometimes when we hear the phrase 'mental health' we might start thinking about mental health *difficulties* such as anxiety and depression. For this interview, when I use the phrase 'mental health', think about it a bit like 'physical health'. We can have both poor physical health and really good physical health (and everything in between). Does this make sense? For this interview 'mental health' means everything from feeling really low to feeling really happy, and from being troubled by distressing thoughts and memories to being completely free of anything that troubles you. Do you have any questions about that? Are you ready to get started?

1. Tell me your story of becoming a mum
2. Can you describe your mental health to me since you've become a mum?
3. Can you tell me about how you manage your mental health?
4. Are there any ways in which motherhood has changed how you might manage your mental health, if indeed it has?
5. This study is about the impact of motherhood on the mental health of care experienced mothers. Is there anything else you would like to share about your own experiences that I have not asked about?
6. How has this interview been for you?

PROFESSIONALS interview schedule:

Pre-amble

Thank you for agreeing to this interview. Today I'm going to ask you just a small handful of questions. They are broad open-ended questions so that you can talk freely about what is most important to you. My questions are more of a guide for us. I will ask you some questions about the women you have worked with, their experiences of becoming a mum and their mental health. When I use the term 'mental health' what I really mean is the whole spectrum of 'health', from mental health difficulties to having really good mental health. Do you have any questions about that? Are you ready to get started?

1. Can you give me a general overview of your professional experiences working with care experienced mothers?
2. Perhaps with a particular mother, or mothers, in mind, can you describe to me your impressions of their experiences of becoming a mother?
3. Can you describe to me your impressions of their mental health since becoming a mother?
4. Are there any ways in which motherhood has changed how they might manage their mental health, if indeed it has?
5. This study is about the impact of motherhood on the mental health of care experienced mothers. Is there anything else you would like to share about your own experiences that I have not asked about?
6. How has this interview been for you?

Additional Prompts:

- I'm interested in / can you tell me more about that?
- What do you mean by _?
- What would be an example of _?
- What did you do?
- How do you feel about _?
- What do you think about _?

Appendix R: Empirical Study: Pattern of Themes Across Participants

	Superordinate Themes	**The value and fragile benefits of motherhood**	**When the past and present collide**		**The value and power of identities**		**Engagement with services: the push and pull**	
	Subordinate Themes		*Motherhood as a source of guilt and anxiety*	*Compensating for the past*	*Developing valued identities*	*Ascribed identities and their consequences*	*The struggle for power and control*	*Imperfect systems*
Mothers								
Cristina		x	x	x	x	x	x	
Kerri		x	x	x	x		x	x
Kayleigh		x	x	x	x	x	x	x
Miranda		x			x	x	x	x
Aileen		x	x	x	x	x		x
Professionals								
Stella		x				x	x	x
Sophie		x	x	x		x		x
Daphne		x				x		**x**
Catriona		x	x	x	x	x		

Appendix S: Empirical Study: Contribution of Superordinate Themes at Group Level to Multi-perspectival Superordinate Themes

Superordinate Themes	Subordinate themes	Case level superordinate themes by group	
		Mothers	*Professionals*
The value and benefits of motherhood		- Motherhood as desirable (Kerri) - The joy of motherhood (Kerri) - Children as a protective factor (Kayleigh) - Desirability and intentionality of motherhood (Cristina, Miranda, Aileen)	- Motherhood as protective (Sophie) - Positive impact of motherhood (Catriona) - Positives of motherhood (Daphne) - Immediately post-partum a high-risk time (Stella)
When the past and the present collide	*Motherhood as source of guilt and anxiety*	- I wasn't prepared (Kayleigh) - Being a new mum is hard (Cristina) - Expectations vs reality of motherhood (Kerri) - Being a 'good enough' mum - Unwanted anxiety and guilt (Aileen)	- Fear and isolation make mothering hard (Catriona) - Fear of history repeating (Sophie) - Mothers' fears and desires (Sophie)
	Compensating for the past	- Compensating for the past through my child (Kerri) - I know what my children need because I didn't have it (Cristina) - Overcompensation (Aileen) - Putting the child first (Kerri)	- Legacy of the past and compensating through the child (Sophie) - Mother role models (Sophie) - Overcompensation (Catriona)

The value and power of identities	*Valued identities*	- The care experienced mother as a valued identity (Cristina) - Working out who I am (Kayleigh) - Shifting values of identities and belonging (Aileen) - Perceptions of self (Miranda) - Struggling to define an identity (Kerri) - Fighting for justice for others like me (Cristina) - Using experiences to help others like me (Aileen) -	- Mother a valued identity (Catriona)
	Ascribed identities and their consequences	- Mental health labels are powerful (Cristina) - Power of MH labelling (Aileen) - Stigma in maternity services (Cristina) - Stigma and judgement of the CE mother with MH issues (Aileen) - The stigma of being CE (Miranda) - Being a care experienced mum in the system (Aileen) - Meeting expectations (Aileen) - The consequences of being a CE mother with MH issues (Kayleigh)	- Value judgements in professional practice (Daphne) - Assessment, assumption and judgement (Stella) - Attitudes towards care experienced mums (Catriona) - Professional attitudes towards CE mums (Sophie)

Engagement with services: the push and pull	*The struggle for power and control*	- Finding my power and taking back control (Cristina) - I need to be in control (Kerri) - Taking back control of my life (Kayleigh) - Lack of autonomy as a CE mum (Miranda) - Parenting under scrutiny (Miranda)	- Power, control and autonomy for mums (Stella) - Lack of supervision and support (Stella) - Power, control and autonomy in the professional realm (Stella)
	Imperfect systems	- Professional and systems are far from perfect (Aileen) - Gaps and failures in support systems (Miranda) - Professional and system failures (Kayleigh) - Insider knowledge as a double edge sword (Aileen) - The institution as the villain (Kerri)	- Social Work as task focussed (Stella) - Service structures a barrier to access and care (Stella) - What effective support looks like (Daphne) - Support is hard to define (Daphne) - Service structures a barrier to support (Sophie)

Appendix T: Empirical Study: Examples of Analysis of Transcripts

Column 2 is original transcript; Column 1 is researcher's initial noting. Descriptive comments are in **bold**, linguistic comments are in *italics* and conceptual comments are underlined. Column 3 is initial emergent themes.

Researchers initial noting: Descriptive, Linguistic and Conceptual	**Original Transcript**	**Initial emergent themes**
Participant 1		
Booking with midwife – asked about care experience – *'thrown', 'embarrassed' – shame?* 'At the time I wasn't very open' – changed over time	Actually, sorry, I've remembered something from pregnancy that I think's really important to say, is that when I went to my first midwife appointment, em, they go through all of the booking in stuff with you. You know where you get that green folder with all your details in. And one of the questions they ask you is if you've ever had any, like, contact with children's social care. And at the time I wasn't very open about my care experience, and that really threw me, and I felt really embarrassed.	Discussions about care experience with professionals (midwife) in the ante-natal period Own feelings about being care experienced changed over time – hidden/shameful to 'special status' Costs of being transparent about care experience with professionals (midwife)
Had to be truthful because it's already on record – no choice? Fear of it being 'discovered' if she lies? Would have hidden it otherwise. Fear of consequences?	But I knew that I had to be truthful because, you know, obviously there's records of me being in care.	Can't escape past
Unsure why it's asked/what will be done with information	Em, and I remember asking her, "Why do you ask?" and she said that if someone said that they'd been in care they then have to	Feeling judged by professionals (midwife) because of care experience

A challenge to authority? Questioning, not total acquiescence **Admission of care experience risks 'referral for unborn baby'** – implying baby at risk of harm	make a decision whether to put in a referral for the unborn baby.	Assumptions made by professionals (midwife) about care experienced mums
Participant 2		
Pregnancy unplanned – surprise *Happy to be pregnant* *Felt young* Missed developmental phase of childhood to adulthood – drug use Sense of self as childlike	So, em, she wasnae planned. She was a wee surprise. But I was so glad I had her, em. I still felt so young at that age, even though I was 24 I felt as if, I don't know, I had spent all my, all those years taking drugs, it was as if it all went by in a total haze. And I never felt like an adult. I still felt like I was s child. It was so strange. And I remember feeling like a really young- even though I wasn't, technically, I felt like, I don't know. I felt as if- there was a wee girl on the ward, about 16, and I remember feeling like, as if, I was more ages with her.	Intentionality of motherhood Feelings about pregnancy Impact of experiences on sense of self
Participant 3		
Feels like record has been 'wiped' – complete erasure of her experiences **Using therapy to manage childhood trauma**	Exactly. It just feels like it's been wiped, and it's just like, you know the whole, one of the big parts of my therapy was like, I'm digging, you know I'm digging this hole in the ground and finding this box and it's buried very	Feeling dehumanised by professionals/services Coping – therapy helpful

Traumatic memories buried deeply Desire to 'uncover' child self – reveal what happened in childhood Medical profession complicit in burying her past? **'Everybody's buried it' – medics, family, self** – something that must be kept hidden	deeply. You know, I've had a lot, I did a lot of dream therapy and I was down in a well, and I, I was underground and you know, there's sort of like a childlike me sat at the bottom of this well. And it was just like, god, I just want to get down there and bring this child out that's been buried. And this whole finding my medical records is all part, part of that because it's just like it's been buried, you know? Everybody's buried it. Now they're burying it. I've buried it. My family have buried it, and it's just like. But that as part of me. That happened to me. It's, it's a… yeah. Yeah, it is important	Facing and understanding childhood experiences part of healing process Beliefs about medical professionals – deceptive Exposing the past – something hidden being revealed

Participant 4

Belief that her care exp not the same as others – she doesn't have a 'bad past'	Yeah, cause I just felt like not everybody has had the same care experience.	Perception of experience in care
No inevitable outcomes from care exp	Not everybody, like, in a way, turns out a certain way from being in care.	Sense of self as capable and competent
Sister went opposite way – not just about quality of care exp? Attributes resilience, ability to parent independently to positive exp in care	Like my sister had that. My sister went kinda like the opposite from me with her kids and things, but I felt like I didn't really need that because I did have a good upbringing when I did get fostered.	Linking past experiences to current skills
No consideration of the individual – assumptions made based on group membership	I just felt like everybody's got to take that whether they've had a good care experience or not. Yeah, it's just kinda pushed on you.	No choice about support

		Assumptions made by professionals about care exp.
Participant 5		
MH support 'wholly helpful' – a safety net	No, it was just like, wholly helpful and it just felt like such a safety net.	Positive experiences of support
'Even when pregnant' – doing more than they had to? **History of inpatient status**	And like even when I was pregnant they said to me, like I'd been an inpatient in a psychiatric unit previously like, years previously, and they even said to me, like,	MH issues pre motherhood
<u>Transparent/explaining scenarios</u> <u>Worst case scenario no longer an unknown</u> <u>Reassurance – will support/facilitate her mother role – but unlikely</u>	worst case scenario you'll take a massive dip when you give birth, like worst case scenario. And if that happens [inaudible] mother and baby unit. Like, we've got somewhere you can both be together. Like, it's not going to happen. We don't think it's going to happen.	Positive experiences of support Positive experiences of support
<u>Support unconditional – safety</u> *Helpful, lovely 'just' – nothing but* *'Didn't do a lot' – no action necessary* *'just kind of there' – present*	But worst case scenario if this happens, we're gonna help you with it. And like, they were just so, em, helpful and lovely. And they didn't really do a lot.	Positive experiences of supportive professional relationships
Participant 6		
Attending professional meetings where many professions represented, formal reports presented – *intense, pressured*	And you know yourself if you have to attend a looked after review, or if you have to attend a child protection conference, or if you have to attend a children's hearing, they're massive	

	formal meetings where reports are provided by a number of people, and there is, there is a huge intensity and it's, it's a lot of pressure.	Working with CE mums can be intense and high pressure
Can't imagine as a parent yourself – if it's hard for the professionals, what is the intensity and pressure for parents?	And you can't imagine, you know, as a parent yourself, you know. You know that everybody's there with the best of intentions but in terms of a kinda, a professional group of people, you're very aware that you're not the only person offering advice and assistance. Or expecting change as well. It's meeting the professional expectation, isn't it, for mums who have looked after experience.	Professional meetings intense for everyone
Everyone expecting mum to 'change', that she should be meeting professional expectations – huge power imbalance. How does mum express her views and opinions?		CE mums disempowered by professionals
Having been through it as a child and now seeing it from the parent perspective *'massive'* – childhood experiences alter the experience as mum?	Cause they've experienced that side of things as a child but they're now experiencing that side of things as a parent, you know.	SW involvement reliving childhood experiences
'The trust is huge' – the necessary trust? Asking a mum to trust professionals? How convincing would this be if they don't agree/share the same views?	It's that, it's a massive thing. And the trust is huge, isn't it.	Professional disagreement erodes mums' trust
Participant 7		
Mother compensating for own childhood experiences	… needed to feel like things were consistent, and so with her children the last thing she wanted to do was be like an authoritarian parent. She didn't want to be super difficult, super harsh.	Compensating for past through child

Mother unable to regulate own or children's emotions Fear of being like foster parents **Lack of parenting role model** Professional supporting mother to identify what kind of mother she wants to be, not just what she doesn't 'Normal' expressions of emotion by children have additional meaning for CE mother Mother no confidence in her parenting ability	So she gave the children a lot of latitude and just didn't really know how to regulate her own emotions or their emotions. Umm, but just would repeatedly be like, "I just don't wanna be like my foster parents." But didn't really have a model of what she did want to be like. Instead, it was just like, "I don't wanna be that." And I was like, "OK, So what kind of parent?" and she was just like, she just, "I don't know. I don't know." Couldn't really remember an experience with being parented in a way that felt secure. And she sort of said, I think at some point one of her sons is like, "I hate you!", like a 5 year old, in the way that five year olds do sometimes. And she was like," I just don't know what to do. Maybe they'd be better off with different parents than with me." So yeah, she just really didn't trust that she could be a parent in many ways.	Lack of self/child emotion regulation skills Fear of being like own parents/care givers Lack of parenting role model Knowing what kind of mother they don't want to be Mother interpreting child's behaviour through lens of her own experiences Lacking confidence in ability to be good enough mum
Participant 8		
Support adapted to needs of mother **Fear of covid restricting activity, isolating** **Making it to mother and toddler group**	…em, really, really paranoid about it all. So she didn't want to meet up and things, which was fine. So we just kinda kept in contact through the phone. And as I said, more recently, she's said that she doesn't go out much, but she goes to a mother and toddler group with her baby.	Service support responding to needs to mother Mother and baby group prioritised over other social contact

Mother inviting professional for coffee – more than just practical support Relationship meaningful to mother? Important to her to share new baby with worker? Professional values it too	Em, so she had asked if we could maybe meet after that for a coffee, em, and catch up because I've not seen him yet. So I've seen photographs and pictures of him, but I've not seen him yet. So that would be quite good. So that's who I'm planning on meeting this week.	Mother and professional both valuing ongoing relationship
Participant 9		
Second mum struggles to trust, reach out for support but has long established relationship with prof – no time limit on support – relationship not conditional – safe base? **Relationship with prof for 4 yrs**	Yeah, I think the lovely thing about our service is we don't have a time scale on support. Em, so I've supported her since 2018. So she's been with us for a very long time. And although, you know, our service, we do have kind of structure in place, we	Long term relationships with profs help mums with trust issues
Service parameters do exist but there is potential for flexibility where it is seen to be in someone's best interest Prioritising mother's needs over service needs	recognize that for this mum in particular, that, yep, in terms of domestic abuse risks are very minimal, but at this point in time, she still needs that support. And when she's got such a great relationship with myself and our team, it would be, make no sense to her and feel like you're setting her up for a fail to then close her to our service to refer on to another service. So, you never want them to become self, self-reliant on you,	Support determined by mother's needs, not service needs
Awareness that dependence on service is a risk and not the intention, but recognising value of having someone to depend upon	and but I do think for her that having that one person that she can pick up the phone to is really the key for her and it's about the, I think for us it's, she doesn't feel the judgment.	Creating dependence vs a safe base

Open, honest, **transparent in relationship with mother –** <u>trust fundamental</u> **Genuine when giving praise** **Aware that false praise can feel patronising**	So she's aware I'm social work trained, aware of my role, aware if I had any concerns I would be passing them on. But I think being up front and honest with her and you know any praise or, or positive she gets from me, she knows that that's me being genuinely honest with her and it's not coming from a place of being patronizing.	Important to be honesty, transparent, genuine

Appendix U: Empirical Study: Additional quotes supporting themes

Themes		Additional quotes supporting themes
The value and fragile benefits of motherhood		• I had a lot, like I had to have a lot of like perinatal mental health and that, cause I think it was just like a really overwhelming thing to do obviously, having a baby. But it was a happy [inaudible]. (M: Aileen, 33-34) • Em, but she's what kind of saved my life. Definitely. If I hadn't had [second born daughter] I don't know what woulda happened. (M: Kayleigh, 25-26) • Em, I think they were quite delighted and it, it seemed quite positive and I was involved in that and the baby's been born and being kind of roundabout just after, after that they seemed, em, really happy and content and A in particular, as I said, it was very happy and seemed to take motherhood quite natural, but I think she was masking quite a lot. (P: Daphne, 289-292)
When the past and present collide	*Motherhood as a source of guilt and anxiety*	• Eh, yeah. I hate everything to do with hospitals. I have a real hospital fear and I've definitely passed that on to [son]. He has a real needle phobia. He is better now because I have tried my hardest, you know, to, to be calm with him around… and also [partner] does tend to do a lot of anything that needs to be done medically with him because I think he does pick up. (M: Kerri, 797-800) • It was the lack of sleep that was really difficult for me because with my depression one of the first signs that I'm having a dip in my mental health is that I don't sleep. Em, so because I wasn't sleeping, that was quite triggering, you know, thinking "Am I getting depressed again?" (M: Cristina, 244-246)

	Compensating for the past	• Yeah. So I think she constantly worries about not being a good enough mum. She feels a lot of guilt, em, around, she's had a child obviously in kinship and another children in care, so she feels a lot of guilt about child not being in her care, but also the risk of losing the other children. And that can be quite overwhelming for her. (P: Catriona, 177-180) • You know, just and I think that, that whole being let down has probably pushed me to be, you know, completely the opposite in my, you know. [Son] often says to me, "oh mum, you're going on!", you know. I often say to him, you know, I'm going on because I care, you know. Because I love you and that's my way. And you know, he gets to the stage now where he just accepts it because that's me. I'm not going to not go on, because I, well I do try not to go on, but that's, but, you know, and I suppose I wish my parents had done, and the people who were supposed to be looking out for me had been a bit more aware. (M: Kerri, 486-492) • Then the guilt comes from that side and then I end up, and then I overcompensate for like 5 days after that cos I'm like "I went out and I left him for the night" and "Oh my God." (M: Aileen, 842-844) • Uh, and so she was getting, like, quite badly physically beat up by her, by her eight year old. She showed me she had like bruises. He'd bitten her like (…) and she was just like, "I can't say, I can't push him away. It doesn't feel fair." (P: Sophie, 342-347)
The value and power of identities	*Developing valued identities*	• Like, they're quite niche with how they work with just mothers. And that's the kind of thing that I'd love to pursue like, further in my career. And I think, I think that is bred a lot from my own experiences as a parent who's experienced that, as well as being a child who was in care. Because I can see both sides of it. (M: Aileen, 10056-1059)

	Ascribed identities and their consequences	• Because I felt like I didn't really need that cause I'm just gonna be ok, but you've got to take it, if that makes sense? (M: Miranda, 61-62) • One particular I'm thinking about youth worker where they really leaned on and used them as a kind of mothering role - then that really helped them grow and develop their own identity as a mother and understand, how do you respond to this baby that's coming into the world? (P: Catriona, 64-66) • I felt like I didn't really need that because I did have a good upbringing when I did get fostered. I just felt like everybody's got to take that whether they've had a good care experience or not. Yeah, it's just kinda pushed on you. (M: Miranda, 77-79) • Yeah. It's, it's just labelling and stereotyping, and there's already so many negative statistics about coming from care, you've then got this really happy moment in your life that can be a turning point for some people, and then you've got a judgemental midwife who, you know, she might know, you know, the area where you live, you know, or she might think you look scruffy or, you know, just make presumptions about your socioeconomic status, and then you've got a referral into social care. Yeah, it's a completely unfair stereotype. It does nothing to change people's perceptions of being in care. It just perpetuates that narrative. (M: Cristina, 105-111) • And you know, other professionals are coming in and making judgements about what they're doing and how they're doing it, as a parent, you know, what they're doing. There's managing a household, you know. How they run their lives. Who they're having relationships with, do you know? It's, there's a whole gambit. (P: Stella, 78-81)
Engagement with services: the push and pull	*The struggle for power and control*	• Yeah. And I was petrified and I was like, well what are you gonna do? And she said that she wasn't going to put in a referral which gave an overwhelming feeling of relief, but

	then left with that, kind of uneasy feeling of it shouldn't, it shouldn't be down to a woman who only met me 10 minutes ago to decide, you know, what's she looking for? (M: Cristina, 88-91) • I sort of went in and I said, I'm pregnant. And he went, you're not sick are you? And I went no. And he said jolly good. But I actually loved him for that. I was like, good! Okay, I'm pregnant. You're gonna let me get on with it. And I said well I just wanna know what I need to do and where i need to go. And he said okay, fine. I'll write everything down for you, when you need to make appointments. And off I went. And I was like, god. Thank god for that. Cause I thought I was gonna be prodded and poked and all the rest of it. And I was like, yes, I'm having a baby. I'm not ill. It was like thank you so much. (M: Kerri, 811-817) • She literally had, you know, a really kind of visceral reaction to the fact that she wanted to buy – I can't remember what she wanted to buy, she wanted to buy something - and didn't see the value in having any window dressings or any cutlery in the kitchen. And I'll always remember standing in this particular shop, I think it was argos to be specific (laughs). And I sort of said, don't you think you're going to need cutlery? Do you think we should maybe just get you a small, you know – 'No! I don't f***ing want cutlery! No I don't f***ing want curtains!' (P: Stella, 214-220)
Imperfect professionals and systems	• And yeah, I put a complaint in, not about what happened. So I don't dispute that they should safeguard children in that way. But like, it was like a lot of pressure and they didn't share information very well. There was breaks in confidentiality for my work. The processes weren't followed properly. And I just felt like pairs of other parents deserve better. (M: Aileen, 440-444)

- So I had told her everything that had happened and she said, em, like I'm gonna have to pass this on. I've got a duty of care. But nobody's every been in touch with me. (M: Kayleigh, 83-85)
- I had mentioned to her about speaking to her health visitor, kind of post-natal depression and things like that and, em, I think she maybe said to me at the time she was teary one day and I said, "oh, it's just like maybe the baby Blues and things". But I did say to her to try and get a bit of, kinda, advice and support from the, the health visitor. (P: Daphne, 297-300)