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DE-PATHOLOGISING MOTHERHOOD

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Introduction: A mother’s mind

This chapter is rooted in our own experiences of motherhood, mental health services and research. One of us (Angie) is a survivor researcher, the other (Billie) is a clinical psychologist and researcher, and we are both mothers. During pregnancy and whilst breastfeeding, Angie was under a mental health midwife team and monitored by a perinatal (pregnancy to one year post-birth) psychiatrist. Billie (coincidentally) worked in the same service as a psychologist and attended a therapeutic group with her daughter elsewhere. We have both worked on a qualitative study of women’s experiences of perinatal mental health services, Billie as the main researcher, which we are calling the Perinatal Study. This study was based in the UK, and whilst the issues we describe reach beyond this context, much of the text relates to UK systems, policies and practices. Inevitably, we also write from our limited, partial positions as heterosexual, cis, working white mothers, with white or mixed race partners and children, living in a metropolitan city in the Northern hemisphere. Whilst we are aware of the important differences in the experiences of mothers who are straight, lesbian, transgender, single, co-parenting, poly-parenting and so on, our focus here is on the underlying structures that influence our varied experiences, and the ways in which gender norms can affect mothers beyond our social positionings. However, we also hope to inspire further research on motherhood from other positions and perspectives within Mad Studies.

Motherhood has, for both of us, been characterised by intense and conflicting emotions: of love and loss; exhaustion and elation; guilt and gratitude; fear and fracture; mayhem and monotony; connection and isolation; and, often, of failure. It is a relentless experience of giving and doing what it can feel beyond our resources to give and do, day after day – no matter how exhausted, how desperately in need of respite. It has also entailed huge transitions in our roles, identities and relationships. These experiences have occurred despite our current, relative socioeconomic privilege.

Faced with dominant cultural beliefs that, as women, we should naturally be nurturing and able to cope with the mothering role, we have often doubted ourselves: why am I struggling? Am I the only one? Am I harming my child? Am I mad? Why do I feel so angry? How can I keep going? We believe there is no one right way to parent and that we only need to be good enough, yet still feel we are falling short. We know that it is possible to not be a good enough mother too and to inflict enormous damage. We find motherhood hard to figure out, and to write about.
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It is in this context, along with our clinical and research experiences, that we question psychiatric conceptualisations of maternal struggles as postnatal depression, postpartum psychosis, or a return/trIGGERING of a pre-existing mental disorder. We have seen how this limits understandings of motherhood and narrows the way society responds. How it can make mothers fearful about discussing their difficulties, and coerce them into adhering to dominant gender norms. And how it promotes medical and individual treatments, whilst diverting attention from the need for broader community, social, political and structural responses.

Throughout this chapter, we include quotes from women who participated in the Perinatal Study. This study included interviews with 52 mothers (between 2015 and 2017), with 6–9-month-old babies, seen in NHS services in England for perinatal mental distress (UCL, 2019). The quotes we have chosen to include are from mothers who shared experiences that resonated with us, sometimes validating and at other times shaping, enriching or changing our evolving perspectives. Some women in the study felt that psychiatric diagnoses explained and validated their experiences, and enabled them to access treatment. Whilst the reasons for this should be considered too, our main focus here is on the voices who felt differently; who questioned the way services responded to their distress; or whose words, we felt, shed light on psychiatry’s limitations.

Natural motherhood

In the UK and beyond, although legislation and mainstream narratives are shifting away from the notion that heterosexual couples are the only acceptable foundation of a family unit, historically and now, across a wide range of cultures, raising children primarily remains women’s responsibility, with emphasis placed on the mother–infant bond and women’s presumed natural ability to nurture. Although some societies have seen recent shifts towards increased paternal involvement, in both Northern and Southern hemispheres, social customs and arrangements tend to perpetuate women’s role as the main caregivers.

This notion of motherhood as natural, innate and inevitable is fuelled by cultural images of the fulfilled mother with contented baby. Although there may be occasional (droll) popular cultural references to some of motherhood’s challenges, like the need for extraordinary levels of multitasking, women are nonetheless depicted as having a natural capacity for this, with fathers at times painted as hapless, bumbling and in need of direction from women. Given this cultural context, women may justifiably expect motherhood to bring joy and contentment.

But this is often far from reality. Although some women may glide easily through motherhood – and experiences may be different in cultures with which we are less familiar – we suspect that the dominant experience can be one of simultaneous emotional extremes and unrelenting monotony alongside a fluctuating sense of fulfilment and struggle. Experiencing complex shifting emotions in cultures that characterise motherhood as natural, joyful and fulfilling whilst often ignoring its many challenges, can reinforce the idea that there is something personally wrong with us. Trying to get by, to be enough, rather than feeling gratitude and delight in these precious moments, can cause huge self-doubt. This is both created and fuelled by the culturally prescribed myth of the perfect mother – the expectation that we will be all, always; gentle, tender and nurturing. That strong negative, angry or ambivalent emotions are abnormal, unfeminine and a sign of illness.

Media analysis has shown that news stories about women experiencing perinatal distress often categorise them as either ‘mad’ or ‘bad’ (Dubriwny, 2010). Some women, who Dubriwny observes tend to be white, middle class and heterosexual, are depicted as ‘diverted good mothers’. They are shown as having gone through an alarming and abnormal, but
ultimately temporary disruption to their natural ability to mother, from which they later recovered. In these cases, there is usually a happy ending, showing them now delighting in motherhood in the expected way. Other mothers – particularly those who are lesbian, single and black and minority ethnic are either absent from news coverage or depicted as ‘bad’ rather than ‘mad’.

(Who is) crossing the line

Recent years have seen increased media attention given to perinatal mental health. This is part of wider efforts to reduce stigma and increase help-seeking through public education about mental illness – ‘an illness like any other’. We are told that ‘baby blues’ and tiredness are a normal part of early parenting, but that there is a line we can cross into postnatal depression or, more rarely, postpartum psychosis, and once crossed, it is essential that we seek help. For instance, in an article about the baby blues, The National Childbirth Trust (NCT1) states that post-birth:

Symptoms might upset you at the time, but they are relatively mild and will usually pass within 10 to 14 days. If they hang around, become more severe or include manic symptoms, they could be signs of more serious postnatal illness. You should speak to your GP or health visitor about getting some help and support.

(NCT, 2018)

The implication – sometimes stated overtly, sometimes implied – is that if we do not seek help, our children may be harmed through the impact of untreated mental illness. Clinicians have the responsibility of i) ensuring that those who are at risk, or who have crossed the line, are identified or educated so that they can appropriately seek help and ii) developing and delivering effective treatments and ensuring mum is monitored. The existence of diagnoses like postnatal depression goes unquestioned – they are seen as concrete, diagnosable, objective illness states afflicting individual mothers. Treatment, in turn, aims to modify a woman’s body and mind – in a sense, to fit ‘diverted mothers’ back into society and the mothering role.

The National Institute for Health and Care Excellence (NICE) has produced clinical guidelines that UK clinicians are expected to follow for women who have crossed the line (2018). The guidelines clearly address difficulties in women rather than, for example, focusing on the wider familial or social context. Recommended treatments include facilitated self-help, cognitive behavioural therapy and medication, increasing to inpatient stays on mother and baby units. Monitoring of the baby becomes necessary for pregnant and breastfeeding mothers because of the potential for treatments, particularly medications, to harm infants.

Electroconvulsive therapy (in which under general anaesthetic, an electric current is passed to the pregnant woman’s brain through electrodes, triggering a seizure) is recommended where a clinician judges that the physical health of the woman or baby is at risk, for instance through suicide. There is a bitter irony to this: a recent systematic review of international case studies found that ECT in pregnancy is associated with adverse outcomes for mother and baby, including foetal heart rate reduction, premature labour and neonatal death: “Lethal outcomes for the fetus and/or baby were stated to have diverse causes, in one case a long lasting severe

1 NCT is a respected, UK-based organisation that supports (predominantly middle class) parents through pregnancy, birth and early parenthood.
grand mal seizure (status epilepticus) induced by ECT” (Leiknes et al., 2015). In a rebuttal of the Leiknes review, the academic psychiatrist Donna Stewart counters that:

[a] 2009 review of 57 case reports involving 339 pregnant women, included only 11 neonatal complications, which included 2 deaths that were likely related to ECT.

(Anderson and Reti, 2009; Stewart, 2015 emphasis added)

For Stewart and others, the risk to the mother and baby is so great that the risks from ECT, including death of the unborn child, do not warrant it being considered an unethical or dangerous treatment. Inevitably, judgement regarding what constitutes an acceptable risk falls on the clinician. The horror of this does not need stating. For those women who have lost unborn children to ECT, what might have been the personal, interpersonal and sociocultural contexts they were navigating? What might have been their personal stories?

**Mind and body**

When a woman’s distress is interpreted as symptomatic of a mental disorder, attention is likely to focus on her body to the neglect of her social circumstances.

(Stoppard 2000:101)

In her doctoral research on postnatal depression, Paula Nicolson interviewed 24 British women during pregnancy and post-birth and found that almost all reported feeling depressed, anxious or tearful, but that:

each gave detailed explanations of what led to their behaviours. They contextualised them within the varied events over the days and weeks following childbirth, making their own reactions logical and meaningful...

(1998:55)

In the Perinatal Study, we found that mothers often faced overwhelming challenges including: poverty; homelessness; chronic sleep deprivation and exhaustion; relationship breakdown; isolation; turbulent and sometimes violent relationships; mothering after a traumatic childhood; lack of support; and traumatic birth experiences. It was common for mothers’ distress to reflect changes going on between and around people as well as within them. Sarah, a young, single, white, working-class mother expressed some of these challenges.

*I was in a good place before I got pregnant. And then when I found out I was pregnant, it knocked me sideways. And then, with everything that happened with his dad [leaving me], it was just a massive blow. So, within the space of a few months, I had lost his dad, fell pregnant, gave up my job, and I was just in a big hole …

… You want to be on your game for your child, you want to be on the ball, perfect mum, and sometimes you just feel so low about yourself and the situation that you’re in. When it’s raining outside, you don’t want to take your baby when you’ve got nowhere to go. You’re not heading anywhere … You’re on your own, you hardly see anyone … You try looking in a baby group or you try stepping in there and some of the women are just … They’ve never been in that situation … So, you go in there and you’re either getting looked at or just dodgy looks …

… There’s nowhere that you can have respite, there’s nowhere that you can just go, I just need an hour sleep, I’m just so tired.
Sarah’s isolation was intensified because she felt that her available ways of connecting with other mothers, such as through playgroups, were dominated by middle-class women living in traditional relationships and with more support. Whilst Sarah was desperate to be the perfect mother amidst poverty and isolation, her family doctor diagnosed her with postnatal depression and prescribed medication.

_They tried giving me different medications at the doctors, and they just didn’t help. If anything, they just made me feel sick … A couple of the doctors’ appointments were terrible. I’d sit there and I’ll explain to them what’s been going on, and they said, ‘So what do you want us to do?’ … And it was just a case of, take some drugs. Take these, see how you feel, then come back to us and let us know … You give up after a while._

Whilst clinicians may agree that young, poor mums like Sarah need interventions beyond psychiatry, they may also consider those diagnosed with postpartum psychosis to be different, mad, unquestionably in need of psychiatric treatment. In postpartum psychosis, biology and physiological changes after birth are seen as causal, with symptoms including sleep problems and delusions. Remarkably, researchers at Cambridge University have likened maternal postpartum psychosis to female pigs biting their newborns to death, and are studying the chromosomes of affected pigs in a bid to identify candidate genes for postpartum psychosis (Quilter et al., 2008). In this model, pigs are equated with humans, postpartum psychosis with pig infanticide, and the role of environment (the pigs lived in harsh conditions) considered irrelevant to understanding behaviours.

Linda, a white British mother in the Perinatal Study (who was neither a pig nor considering biting her baby to death) with no previous contact with psychiatry, was hospitalised for postpartum psychosis shortly after giving birth when she became convinced that her partner and others were trying to harm her and her baby. Linda’s account describes how hospital practices made her feel unsafe, helpless and unable to sleep in the run-up to diagnosis.

_They decided that I was just so tired that I had to have an epidural. And I hadn’t wanted to have an epidural. So they administered that and then that didn’t, it only numbed part of my body … I ended up with sort of two or three different cannula for different things … I really felt like, immobilised by that … I couldn’t, when she was born I couldn’t hold her to try and feed her …

The first couple of nights … I was having trouble sleeping. Not necessarily because of my baby, but because of the people around me … Eventually they got us a room so [my partner] could stay with me and, I mean, that was good, but … all night there was the alarm … beep beep … And also the heating was broken … And we couldn’t open the window because the window was broken. So it was like this horrible mix of noise again and the kind of heat …

I was getting paranoid about [my partner’s] ability to look after our baby while I was asleep because they’d asked me to put earplugs in. But I was finding that, when I put earplugs in, I became really paranoid … I felt really sort of unsafe by putting them in …

Yet, despite Linda’s vivid account of her environment, there was little attempt to understand her sleep problems and fears as anything other than ‘symptoms’ of a disorder. The role of hospital practices, familial support, or the normative social rules surrounding infant care were disregarded, and Linda was admitted to a psychiatric ward and then a mother and baby unit (MBU) and medicated.
Of all the services that women in the Perinatal Study had accessed, MBUs were amongst the most well liked. MBUs are a specialist model of inpatient care for women diagnosed with severe perinatal psychiatric difficulties that admit the mother and baby together. They enable a residential stay that takes women away from the stresses of parenting a newborn at home, often with little support, and can relieve women’s concerns about providing for their babies, financially, practically and emotionally. Staff in MBUs help care for newborns, meaning that, for instance, women are able to shower or sleep, things they may have struggled to do at home. Mums often said they developed supportive relationships with other women who were struggling; this too was unique.

Even so, MBU admissions fragment families (although in a world of gender-based violence, this may sometimes be welcome), reinforcing the idea that the mother–infant bond should be prioritised above all others. Thomas Main, a pioneer of joint mother–baby admissions, wrote,

> Just as it seemed important to keep a man patient in touch with his job and to treat him for the difficulties he might meet there, so it seemed important that a mother should be kept in touch with her job, and the children who were part of it.

(Main, 1958:845)

Whilst keeping mums and babies together is to be welcomed, MBUs risk simply returning ‘diverted’ mothers to their natural caring state. Wider social contexts are largely ignored, as described by Yvonne, a young, single, black British mother:

> And then when she was around like fi ve months I came back out [of the MBU] and things went well for quite a while. It was like the happiest I’d ever been. I had bonded with her and everything was really good. But I just felt, I don’t know. I just felt kind of like this is not real life and it didn’t really, I think I was on such a high and so comfortable and so bonded, but then when I went back out into the like real life when you have to cook and clean for yourself, wash clothes for yourself and look after your baby 24/7 yourself, it’s like it was just a big shock. So I kind of broke down again.

Yvonne had been diagnosed with postnatal depression in the context of a traumatic birth, relationship breakdown, homelessness and socioeconomic deprivation. She clearly valued the support and respite provided by the MBU. But the failure to address her wider context meant she soon struggled again. Her ongoing difficulties coping with her baby also resulted in child protection concerns, meaning she now risked moving from ‘diverted mother’ to ‘bad mother’, further increasing her distress and eroding her ability to cope.

Where is the justice

I grew up in a crack house. My mum was a crack user and my stepdad was a crackhead. My house was filthy. My house was … so filthy I couldn’t invite people in … friends … A lot of dysfunction was going on in my house.…

…I wasn’t ready to be a mother. I was sexually assaulted at age thirteen, fourteen. I was told that I couldn’t have children because he had damaged me so much down there. When I found out I was pregnant I was, I was shocked. My mum said she’d stand by me no matter what; if I want to keep it or termination. My mum did not stand by me. My mum taught me nothing. My mum never taught me about periods. She never taught me about nothing. All my mum
taught me is how to use a crack pipe … Social services should’ve worked with me better. They say that they like to keep families together. I truly believe that I’ve just been set up…where is the justice in this world?

(Sheryl, a single, black British mother diagnosed with personality disorder whose baby had been taken into care)

Like Sheryl, several mothers in the Perinatal Study were diagnosed with borderline personality disorder, a diagnosis more commonly given to women. These women often described growing up, and now parenting, in acutely traumatic and socially deprived contexts, including relationship breakdown, violence and sexual abuse in child and adulthood, sex work and criminal justice involvement. It was in these contexts that some were feeling ambivalent towards their babies and struggling to parent.

The diagnosis of personality disorder – seen to include persistent or frequent angry feelings, unstable and intense interpersonal relationships, and an unstable sense of self – labelled these mothers’ feelings of anger, distress and instability as abnormal; outside of the bounds of what it is reasonable for a woman to feel; a far cry from the mild restraint of the perfect mother. Many of these women felt that they were judged as unfit. These were not diverted mothers; they were bad mothers. There were few attempts to understand how their rage might be legitimate, or how expecting a woman to have a stable sense of self during the transition to motherhood might be unreasonable, especially under these circumstances (for a wider discussion see Rowan Olive 2019).

Several of these mothers felt that their diagnosis and/or a refusal to understand or accept that they could be good mothers, contributed to coercive and discriminatory behaviour against them, particularly by social workers. Serious child protection concerns had been raised in relation to the vast majority, and several had had children removed from their care. Whilst we are aware that, as parents, we can irrevocably harm our children, these mothers felt blamed for their difficulties, judged as inadequate and monstered. Little attention was paid to structural inequalities, trauma contexts, and their lack of access to adequate support. Many felt that they were set up to fail.

More broadly, women are at high risk of deprivation during motherhood (Rabindrakumar, 2018). UK austerity has meant that single parent families and those with three or more children are the most likely to use food banks, often driven by in-work poverty and welfare sanctions (Loopstra et al., 2018a, 2018b). Simone Du Toit (2017) analysed interviews from 11 low income mothers in South Africa diagnosed with postnatal depression and found that many were attempting to mother whilst unable to meet their children’s basic needs for food, clothes and school fees. She writes:

Kruger and Lourens (2016) points out that neoliberal discourse of self-sufficiency in solving one’s own problems translates into women’s feelings of guilt and shame when they fail to meet their children’s needs. Ultimately, the tension between low-income women’s constructions of ideal motherhood and their inability to meet these ideals due to poverty-related constraints mean that providing for children is not only a daily struggle but also a marker of personal failure.

Women’s twentieth century move into the workplace has not been accompanied by great changes in home set ups, with working mothers in heterosexual relationships typically undertaking the bulk of domestic and emotional labour. Unsurprisingly, mothers, especially with two or more children, are amongst the most stressed in the workplace, with a reduction in
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working hours within flexible patterns singularly found to reduce stress (Chandola et al., 2019). However, irrespective of personal preference, this is economically unviable for many.

Maternal struggles to provide and survive are juxtaposed with frequent calls by commentators and politicians for parents (mothers) to turn screens off, provide healthier food, read bedtime stories, with middle class parenting approaches – rather than their associated resources – seen as the gold standard. In a further injustice, women’s psychiatric diagnoses are seen as a greater cause of damage to their children than their socioeconomic circumstances. Consider the findings of this study, blogged under the title ‘Mothers’ Depression more Harmful than Poverty for Children’s Mental Health’:

> there were very early signals that a child might develop symptoms of mental illness. For example, 3-year-olds with poor speech development or irregular bedtimes were more likely than other children to go on to develop symptoms of mental ill health at ages 5 and 11.

*(UCL blog, 2017)*

The same study also found that fathers’ mental health had little influence on children (Fitzimons et al., 2017), perpetuating the need for the diverted mother to become the perfect mother. But pathways to mental distress are not set in stone by variable bedtimes. Instead, these children, growing up in difficult circumstances, are being set on a path to having the realities of their lives permanently pathologised.

**A different way**

Returning to the mother who has lost her unborn child to ECT, what might her account of her distress have been, her personal story? Some of the issues that occur in the perinatal period – some of which we’ve touched on, some not – that can cause intense stress and distress, include: interpersonal and social transitions and conflicts; changes in social status, identity and employment; traumatic births; chronic sleep deprivation; exhaustion; isolation; lack of community; maternal poverty; mothering through grief; parenting following maternal childhood trauma; gender-based violence; raising children in unequal societies, including the contexts and impacts of racism and homophobia; and sociocultural expectations of women and motherhood including a fear of being honest about the challenges. These factors will come together in different ways for different women, and each will have a complex and shifting account of what is causing her distress (Nicholson, 1998) – her own personal narrative. Put simply, parenting is hard.

Women are socialised to keep going, to put one foot in front of the other, to give to others and ensure their needs are met before our own, to be perfect wives, mothers and colleagues. As we’ve described, when we deviate from these expected female behaviours – because we are unable to give more, because we are angry, exhausted and operating beyond our resources, because parenting feels like a near impossible undertaking – mental health services tell us we are ill and step in to return diverted mothers to good mothers through diagnosis, medication, hospitalisation and ECT. The bad mothers – those with diagnoses, emotional expressions and behaviours that we cannot accept – are policed and scrutinised.

As we noted in our introduction, some women in the Perinatal Study welcomed psychiatric diagnoses, arguably in part because this granted access to a blameless, diverted mother narrative, with services responsible for returning women to their natural caring state. Yet Dubriwny (2010) describes how this narrative turns attention away from the need to challenge...
the problematic discourse of the ‘essential/good mother’. And how access to this narrative is not equitable, with white, middle-/upper-class women who experience perinatal distress likely to be seen as diverted, while ‘out-group’ women – typically those of colour, single, deprived, or otherwise mothering outside of dominant cultural norms – are rejected as ‘bad mothers’ and policed by social services and the criminal justice system. Dubrwny writes: “This replication of the mad/bad mother dichotomy in which a woman is either “afflicted by her hormones or by evil” has negative implications for all women” (2010:297).

In losing interpersonal and sociocultural understandings of the difficulties of motherhood, a focus on familial and sociocultural responses is also lost. Survivor-led and coproduced research could enable an understanding of women’s perinatal experiences in their broader context. The aim should not be to impose a single model of understanding on women’s experiences, or to produce outputs that re-educate people into a single way of thinking, but to engage with women’s perspectives on their circumstances, the causes of their distress, the intersections with their support needs and the implications for whose needs are being met, whose are unmet, and how support gaps might be addressed. This should be underpinned by a fundamental belief in the potential for women’s experiential knowledge to transform how distress is conceptualised and responded to, and include, and be led by, women who mother outside of mainstream norms. Whilst we do not want to predict the support that women need, our belief is that it should be trauma-informed, community-based and address structural inequalities (Becker-Bleasley, 2017). This includes implementing or strengthening policies that, for instance, lessen economic pressures on women and families; enable shared parental leave; ensure fair and timely access to welfare; and address discrimination and protect rights.

Whilst we do not naively assume that children would not be taken into care if mothers had adequate support, we do believe that without meaningful support and in an absence of social justice, this becomes inevitable for some. Isobel et al. (2018) found that intergenerational trauma can best be prevented by addressing parental trauma and supporting parent–infant attachments within an approach that includes individuals, families, communities and society. In the Perinatal Study, women at risk of having their children taken into care often valued the support of Parent–Infant Teams. Key is that this avoids simply becoming another way to return mad/bad mothers to their natural mothering role. A further example is provided by Smith and colleagues (2017) in the Norfolk Parent-Infant Mental Health Attachment Project which provides intensive, trauma-informed and systemic support to young families considered ‘at risk’ – and who would ordinarily be monitored by social services. The project significantly increased the number of children able to remain safely with their families.

Unsurprisingly, where they were able to, women in the Perinatal Study valued connecting with other mums who were struggling. Perinatal peer support has been found to create a sense of connection and validation, and a place to be heard (McLeish and Redshaw, 2017). However, much research into peer support focuses on structured approaches, typically peer support workers employed in the mental health system. We also advocate access to mutual, intentional and trauma-informed peer support outside of psychiatric systems (e.g. Blanch et al., 2012; Filson and Mead, 2016). This is particularly important for perinatal women who can experience distress and overwhelm as the norm in a cultural context of perfect mothers, and who need a place to be honest about their difficult feelings. Certainly, this would have helped us.

Afterword

A final word to our children: we want you to know how much love and joy you brought into our lives as your mums, without at the same time romanticising the task of motherhood.
If you, our daughters, choose the path of motherhood, know that you will make infinite mistakes against the backdrop of society’s expectation that women are perfect nurturers, and that this will cause great angst. Know too that your distress, despair, doubt and emotional extremes are ok, and that any struggles you encounter in providing for your child matter. What you will need – what we all need – is compassionate, meaningful support. We hope that by the time you arrive at motherhood (if that is what you choose), that support is something that all women will have.

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