

“Magic happens when women come together”: An exploration of perinatal mental health and the role of social relationships in supporting mothers

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Overview

Perinatal mental health difficulties are considered a key global health concern and if undetected and untreated, can negatively affect maternal wellbeing and infant development. This thesis explores women's experiences of perinatal mental health difficulties and what supports them in this period, both in the UK and in a range of Low- and Middle-Income Countries, along with accounts from clinicians working in perinatal services.

Part one is a systematic review and meta-synthesis of qualitative studies which explore women's experiences of perinatal psychological distress in Low- and Middle-Income Countries. A systematic search found 20 studies, the findings from which were synthesized using thematic analysis. The review discusses salient themes and how learning from these may be used to inform services providing support for women experiencing perinatal psychological distress both in Low- and Middle-Income Countries and potentially in other socio-cultural settings.

Part two is a qualitative study seeking to understand mothers' experiences of accessing, and clinicians' experiences of providing, perinatal mental health services in the UK. Thirteen mothers and the same number of clinicians were interviewed about their experiences. The interview transcripts were analysed using thematic analysis. Themes relating to barriers and facilitators to mothers' disclosing their mental health difficulties and concerns relating to the parent-infant relationship were derived, with a thread of the importance of social support and relationships being key. The findings support existing literature on mothers' experiences of perinatal services as they highlight the social nature of the perinatal period, the role of relationships across system levels and the importance of compassionate, non-judgmental support in order to facilitate access to services. The findings have implications for service planning and delivery.

Part three is a critical appraisal of the research process, examining the researcher's perspective through personal reflexivity and the impact of this on the research. Contextual factors of power and privilege, along with the context of the COVID-19 pandemic on the present thesis are discussed.

Impact Statement

To the authors' knowledge, the present thesis contains the first meta-synthesis of qualitative studies exploring the lived experience of women with perinatal psychological distress in Low- and Middle- Income Countries (LMICs). Academically, this provides new insight into the cross-cultural thematic commonalities in the experience of psychological distress in the perinatal period, for women in a range of LMICs.

Previous qualitative research into mothers' experiences of accessing perinatal mental health services in the United Kingdom (UK) suggests a need to better tailor mental health services to the perinatal context, including a need for collaborative and integrated care, which holds in mind the mother-infant dyad as a distinct system; stigma and fears about loss of custody; and the importance of non-judgemental and compassionate support. The present empirical paper builds on existing literature on the experiences of women in the UK who have accessed perinatal mental health services, with a novel focus on how services assess and work therapeutically with the mother-infant relationship. It also provides early, exploratory findings on the impact of the COVID-19 pandemic on mothers and their babies who have been born in this period.

Both papers found themes relating to the key role of interpersonal relationships, highlighting the social nature of managing psychological distress in the perinatal period and in facilitating access to services.

Clinically, whilst the present meta-synthesis reviewed studies from LMICs, the findings may be of value in other socio-economic and cultural settings in terms of service planning and provision. They highlight the importance of culturally-syntonic conceptualisations of and interventions for psychological distress in the perinatal period. Further, the fact that there are thematic commonalities between the findings of the meta-

synthesis and empirical paper, indicates that treatments developed in a range of LMICs may have clinical implications in other socio-cultural settings. This contradicts the tradition of psychological interventions for mental illness being developed in a Westernised context and then exported to other cultural climates. The critical role of social relationships for mothers in the perinatal period, both in LMICs and the UK, indicated that peer-led provisions, provisions focussed on or centred in religious centres, family, group and community-focussed interventions may be of value cross-culturally.

The findings from the empirical paper provide early insights, to the impact of the COVID-19 pandemic on services provision in the UK, indicating that services would be wise to continue a virtual offer, even as face-to-face services become more available again. Whether in person, virtual or a blended service offer, the findings highlight the need for flexible, service-use lead treatment options, which hold the mother-infant relationship at their heart.

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Part I: Systematic Review

**Causes, Concepts, Coping and Cures - Women's Experiences of Perinatal
Psychological Distress in Low and Middle Income Countries: A Systematic Review and
Meta-Synthesis of Qualitative Studies**

Abstract

Objective: This review synthesized findings from qualitative studies exploring women's experiences of perinatal psychological distress in Low and Middle Income Countries (LMICs).

Method: A total of 20 studies were identified through searches of three electronic databases. The Critical Appraisal Skills Programme (CASP, 2018) checklist was used to assess the methodological quality of the studies. Thematic analysis of the findings was conducted using NVivo 12 (QSR International, 2020).

Results: The findings from the 20 studies were synthesised into four domains, each containing two to five themes; Causes (culturally specific causes; physical causes; resources; social relationships; and thinking and worries); Concepts (affective; behavioural; cognitive – thoughts and beliefs; and physiological); Coping (interpersonal; and intrapersonal) and Cures (culturally relevant cures; medical intervention; social interventions; barriers).

Discussion: To the authors' knowledge, this is the first meta-synthesis of qualitative studies exploring the lived experience of women with perinatal psychological distress in LMICs. A salient theme, presenting in various forms but consistently across domains, was the social nature of the perinatal period and experiences of difficulties in this life stage. These findings may be instrumental in informing service design and provision in LMICs, and there may also be learning from these findings which can be applied to support women in other socio-cultural settings as well.

Introduction

The perinatal period, that is, pregnancy and the first year after birth, is often a positive and joyous time for many women and their families. However, it is also a high-risk period for developing mental health difficulties, with up to one in five women experiencing a perinatal mental health problem (Royal College of Obstetricians and Gynaecologists, 2017; Bauer et al., 2014). Symptoms experienced by mothers with perinatal mental health difficulties range from mild to moderate anxiety or low mood, through to more complex and acute presentations such as obsessive-compulsive disorder, bipolar affective disorder and postpartum psychosis (Nakku et al, 2016; Tripathy, 2020). Perinatal psychological distress is considered a global health concern, as each year around 10% of mortality among women in the perinatal period is caused by suicide (Kim et al., 2010). In addition to the distress caused to mothers, perinatal mental health difficulties are also associated with negative outcomes for the child, including physical and cognitive developmental delays and psychosocial problems (Stein et al., 2014).

There is a heterogeneity in the incidence of perinatal mental health problems globally, with prevalence ranging between 10-15% in High-Income Countries (HICs) compared with to 10-41% in Low and Middle-Income Countries (LMICs; O'Hara, 1996; Ross & McLean, 2006; Stewart et al., 2003). In a systematic review of international studies, Fisher et al., (2012) found a higher prevalence of perinatal mental disorders in LMICs compared with high-income countries. In LMICs, both ante- and postnatal depression are associated with higher instances of issues of social adversity, including marital problems and poverty (Schafer & Koyiet, 2018; Mootz et al., 2019). Whilst there is a wealth of evidence to support the amenability of perinatal mental health difficulties to psychological intervention, in LMICs

these disorders are under-detected and availability of evidence-based treatments is extremely limited (World Health Organisation; WHO, 2016).

These quantitative studies provide a picture of prevalence and distribution of incidence of perinatal mental health difficulties between HICs and LMICs, but not the idiographic nature of these experiences. There is a burgeoning body of literature which explores mothers' experiences of perinatal mental health services. There have also been systematic reviews and meta-syntheses of the findings, however these appear to collate studies from HICs, particularly those in the UK, USA and Western European countries (e.g. Smith et al., 2019).

With the construct of culture impacting every facet of the universal experiences of conception, pregnancy, childbirth and parenting, it is essential to hear the experiences of women from multiple cultures in order to draw a more comprehensive picture. Patel (2012) notes the importance of mental health interventions being “driven by local knowledge” and that “such knowledge should flow in both directions between the global south and the global north” (as cited in Bemme & D’Souza, 2014, p. 2). Psychological and mental health research has long been criticised for focusing on research samples made up of people from Western, educated, industrialized, rich and democratic (WEIRD) societies, who are thought to represent up to 80% of study participants, but only 12% of the world’s population (Henrich et al, 2010). To begin to address this gap in the research and in order to take a global, cross-cultural perspective on a universal experience – the perinatal period – the present systematic review and meta-synthesis draws together research from LMICs around the world, which explores the lived experiences of women suffering from psychological distress in the perinatal period. The current review therefore, aims to address the gap in the literature by considering: What do qualitative studies reveal about women’s experiences of perinatal psychological distress and their treatment in LMICs?

In undertaking such a task, Timulak (2014) notes the importance of the meta-analyst owning and presenting to the reader, the epistemology of a given qualitative meta-synthesis. The epistemological stance of any researcher is informed not only by their theoretical stance and methodological preferences, but also the lenses through which they view the world. The present meta-synthesis uses social constructionism as the epistemological framework, which posits that researchers construct meanings and realities within the interaction process with both participants and the generated data (Cisneros-Puebla, 2007). This implies that the role of the researcher needs to become transparent in both data collection and subsequent analysis. Therefore, findings cannot be presented independently and objectively, but as a result of the subjective construction (Lock and Strong, 2010). Social constructionism also states that language constitutes reality (Lasantos et al., 2016) and the focus on direct quotations from the included studies in the present meta-synthesis is informed by this assumption. A core research value driving the present review is to challenge the post-colonial, Western-centric paradigms of the majority of psychological research and hold a curious, exploratory stance in the secondary analysis of qualitative studies which present the idiographic representation of women's experiences of perinatal psychological distress in LMICs.

Method

This section describes the methodological approach to the present systematic review and meta-synthesis. This includes the methods of data collection, the meta-analyst researcher's epistemological stance and background, a summary of the study characteristics and the methods of analysis; namely, quality appraisal of the studies and the meta-synthesis method.

Data collection

Databases and search terms

Studies were identified through searches in three electronic databases: Embase, PsychINFO and Medline. The following combination of search terms was used:

women or client* or service user* or patient* or participants* or people or mother* or consumer*

AND

experience* or perspective* or feedback or view* or perception* or reaction* or narrative*

AND

perinatal or peri-natal or natal or partum or postpartum or post-partum or puerperal or postnatal or post-natal or antepartum or antenatal

AND

mental health or psychological distress or mental illness

AND

service* or unit* or care or treatment* or intervention* or therap* or support

AND

qualitative* or mixed-method* or interview* or focus group*

The asterisks at the end of several of the above search terms indicate the search was broadened to include variations of those specific words, for example therap* should include search hits on content including the words therapy, therapies and therapist. Only studies published in English were included. The criteria of LMIC was not implemented at the point

of the database searching, as papers reporting on original studies are typically published with the country of the study site rather than stating income rating of the country. Therefore the process of selecting papers from LMICs was conducted manually whilst screening titles and abstracts, using the Development Assistance Committee (DAC) list of Official Development Assistance (ODA) recipients (Organisation for Economic Co-operation and Development; OECD, 2018), to identify studies which had been conducted in LMICs. The study selection process was conducted by HS in consultation with PF. Following the electronic database searches, citation searches were conducted by reviewing the reference lists of identified papers.

Inclusion Criteria

- i. Employing qualitative methodology.
- ii. Published (any time up to October 2020), in English.
- iii. Studies conducted in LMICs, according to the DAC list of ODA recipients (OECD, 2018).
- iv. Exploring women's experiences directly (that is, through interviewing women who experienced perinatal psychological distress directly, rather than those studies whose sample is made up of other stakeholders such as health care professionals or family members).
- v. As well as studies including women with formal diagnoses of perinatal mental health problems, we also included research which reported on interviews with pregnant women and mothers who experienced psychological distress in the perinatal period but had not received a formal diagnosis nor accessed formal mental health services for their difficulties.

In their paper, Nakku et al. (2016) note that where they conducted their study in the Kamuli district of Uganda, only perinatal women who are deemed to have psychosis

or be suicidal are referred to the regional hospital for treatment. Here, common perinatal mental health conditions such as depression, are thought to normally remain undetected and untreated at the community care level. They further note that in community where their study took place, traditional healers appear to form the basis of perinatal mental health care, because of how such illness is understood. Therefore, in order to capture this understanding and for the present review to be informed by practice beyond the westernised, biomedical model of perinatal mental health care, studies which record the voices and experiences of these women have been included.

Extraction of study characteristics

A data extraction framework was constructed to summarise the characteristics of the studies included in the meta-synthesis. Information regarding the study aims, setting, sample size, data collection and methods of analysis were extracted using this framework. Table 1.1 (see Appendix 1) lists the key characteristics of the included studies.

Meta-synthesis Researcher's Background and Preconceptions

The research team was made up of two researchers, both with clinical and research backgrounds. The lead researcher (HS) is a trainee clinical psychologist with experience working clinically with mothers in the perinatal period. HS is a white-British woman, living in the UK (a HIC), who at the time of this meta-synthesis is not a mother and thus has not personally experienced the perinatal period. In order to reduce the impact of preconceptions around perinatal psychological distress and interventions for these, bracketing was used alongside a sample of the papers included being second coded by another doctoral researcher. The second researcher (PF) is a father, partner and white-British professor of clinical psychology with clinical and research experience, specialising in parent-infant relationship and attachment theory.

As perinatal psychological distress in LMICs are known to be under-detected (WHO, 2016), and in several of the papers reviewed (e.g. Nakku et al., 2016) it is noted that mild to moderate disorders in the perinatal period typically remain undetected and untreated, the decision was made to include studies which explore psychological distress in the perinatal period, even where formal diagnoses were not recorded nor evidence-based interventions available.

Description of Study Characteristics (See Appendix 1 for summary table)

i. Study aims

All studies included took an exploratory stance towards understanding the experiences of women in the perinatal period in LMICs. Whilst some studies also examined additional topics that were not directly relevant to the present meta-synthesis, or were embedded in larger, mixed-methods studies, those studies were included where the results that were relevant to the present review were readily extractable.

ii. Participants

The sample size in the included studies ranged from eight to 98 women, who were either pregnant or post-partum. Several studies also interviewed other key stakeholders such as health workers and family members, however only studies where the women's responses are distinguishable have been included.

iii. Setting

The studies included were conducted in the following locations: Vietnam; Nigeria; Indonesia; Pakistan; Ethiopia; Nepal; South Africa; the Thai-Myanmar

Border; Ethiopia; Mali; Ethiopia; Zambia; Uganda; Goa, India; Uganda; Malawi; and China (People's Republic of).

iv. Data collection and analysis

Data from 12 studies was collected using only individual interviews and four used only focus groups. Three studies made use of both of these methods and a final study (Tol et al., 2018) employed what the authors describe as 'rapid ethnographic methods (free listing and ranking; semi-structured interviews; key informant interviews and pile sorting)'.

The following analysis methods were used: Grounded Theory; Thematic (content) Analysis; Framework Analysis; Inductive analysis; Qualitative Content Analysis; Iterative Thematic Analysis and Emergent Thematic Analysis. Tol and colleagues (2018) conducted analyses of interview transcripts following an inductive and thematic approach and used Smith's Saliency Index was for analysis of free listing data.

Analysis

Method of appraising study quality

The Critical Appraisal Skills Programme (CASP, 2018) checklist was used as a framework to appraise the methodological quality of the studies included. The tool, regularly used in qualitative meta-synthesis, focusses on 10 areas of assessment as follows: the clarity of research aims; the suitability of qualitative methodology; the appropriateness of the research design and more specific qualitative approaches; the recruitment strategy; the data collection methods; the description of the relationship between participants and researchers; the consideration of ethical issues; the data analysis methods; the presentation of findings; and the overall value of the research (Dixon-Woods et al., 2007).

Given that the aim of the present meta-synthesis was to broaden understanding of women's experience of the perinatal period, with a cross-cultural perspective by looking at studies from a range of LMICs, we believed it was important to include all relevant evidence in the meta-synthesis. In light of this, the CASP (2018) was not used with the intention of providing an overall quality score and so excluding studies, therefore even studies which returned low scores – signifying the study to be methodologically poor – were included in service of gaining a richer understanding (Atkins et al., 2008; Dixon-Woods et al., 2007).

Meta-synthesis method

The aim of the present meta-synthesis was to summarize a broad range of experiences reported by women in the perinatal period, from multiple LMICs, as opposed to developing more of an interpretive explanatory theory. According to guidance from the Cochrane group on conducting qualitative meta-synthesis (Noyes & Lewin, 2011), a suitable method of analysis for a synthesis of this nature is a thematic analysis. For the purposes of this synthesis it was agreed that the thematic analysis approach described by Braun and Clarke (2006) would be used. The present analysis focussed on the voice of women, namely mothers. To this end, not all text in articles was treated as data for the current meta-synthesis. The 'data' therefore, for the purpose of the present synthesis, consisted of information drawn from the results sections of the papers, with a particular focus on verbatim quotes from respondents or sections of commentary by the authors which were demonstrably supported by direct quotes.

The analysis was conducted using NVivo 12 (QSR International, 2020), guided by the six phases of thematic analysis proposed by Braun and Clarke (2006). The first stage of analysis was to read all included articles in full, in order for the first researcher to familiarise herself with the data and make initial coding notes. Following initial readings of all included studies, electronic versions of the papers were imported into NVivo 12 (QSR International, 2020) for line-by-line coding. A combination of coding types were utilised, including

descriptive and in-vivo coding (Saldaña, 2021). A sample of papers were second coded by another doctoral researcher as a credibility check and differences in coding were discussed until a consensus was reached. Once all data were coded, the codes were grouped together into descriptive themes and sub-themes, derived inductively from the data. Following the identification of themes, the data were re-read to ensure no data – supportive of or contradicting the theme – had been missed that the coding stage. Next, a process of refinement resulted in themes being either discarded, for example where there were not sufficient data to support a theme, or combined, where two or more themes were thematically similar enough to do so. With the aim of the meta-synthesis held in mind throughout the analytic process, the next stage was of the development of four overarching domains, under which the themes were then organised. The last phase of analysis involved the process of writing up the meta-synthesis. This process facilitates a dynamic process which allows for further refinement of and reflection on the domains, themes and sub-themes.

Results

Overview of results

The database searches yielded a total of 1095 articles. Of these, 352 abstracts were read the inclusion/exclusion criteria applied, resulting in 56 potentially relevant studies being identified. These papers were read in full, with a further 40 being excluded by the criteria and 16 papers were found to meet inclusion criteria. A further four of these were screened out after in-depth reading, due to either a research question not focussing on PNMH (n = 2) or despite being described as mixed-methods in the abstracts, were in fact papers where only the quantitative data was presented (n =2). A thorough review of the reference lists of each of the original 16 papers was also conducted, generating a list of 29 further papers for screening. Of these, 11 met the inclusion criteria. Upon reading these in full, one further paper was excluded as the focus was more on the dual diagnosis of HIV and postnatal depression. A

further study (Wilson-Mitchell, Bennett & Stennett, 2014) which looked specifically at adolescent mothers in Jamaica, was excluded as the focus was specifically on experiences of becoming a parent in early adolescence. A third paper from the citation search (Tang et al 2016) was excluded as it presented the same findings as another paper already included (Tang et al 2020). Therefore a total of 20 papers were included in the meta-synthesis.

Study Design

Of the twenty studies, seventeen employed a purely qualitative design (Abrams et al., 2016; Andajani-Sutjahjo et al., 2007; Atif et al., 2016; Bitew et al., 2020; Clarke et al., 2014; Fellmeth et al., 2015; Hanlon et al., 2010; Kathree et al., 2014; Lasater et al., 2018; Mwape et al., 2012; Nakku et al., 2016; Niemi et al., 2015; Rodrigues et al., 2003; Sarkar et al., 2018; Stewart et al., 2015; Tang et al., 2020; Tol et al., 2018). Two studies reported on qualitative findings, though formed part of a larger, mixed methods studies, with the quantitative findings reported elsewhere (Adeponle et al., 2017; Davies et al., 2016). Finally, one study utilised a mixed methods approach (Molenaar et al., 2020).

Quality Assessment

Whilst there was variance in the overall methodological quality of the studies as assessed through the CASP (2018) framework, all studies included were assessed to present their findings in a sufficiently rigorous and accessible way for the purposes of the present meta-synthesis. However, it was noted that those studies which provided a “thick description” (Geertz, 1973) of the phenomena described in the article and evidenced this with direct quotations from respondents, contributed richer data to the present meta-synthesis.

Of note, one of the criteria on the CASP (2018) relates to the primary researchers' reflections on their background and preconceptions and asks the question, ‘has the relationship between researcher and participants been adequately considered?’

Acknowledgement of this criteria was scantily discussed in the articles; occasionally touched on in the discussion sections (e.g. Clarke et al., 2014; Tol et al., 2018) or in relation to who conducted the interviews (e.g., bilingual researchers as in Niemi et al., 2015; Tang et al., 2020). The exceptions were Fellmeth et al., (2015) who noted the researcher leading the focus group discussions in fact lived in the camps for over 25 years, completed her training in the camp and worked with pregnant women locally but was not directly involved in any of the participants care and was fluent in Karen, Burmese and English; and Hanlon et al., (2010) who provide detailed description of who conducted each interview and focus-group, along with the rationale for this in context of the relationship between researchers and participants.

Given that reflexivity is considered a central tenet of qualitative research and a distinguishing feature from the positivist paradigm, it seems important to note the absence of it and lack of acknowledgement of researchers' positions and impact on research. The researchers position influences all phases of the research, from their theoretical stance influencing the development of the research aims and questions, to the influence of the power and privilege of the data collectors (for example interviewers) relative to the respondents, through to their socio-political leanings forming lenses through which they understand and analyse the data.

Meta-synthesis findings

The findings from the 20 studies were synthesised into four domains of themes (Table 1.2). The first domain, *causes*, comprise of five themes that describe perceived causes of perinatal psychological distress presented by respondents (*culturally specific causes; physical causes; resources; social relationships; and thinking and worries*). The second domain, *concepts*, is made up of four themes which describe the lived experiences of respondents – that is, the symptoms – of perinatal psychological distress in LMICs (*affective; behavioural; cognitive – thoughts and beliefs; and physiological*). The third domain of *coping*, describes

how women in LMICs who took part in the studies manage – cope with – perinatal psychological distress and is made up of two themes (*interpersonal* and *intrapersonal*). Lastly, the fourth domain, *cures*, is made up of four themes which describe the treatments respondents in LMICs accessed – or not in the case of the theme of barriers – for perinatal psychological distress (*barriers; culturally relevant cures; medical intervention; and social interventions*).

Table 1.2

List of domains, themes and sub-themes

Domain	Theme	Sub-theme
Causes	1. Culturally specific causes	1.1 Gender of baby 1.2 Supernatural or spiritual
	2. Physical causes	2.2 Pregnancy and birth 2.2 Medical model 2.3 What the body needs (food and rest)
	3. Resources	
	4. Social relationships	4.1 Family 4.2 Marriage or partner
	5. Thinking and worries	5.1 Thinking too much 5.1 Worries for children
Concepts	6. Affective	6.1 Emotional symptoms 6.2 Suicide or suicidality
	7. Behavioural	7.1 Behavioural change 7.2 Social withdrawal or isolation
	8. Cognitive – thoughts and beliefs	8.1 Supernatural or spiritual 8.2 Thinking too much
Coping	9. Physiological	
	10. Interpersonal	10.1 Family support 10.2 Marriage or intimate relationship 10.3 Social or community support 10.4 Talking support
Cures	11. Intrapersonal	
	12. Culturally relevant cures	12.1 Food 12.2 Spiritual practices
	13. Medical intervention	
	14. Social interventions	14.1 Social or community intervention 14.2. Talking therapies
	15. Barriers	15.1 Access to services 15.2 Not disclosing

Causes

Culturally specific causes

Culturally specific causes related to perceived causes of perinatal psychological distress which were deemed relevant specifically to the culture in which the original study took place. For example, Bitew et al., (2020) describe how in Ethiopia, their participants understood their experiences of perinatal psychological distress as being related to diseases and spirits that could be encountered or caught outdoors. In total, nine papers referenced supernatural or spiritual influences, which women who took part in the studies perceived to have caused their difficulties (Adeponle et al., 2017; Bitew et al., 2020; Clarke et al., 2014; Fellmeth et al., 2015; Hanlon et al., 2010; Molenaar et al., 2020; Nakku et al., 2016; Sarkar et al., 2018; Stewart et al., 2015). Whilst references to supernatural or spiritual causes were raised by participants in Nigeria, Ethiopia, Nepal, Thai-Myanmar, Uganda and Malawi, it was often noted (e.g. Fellmeth et al., 2015,) that these were not commonly held beliefs, rather that it was typically a minority perspective. Sometimes when these beliefs were raised by participants, they were described as something that others, but not the respondents themselves, believed. Women who took part in studies in Nepal, Vietnam, India and China reported that the gender of the baby was a cause of distress, due to a preference for sons, which could lead to perinatal psychological distress (Clarke et al., 2014; Niemi et al., 2015; Rodrigues et al., 2003; Tang et al., 2020).

Physical causes

In most countries, participants understood their difficulties to be associated with a physical cause and this was described in 17 studies. Tang et al (2020) found that in China, respondents reported on issues relating to birth and pregnancy, such as birth complications. In Ethiopia, South Africa, Zambia, Uganda, Indonesia, Pakistan, Vietnam and Malawi, women who took part in the studies associated their distress in relation to unplanned or unwanted pregnancies (Hanlon et al., 2010; Kathree et al., 2014; Mwape et al., 2012; Tol et al., 2018), or birth worries (Andajani-Sutjahjo et al., 2007; Atif et al., 2016; Hanlon et al., 2010;

Molenaar et al., 2020; Mwape et al., 2012; Niemi et al., 2015; Stewart et al., 2015;). Six studies reported that respondents in Ethiopia, Thai-Myanmar, Uganda and India commonly understood their experience of perinatal psychological distress within a medical model explanation for the causes of their distress (Bitew et al., 2020; Fellmeth et al., 2015; Molenaar et al., 2020; Nakku et al., 2016; Rodrigues et al., 2003) which were sometimes linked to specific diseases such as HIV or malaria (Sarkar et al., 2018). Lastly, seven studies reported that women who took part in the studies commonly understood their experience of perinatal psychological distress to be related to deficiencies in bodily needs. In Nigeria, Zambia and India, respondents associated this with lack of rest post-partum (Adeponle et al., 2017; Mwape et al., 2012; Rodrigues et al., 2003), whilst in Vietnam, Ethiopia and Uganda, respondents spoke more of insufficient nutritious food during pregnancy or after birth (Abrams et al., 2016; Bitew et al., 2020; Molenaar et al., 2020; Sarkar et al., 2018).

Resources

Paucity of resources were frequently reported as perceived causes for perinatal psychological distress in most countries, as reported in 17 of the articles included. Sixteen studies reported that women who took part described poverty generally as a cause for their distress, with respondents in Vietnam, Ethiopia and Uganda describing a lack of access to nutritious food more specifically (Abrams et al., 2016; Bitew et al., 2020; Molenaar et al., 2020; Sarkar et al., 2018). The theme of resources was often linked to the theme of social relationships when considered as causes for perinatal psychological distress. For example, in South Africa, women taking part in the study reported feeling trapped in abusive marital relationship due to poverty and increased family tensions due to lack of income (Kathree et al., 2014). In Pakistan, respondents understood culturally specific binds between social relationships and finances, as with the practice of dowries to cause their distress in the perinatal period (Atif et al., 2016).

Social relationships

Social relationships was the most cited theme within the domain of causes, with women in 19 of the studies reporting the cause of their distress to be rooted in interpersonal difficulties. Difficulties in the marital or intimate partner relationship specifically was reported by respondents in almost all countries, with intimate partner violence being reported by women who took part in the studies in Indonesia, Ethiopia, South Africa, India, Malawi and Uganda (Andajani-Sutjahjo et al., 2007; Bitew et al., 2020; Hanlon et al., 2010; Kathree et al., 2014; Molenaar et al., 2020; Rodrigues et al., 2003; Stewart et al., 2015; Tol et al., 2018). In Nigeria, Nepal and Mali, respondents spoke of distress caused by difficulties in polygamous marriages (Adeponle et al., 2017; Clarke et al., 2014; Lasater et al., 2018), whilst women who took part in studies in Uganda, South Africa, and Zambia, identified infidelity as perceived causes of perinatal emotional distress (Stewart et al., 2015; Kathree et al., 2014; Mwape et al., 2012). In many countries, tensions in familial relationships, particularly relating to difficulties with in-laws, were understood as causes of distress by participants (Abrams et al., 2016; Adeponle et al., 2017; Atif et al., 2016; Clarke et al., 2014; Kathree et al., 2014; Lasater et al., 2018; Mwape et al., 2012; Niemi et al., 2015; Rodrigues et al., 2003; Tang et al., 2020).

Thinking and worries

Women who took part in 14 of the studies reported that they understood thinking and worries to be causes of their experience of distress in the perinatal period. Participants in nine studies reported worries as a cause of distress and in Indonesia, Pakistan, Ethiopia, Nepal, Thai-Myanmar Zambia and India, these related to worries for unborn babies or children's futures (Andajani-Sutjahjo et al., 2007; Atif et al., 2016; Bitew et al., 2020; Clarke et al., 2014; Fellmeth et al., 2015; Mwape et al., 2012; Rodrigues et al., 2003). Women who took

part in studies in Uganda reported on worries relating to infectious diseases such as AIDs/HIV (Nakku et al., 2016; Sarkar et al., 2018) as a cause. The subtheme of thinking too much was frequently cited, with participants in most countries understanding this as a perceived cause for their experience of distress (Adeponle et al., 2017; Andajani-Sutjahjo et al., 2007; Bitew et al., 2020; Clarke et al., 2014; Davies et al., 2016; Fellmeth et al., 2015; Nakku et al., 2016; Niemi et al., 2015; Rodrigues et al., 2003; Sarkar et al., 2018; Stewart et al., 2015; Tol et al., 2018). Respondents in many countries also often perceived thinking too much as a concept caused *by* – or described this as a symptom of – perinatal mental distress (see theme of *cognitive – thoughts and beliefs* under the domain of *concepts* below).

Concepts

Affective

The theme of affective concepts relates to the experiences of perinatal psychological distress described by participants in many countries, as relating to the internal, emotional world, which were reported by 14 of the studies. The emotional experiences which respondents spoke of in South Africa, China and Thai-Myanmar included crying (Kathree et al., 2014), a sense of darkness (Davies et al., 2016; Tang et al., 2020), anger (Fellmeth et al., 2015; Kathree et al., 2014). In Indonesia, South Africa and India, women who took part in the studies reported on negative feelings towards the baby, as a part of their experience of distress in the perinatal period (Andajani-Sutjahjo et al., 2007; Davies et al., 2016; Rodrigues et al., 2003). The theme of suicide or suicidality, as a severe symptom or result of distress in the perinatal period, was described by respondents in many countries, with 14 of the studies included reporting this.

Behavioural

Behavioural concepts describe symptoms which respondents reported seeing in their own behaviour, associated with their psychological distress and were reported by women in 12 studies. These fell into sub-themes of behavioural change and social withdrawal or isolation. Women who participated in studies in Vietnam, Nigeria, South Africa, Thai-Myanmar, Mali, Ethiopia, Uganda and India described behaviours such as wandering aimlessly or verbal or physical aggression (Abrams et al., 2016; Adeponle et al., 2017; Davies et al., 2016; Fellmeth et al., 2015; Kathree et al., 2014; Lasater et al., 2018; Molenaar et al., 2020; Nakku et al., 2016; Rodrigues et al., 2003; Sarkar et al., 2018). Respondents in Ethiopia, South Africa, Thai-Myanmar and Malawi spoke of social withdrawal or isolation as key concepts associated with their experience of perinatal distress (Bitew et al., 2020; Davies et al., 2016; Fellmeth et al., 2015; Kathree et al., 2014; Stewart et al., 2015).

Cognitive – thoughts and beliefs

The cognitive concepts, that is the thoughts and beliefs associated with the experience of psychological distress in the perinatal period, were reported by women in 14 studies. As noted in causes, the sub-theme of thinking too much was perceived to be both a cause and consequence of distress in the perinatal period by respondents in many countries (Adeponle et al., 2017; Andajani-Sutjahjo et al., 2007; Bitew et al., 2020; Clarke et al., 2014; Davies et al., 2016; Fellmeth et al., 2015; Nakku et al., 2016; Niemi et al., 2015; Rodrigues et al., 2003; Sarkar et al., 2018; Stewart et al., 2015; Tol et al., 2018). A second subtheme was that of supernatural or spiritual beliefs, which were reported by women in nine studies as concepts that describe their experiences of perinatal distress (Adeponle et al., 2017; Bitew et al., 2020; Clarke et al., 2014; Fellmeth et al., 2015; Hanlon et al., 2010; Molenaar et al., 2020; Nakku et al., 2016; Sarkar et al., 2018; Stewart et al., 2015). In Ethiopia, respondents described understanding that their distress in the perinatal period as the will of God (Bitew et al., 2020), or the result of a supernatural attack (Hanlon et al., 2010). This concept of how women who

tok part in the studies made sense of their lived experience of psychological distress does overlap in part with causes, however related more to the ongoing experience of distress rather than the perceived cause of it.

Physiological

Physiological concepts of perinatal psychological distress were described by respondents in many countries and were reported by 15 of the studies, with women from 11 studies describing specific symptoms relating to the body. Women who took part in studies in Vietnam, Nigeria, Ethiopia, Nepal, South Africa, Mali and China described experiencing their distress having an effect on sleep (Abrams et al., 2016; Adeponle et al., 2017; Bitew et al., 2020; Clarke et al., 2014; Davies et al., 2016; Kathree et al., 2014; Lasater et al., 2018; Molenaar et al., 2020; Tang et al., 2020). Whilst respondents in Vietnam, Nigeria, Indonesia, Nepal, South Africa, Mali, India, Malawi and Uganda reported experiencing an impact on their appetite (Abrams et al., 2016; Adeponle et al., 2017; Andajani-Sutjahjo et al., 2007; Clarke et al., 2014; Davies et al., 2016; Kathree et al., 2014; Lasater et al., 2018; Rodrigues et al., 2003; Stewart et al., 2015; Tol et al., 2018). Women who took part in studies in Indonesia, Nepal, South Africa, Mali and Uganda, described physiological symptoms relating to their hearts, such as palpitations or pain (Andajani-Sutjahjo et al., 2007; Clarke et al., 2014; Davies et al., 2016; Lasater et al., 2018; Tol et al., 2018)

Coping

Interpersonal

Interpersonal coping strategies were reported by respondents from all countries included in this meta-synthesis and whilst difficulties in the marital or intimate partner relationship were reported as a common *cause* of distress, respondents from all countries also reported that the marriage or intimate relationship could be a source of support and resource

for coping with psychological distress in the perinatal period. Further subthemes relating to interpersonal support, which were also described by women who took part in studies in most countries as key in coping with perinatal emotional distress, included family support (Abrams et al., 2016; Andajani-Sutjahjo et al., 2007; Fellmeth et al., 2015; Kathree et al., 2014; Lasater et al., 2018; Molenaar et al., 2020; Rodrigues et al., 2003; Sarkar et al., 2018; Stewart et al., 2015; Tang et al., 2020) and social or community support (Abrams et al., 2016; Bitew et al., 2020; Clarke et al., 2014; Fellmeth et al., 2015; Kathree et al., 2014; Molenaar et al., 2020; Nakku et al., 2016; Niemi et al., 2015; Sarkar et al., 2018; Stewart et al., 2015; Tang et al., 2020; Tol et al., 2018). Six studies reported on women's experiences of not disclosing their psychological distress in the perinatal period, which is summarised under the theme of barriers, within the domain of *cures*.

Intrapersonal

Intrapersonal coping strategies that is, ways of coping which women resolved to turn to within themselves, were reported far less frequently by the women in the studies. One example of intrapersonal coping was from respondents in Vietnam and China, who reported that changing their thinking, for example to think more positively or calmly helped them to cope with their distress (Niemi et al., 2015; Tang et al., 2020), whilst in Ethiopia, respondents reported finding work as a means of coping (Hanlon et al., 2010).

Cures

Cures relates to any intervention or treatment perceived to heal or support recovery from psychological distress in the perinatal period and fell into the themes of culturally relevant cures, reported by 10 studies; medical intervention, reported by five studies; and social interventions, the most frequently reported, as described in 14 studies.

Culturally relevant cures

Within the subtheme of culturally relevant cures, women who took part in the studies in Vietnam, Ethiopia, and Uganda perceived certain foods to have supported their healing process (Abrams et al., 2016; Bitew et al., 2020; Molenaar et al., 2020; Sarkar et al., 2018) and respondents in Nigeria, Ethiopia, Nepal, Thai-Myanmar, Uganda and Malawi considered spiritual practices, such as prayer or worship as an instrumental part of their healing process (Adeponle et al., 2017; Bitew et al., 2020; Clarke et al., 2014; Fellmeth et al., 2015; Hanlon et al., 2010; Molenaar et al., 2020; Nakku et al., 2016; Sarkar et al., 2018; Stewart et al., 2015).

Medical intervention

Medical interventions were the least cited method for treating psychological distress in the perinatal period, with women who took part in the studies in Ethiopia, Thai-Myanmar, India and Uganda suggesting seeking hospital treatment or taking medication as being options they had considered in relation to their experiences (Bitew et al., 2020; Fellmeth et al., 2015; Molenaar et al., 2020; Rodrigues et al., 2003; Sarkar et al., 2018).

Social interventions

Conversely, social interventions were the most frequently cited treatments, with women in 12 studies reporting on social or community intervention as having been helpful in their experience. In Ethiopia, women who took part in the study described meeting with neighbours (Bitew et al., 2020) and in Nepal, respondents spoke of the village council being an important resource (Clarke et al., 2014). Women in studies conducted in Pakistan, Ethiopia, Thai-Myanmar, South Africa, Vietnam, India, Uganda and China reported that they had accessed talking therapies, such as seeing a health care worker or therapist, for counselling or group support (Atif et al., 2016; Bitew et al., 2020; Fellmeth et al., 2015;

Kathree et al., 2014; Molenaar et al., 2020; Niemi et al., 2015; Rodrigues et al., 2003; Sarkar et al., 2018; Tang et al., 2020; Tol et al., 2018).

Barriers

Barriers to making use of these interventions were also reported by women in 11 of the studies and fell broadly into issues of accessing the service and respondents not being able to disclose their psychological distress in this period. With regard to issues of access, respondents in South Africa, Uganda and Malawi described lack of access to transport to travel to hospitals or clinics (Kathree et al., 2014; Sarkar et al., 2018; Stewart et al., 2015) and respondents in Nepal, Mali and India described the cost of care being inaccessible (Clarke et al., 2014; Lasater et al., 2018; Rodrigues et al., 2003). The main reason for women not disclosing their distress was around worries that this would lead to increased interpersonal tensions, as described by respondents in Vietnam, Indonesia, Ethiopia, South Africa, India and China (Abrams et al., 2016; Andajani-Sutjahjo et al., 2007; Bitew et al., 2020; Davies et al., 2016; Rodrigues et al., 2003; Tang et al., 2020).

Discussion

To the authors' knowledge, this is the first meta-synthesis of qualitative studies exploring the lived experience of women with perinatal psychological distress in LMICs. The systematic search found 20 studies which met inclusion criteria, the findings of which were then synthesised using thematic analysis (Braun & Clark, 2006). The analysis identified 15 themes, which were organised into the four domains of *causes*, *concepts*, *coping* and *cures*. The first domain, *causes*, described a range of perceived causes for perinatal psychological distress in the studies, which were synthesised into five themes including *culturally specific causes*; *physical causes*; *resources*; *social relationships*; and *thinking and worries*. The second thematic domain of *concepts* – related to the experiential understanding of women

with perinatal psychological distress in LMICs who took part in the studies – describes symptoms and the conceptualisation of these, including *affective; behavioural; cognitive – thoughts and beliefs; and physiological*. The third domain of *coping*, describes how women in LMICs who took part in the studies cope with perinatal psychological distress and these strategies are organised into two themes including *interpersonal* – that is, in the context of relationships with others; and *intrapersonal* – within the self. Finally, *cures*, is comprised of four themes which describe the treatments respondents accessed for perinatal psychological distress and the barriers which prevent or reduce access. The themes within this domain are *culturally relevant cures; medical intervention; social interventions; and barriers*.

The meta-synthesis highlights the wide range of experiences of women with perinatal psychological distress from LMICs, which is perhaps unsurprising given the cultural heterogeneity of participants included in the present review. The studies included were conducted in Vietnam; Nigeria; Indonesia; Pakistan; Ethiopia; Nepal; South Africa; the Thai-Myanmar Border; Ethiopia; Mali; Ethiopia; Zambia; Uganda; India, India; Uganda; Malawi; and China (People’s Republic of). Nonetheless, common themes were found, which perhaps speaks to the universal nature of the experience of pregnancy, childbirth and becoming a parent, as well as the psychological impact of this, particularly within the socio-economic context of LMICs.

A salient theme, presenting in various forms but consistently across domains, was the social nature of the perinatal period and experiences of difficulties in this life stage. Women in many of the studies reported tensions in family or marital relationships as a commonly perceived cause and social isolation and withdrawal as frequently experienced consequences of psychological distress in the perinatal period. Furthermore, the *interpersonal* theme within the domain of *coping* and *social interventions* being the most frequently reported ‘cure’, highlight the importance of social relationships in this period. This finding illustrates the

social and collectivist notion embodied in the proverb ‘it takes a village to raise a child’. This proverb, thought to originate from the continent of Africa, with several countries – from Tanzania to Nigeria – staking a claim, has been described to reflect a social reality in some rural areas of African countries, where parenting practices are established around moral well-being of the community (Mbogoni, 2013). The importance of the social context for the causes, concepts, coping and cures for perinatal psychological distress in LMICs, may speak to a more collectivist approach to family life and child-rearing (Triandis, 2001).

Even the theme of *resources*, within the domain of *causes*, is inextricably linked to its social context. For example, in South Africa, in the context of abusive marital relationships and intimate partner violence, stressors caused by financial hardship exacerbated interpersonal conflict, and vice versa (Kathree et al., 2014). Likewise in culturally specific practices such as the payment of dowries, described by women who took part in the study in Pakistan (Atif et al., 2016), the link between financial resources and social relationships intertwine in their perceived causation of psychological distress in the perinatal period

The theme of *thinking too much* presents in both the domains of *causes* and *concepts* and was referenced by women in the studies as both a factor which contributed to the development of their distress and was perceived to be a consequence of this. This notion of ‘thinking too much’ perhaps reflects the diagnostic criteria of rumination for common perinatal mental health disorders such as anxiety and depression (WHO, 2019). Commonalities with international diagnostic criteria and symptoms were also evident in the themes of affective, behavioural and physiological concepts of perinatal psychological distress. The theme of *suicide or suicidality* was reported by women frequently – in 14 of the studies – as a severe symptom or result of perinatal psychological distress. However, one study noted that “suicide was not seen as an end-point or extreme manifestation of mental illness so much as a separate condition, the causes of which included shame, guilt, economic

and family issues and spiritual causes – suggesting that suicide was not necessarily attributed to mental illness” (Fellmeth et al., 2015, p. 6).

The way in which women in LMICs who took part in the studies reviewed here cope with perinatal psychological distress also appears to have a strong social element. As noted above, although difficulties in interpersonal relationships were considered to be a common cause for perinatal psychological distress, when relationships were positive, they were considered to be an important resource and source of support. This is an important finding for informing provisions of formal support for women in LMICs or other resource restricted settings, where group support may be highly valued. Intrapersonal methods of coping – those which focus on the individual, were far less common than interpersonal methods in the studies. Where they did present, they did so with a markedly pragmatic stance, for example in respondents reporting that in order to manage their perinatal psychological distress, they should change their thinking or find work to occupy their busy minds. This could indicate that treatments which focus on cognitive or behavioural symptoms of perinatal psychological distress, such as cognitive behavioural therapy (CBT), would be less acceptable to women in LMICs than socially focussed interventions.

The domain of *cures* provides significant further insight into potential intervention for perinatal psychological distress in LMICs. In keeping with the themes relating to the social context of perinatal period found in the domains of *causes* and *coping*, the most frequently reported *cures* for perinatal psychological distress fall into the theme of *social interventions*, as described in 14 of the studies. These included social or community intervention, which was perhaps a less formal approach, such as meeting with neighbours or the village council. The steps that women in the studies described taking did however, also include seeking more formal talking therapies, such as seeing a health care worker or therapist, for counselling or group support.

Conversely, and perhaps reflective of the low frequency of reporting perceived causes of perinatal psychological distress within a medical model, medical interventions were the least cited method for dealing with perinatal psychological distress, with seeking hospital treatment or taking medication being options described by participants in only five studies. Abrams et al., (2016) noted that the women in their study in Vietnam seldom mentioned the possibility of pharmaceutical medication, with some even stating that “it is unsafe for women who are pregnant or breastfeeding to use western pharmaceutical medications at all.” (p. 6). Likewise, one study highlights how women in rural Ethiopia saw seeking medical intervention for postpartum distress as inappropriate (Molenaar et al., 2020).

More culturally relevant cures for perinatal psychological distress included foods that were perceived to support the healing process, including herbal ingredients used in traditional medicine (Abrams et al., 2016) or as in one study “‘have a sheep slaughtered’ ... to provide ‘blood to drink and good food’ and that a diet with ‘butter, milk, meat and gruel’, and ‘drinking coffee’ were considered as ideal in the postnatal period” (Molenaar et al., 2020, p. 5). Other culturally-syntonic interventions for perinatal psychological distress, associated with supernatural or spiritual perceived causes, included practices such as prayer or worship as a means of treating the psychological distress.

However, for women to access treatment for their perinatal psychological distress, they must first disclose their distress and not doing so was identified as a key barrier to accessing support in the studies reviewed here. Often, studies reported that the women they interviewed chose not to report on their psychological distress, for fear that doing so would lead to increased interpersonal difficulties. Once again, the social context of perinatal psychological distress provides an important insight into understanding factors which may impede – and thus those which may facilitate – women seeking support for their perinatal psychological distress in LMICs. Other important barriers, particularly salient in resource-

restricted contexts, were those of services being inaccessible either due to their location and the lack of transport or the cost of care being beyond the means of the women requiring input.

Limitations

One limitation pertaining to the early stages of this meta-synthesis relates to the databases which were – or more specifically, those which were not – searched during the systematic review process. Embase, PsychINFO and Medline are extensive databases, commonly used in meta-synthesis of this scale and the process of manually applying the filter of research conducted in LMICs was designed to avoid inadvertently excluding relevant papers. However, conducting further searches of databases recommended by the Cochrane Collaboration for conducting research relating LMICs (Stansfield et al., 2013) and specifically African research (Pienaar et al., 2011), will likely have increased the reach of the search and thus the inclusion from relevant research from LMICs around the world, into the present meta-synthesis.

The criteria of only including articles which are published in English presents a significant limitation, particularly in the context of the authors aim to produce research which challenges Western-centric, post-colonial paradigms. This limitation is two-fold. Firstly, there is a significant risk of excluding articles, and thus important findings which would likely change the overall findings of the present meta-synthesis. For example, of 53 the countries in Africa, 21 have French as the official language – the highest proportion, with English being the second highest as the official language in 19 countries (Bamgbose, 1991). From this statistic alone it is likely that the present systematic search will have missed a significant proportion of the research conducted in African countries and published in French.

Secondly, as noted in several of the original articles (e.g. Nakku et al., 2016), much of the data in the original studies – that is, interview or focus group discussion transcripts, was subject to translation, from the indigenous languages of the study sites into English. This

creates the potential for losing meaning of the respondents' perspective and experiences, as nuance of language and ideographic communication is lost in translation. The decision to focus on verbatim quotes from respondents or sections of commentary by the authors which were demonstrably supported by direct quotes, was taken with the aim of reducing the cultural influence on interpretations of the data by the researchers in the original studies, compounded by that of the researchers in the present meta-synthesis.

Additionally, whilst efforts were made through bracketing and second coding to safeguard against the lead researcher's preconceptions influencing the findings of the meta-synthesis, due to the reflexive nature of qualitative research, this phenomena is inevitable. Consultation from experts by experience, be that academics with a background in conducting research in LMICs, to women with experience of perinatal psychological distress from these settings, would have no doubt enriched the analysis and interpretation of the data synthesised here. Given the cultural background of the researchers, in order to refine the interpretation of the findings, reflect on differences in interpretation and more broadly situate the findings from a less global north perspective, we plan to work with colleagues from other parts of the world.

Implications for Clinical Practice

Whilst the present meta-synthesis reviewed studies from LMICs, the findings may be of value in other socio-economic and cultural settings. Historically, psychological interventions for mental illness have been developed in a Westernised context and then exported to other cultural climates. However, there is critical learning here, around the social nature of the perinatal period and as noted by Patel (2012), mental health interventions should "driven by local knowledge" and "such knowledge should flow in both directions between the global south and the global north" (as cited in Bemme & D'Souza, 2014, p. 2). Therefore, these findings may be instrumental in informing service design and provision in other parts of

the world. By hearing the voices of women from around the world when they share their experiences of perinatal psychological distress, their perceived causes, acceptable cures and why they may not seek psychological support or access formal services, we can consider factors which contribute to this as important service guiding principles. For example, peer-led provisions, provisions focussed on or centred in religious centres, family, group and community-focussed interventions. That is to say that these findings highlight the danger of perpetuating research with solely WEIRD populations (Henrich et al, 2010) to inform treatments, as they centre treatments which only consider and serve a comparative minority vector of society.

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Part II: Empirical Paper

‘Magic happens when women get together’: A qualitative study of mothers’ and clinicians’ experiences of perinatal mental health services.

Abstract

Aims: The present study aimed to better understand mothers' experiences of mental health difficulties; their babies' difficulties and the parent-infant relationship, during the perinatal period. It also aimed to better understand mothers' experiences of disclosing these difficulties and experiences of accessing perinatal mental health services (PNMHS), focussing on how services address the parent-infant relationship. Lastly, it aimed to understand clinicians' experiences of working in PNMHS, with a focus on the experience of working with the parent-infant relationship.

Methods: Thirteen mothers and thirteen clinicians took part in semi-structured interviews. The interviews were analysed using thematic analysis (Braun and Clark, 2006).

Results: Seven themes relating to the research questions were extracted, which describe mothers' and clinicians' experiences of PNMHS, working with the parent-infant relationship and barriers and facilitators to accessing and engaging in support in the perinatal period. A further three contextual themes were also derived from the data; including themes of identity, the impact of the COVID-19 pandemic and service-level factors which impact care.

Conclusions: The findings are consistent with previous research exploring mothers' experiences of accessing PNMHS. Results highlight the social nature of the perinatal period, the key role of relationships within this time and in facilitating access to PNMHS. The results have implications for further research relating to the perinatal period within the context of the COVID-19 pandemic. They can also inform service provision following the pandemic, with an emphasis on flexible, service-user led treatment options, which hold the mother-infant relationship at their heart.

Introduction

The perinatal period refers to the period of pregnancy and the first year after birth and represents a high-risk period with respect to mental health, with more than one in ten women develop a mental illness perinatally (Khan, 2015). For some women, perinatal mental health (PNMH) difficulties may be their first experience of mental illness and accessing services for this, and women with pre-existing severe mental illness may be at risk of relapsing perinatally (Kurinczuk et al., 2014). Evidence suggests that maternal mental health difficulties are often not correctly identified and few new mothers receive appropriate intervention (Austin et al., 2013; Glover, 2014; Rothera & Oates, 2008). Difficulties in the perinatal period can range from mild to severe and can include post-partum depression, anxiety (and related disorders such as obsessive-compulsive disorder), bi-polar disorder and post-partum psychosis (O' Hara et al., 2014). This contributes to a significant proportion of maternal mortality, as maternal suicide remains the leading cause of direct deaths occurring within a year postpartum (Knight et al., 2020).

Maternal mental health difficulties are associated with low parental involvement and reduced parental sensitivity (Hosman et al., 2009), which has a significant, negative impact on the infant's attachment style (Murray et al., 1996). "Reflective function" (Beebe et al., 2010) or "mind-mindedness" (Meins et al., 2001) refers to the parental ability to interpret and respond appropriately to infant's internal emotional state. This ability can be impacted by maternal mental illness, which is thought to mediate the effects of these mental health problems on infant outcomes (Barlow et al., 2015; Madigan et al., 2006). If maternal mental health difficulties in the perinatal period are chronic and untreated, they can impact the cognitive, emotional, social, educational, behavioural and physical development of the infant (Hanley, 2013), which may continue into adolescence (Stein et al., 2014). Specialist perinatal

mental health services (PNMHS) offer a range of interventions including individual and group psychotherapies and video feedback interventions, which involve filming mother-infant interactions and providing mothers with feedback, with the aim developing more attuned patterns of interacting (Stein et al., 2014).

A recent review and meta-analysis of interventions for infant development and mother-infant relationship outcomes found common components which potentially underpin effective interventions for infants whose mothers are experiencing PNMH problems, including: facilitation of positive mother-infant interactions; helping mothers to understand their infant's perspective or inner world; and making use of video feedback (Newton et al., 2020). This review provides substantial quantitative evidence for interventions focussed on the mother-infant relationship, however the qualitative part of the picture, relating to how mothers experience assessments and interventions focussed on the relationships with their infants, remains to be painted.

The development and evaluation of PNMHS is a burgeoning area of research. In the first study to explore service user and therapists' experiences of a perinatal Improving Access to Psychological Therapy (IAPT) service, Millett et al (2017) found that overall, the women who accessed the service reported positive experiences. However, they also found that issues relating to barriers to access and a need to better tailor therapy to the perinatal context were raised by service users and therapists. In their systemic review and meta-synthesis of qualitative research of women's experience of care for mental health problems in the perinatal period, Megnin-Viggars et al (2015) identified seven key themes. These were: an unmet need for collaborative and integrated care; stigma and fears about loss of custody; healthcare professionals' inability or unwillingness to address psychological needs; focus on babies over mothers; importance of non-judgemental and compassionate support; an unmet need for information; importance of service user involvement in treatment decisions.

Guidance for perinatal mental health care emphasises the importance of assessing not only maternal mental health but the quality of the mother-infant relationship, so that suitable interventions can be provided (Howard et al., 2014). In their latest service guidance, The Royal College of Psychiatrists (RCPSYCH, 2018) highlight that services are required to offer assessment of the mother-infant relationship. However, there is a lack of good evidence regarding how best to implement these forms of assessment, and the concerns highlighted by women in the Megnin-Viggars et al (2015) and Millet et al (2017) studies suggests that care is needed in designing forms of assessment and this process should be conducted in collaboration with involve the women who have accessed the service. It is therefore important that the experiences of women seeking support for PNMH difficulties are understood and used to inform the development of services. As part of the Five Year Plan (NHS England, 2016), PNMHS improvements have been underway with a planned investment intended to provide specialist care to an additional 30,000 women per year, by the end of 2021. This has led to increased funding to and rapid expansion of NHS funded PNMHS in the UK in recent years.

Feedback from service users is recommended as an essential component of service evaluation and improvement (Lammers & Happell, 2003). The National Institute of Health and Clinical Excellence (NICE, 2011) guidelines quality statements propose that ‘people using mental health services [should] feel confident that the views of service users are used to monitor and improve the performance of services’. By employing a qualitative, inductive approach we hope to capture service users’ personal accounts of their experience of mental health difficulties in the perinatal period and of the treatment they received. With this insight into women’s experiences of accessing PNMHS, we hope to apply this understanding to improving access to and delivery of these services.

Aims

To build on previous literature on women's experiences of accessing PNMHS (e.g., Megnin-Viggars et al., 2015; Millet et al., 2017) and given the RCPSYCH (2018) guidance on assessing the mother-infant relationship, the present study aimed to explore mothers' and clinicians' experiences of PNMHS, specially relating to assessments of and interventions focussed on the parent-infant relationships. In service of this overarching aim we selected methodology and designed an interview schedule based on areas of interest. These included developing a better understanding women's experiences of mental health difficulties; their babies' difficulties and their relationships with their babies, during the perinatal period. By exploring women's experiences of disclosing their mental health difficulties and their experiences of accessing PNMHS, we hope to address the issues identified in previous research (e.g., Megnin-Viggars et al., 2015; Millet et al., 2017) relating to barriers to access and tailoring therapy to the perinatal context.

In the context of the RCPSYCH (2018) guidance and the issues identified by Megnin-Viggars et al (2015) including stigma, fears about loss of custody and the focus on babies over mothers, we also asked questions around how women seeking support for their mental health difficulties in the perinatal period experience disclosing difficulties in their relationships with their babies. In order to provide a more qualitative picture to expand on the findings from Newton et al (2020) on interventions for the mother-infant relationship for mothers with mental health problems, we also explored women's experiences of how PNMHS assess and more broadly address mother-infant relationship difficulties, including experience of video feedback methods. Finally, we also interviewed clinicians regarding their experiences of working in PNMHS, in order to explore potential barriers and facilitators to assessing and working with the parent-infant relationship, in order to elucidate further service users' experiences, from a service provider perspective.

Method

Participants

Eligibility criteria. Women aged 16 or above who had accessed services for their mental health during the perinatal period (either during their pregnancy and/or up to a year after birth) and spoke fluent English were eligible to take part in the study.

Recruitment. Participants were recruited via social media (Twitter, Instagram, Facebook and LinkedIn) through the researchers' personal/profession networks on these sites. The first round of recruitment advertised for experts by experience to provide consultation on the proposed interview schedule, prior to recruiting respondents for the interviews. The second round of recruitment was for interview respondents. Prospective participants were guided to follow a hyperlink to a relevant participant information sheet (either mother or clinician) and from there, they were able to provide informed consent via an electronic consent form, and supply demographic and contact information. Sixteen mothers and 14 clinicians signed up, however three mothers and one clinician did not respond to invitations to interview.

Procedure

All interviews took place via video call, were digitally recorded and lasted an average of 37 minutes (range: 22-81 minutes) and 41 minutes (range: 19-69 minutes), for clinicians and mother respectively. All participants were given the option to have their camera on or to have audio only recorded.

Semi-Structured Interview

The semi-structured interview guide (Appendix 2) was developed by the researchers, based on the research questions. As noted in the recruitment section, we advertised for women with lived experience to provide consultation on the interview questions, however we

did not receive feedback from any mothers. We did receive consultation from a clinical psychology colleague with clinical and research experience in the area of PNMH, who is also a mother and the interview guide was amended in line with the feedback provided. As we did not receive formal consultation from service users, and in line with good practice guidance (Barker & Pistrang, 2005), the first four interviews with mothers acted as pilot interviews and the respondents were asked to provide feedback on the questions they had been asked at the end of the interviews and some further minor amendments were made to reflect this.

The interview schedule for mothers included questions regarding their perinatal journey and accessing PNMHS; about elements which were helpful or supportive and those which were challenging or problematic. Later in the interview, mothers were asked about their relationship with their baby throughout the perinatal period, who they spoke to about this and if this was discussed with professionals in the PNMHS they accessed. Finally, mothers were asked about their experience of how the services they accessed used assessment and interventions focussed on the parent-infant relationship and for ideas on how services could improve their practice around this in the future. The final section included questions relating to video feedback approaches; experiences of this where applicable and reactions to the notion of this where not.

The interview schedule for clinicians included questions relating to reasons for and perceived experiences of women's referrals into their services, along with questions regarding accessibility, what works well in their services and what they felt needs to improve. Clinicians were then asked about their experience of the work, in relation to working with mothers, what they report on and working with the parent-infant relationship. Finally, clinicians were asked about any measures they use to assess the parent-infant relationship and more broadly, ideas about approaches or tools which could facilitate conversations around this, including used of video feedback approaches.

Qualitative Data analysis

The interviews we conducted via Microsoft Teams, which records the interviews and produces an auto-generated transcript of the audio. These transcripts were then checked manually and fully anonymised by the lead researcher and a volunteer research assistant to ensure verbatim transcripts of the interviews. Anonymised transcripts were then imported into N-Vivo 12 (QSR International, 2020) and analysed using Thematic Analysis (Braun and Clark, 2006). For this study, we aimed to recruit 12-15 respondents for each group – that is, mothers and clinicians – in order to reach data saturation as described by Guest et al (2006). This resulted in a relatively large sample and data set, in qualitative research terms, and thematic analysis was agreed upon as a method of analysis that is both sufficiently flexible and systematic to allow the researchers to analyse this amount of data. In order to centre the respondents' idiographic experiences, an inductive, data-drive approach was employed throughout the analysis.

Analysis followed Braun and Clark's (2006) six step guide to conducting thematic analysis. All 26 transcripts were read through in full prior to coding and preliminary notes for coding were made. In Nvivo 12 (QSR International, 2020), line-by-line coding for the entire dataset was completed, using a combination of coding types, including descriptive and in-vivo coding (Saldaña, 2021). Next, the codes were sorted into preliminary themes, organised by the aims of the research. A preliminary set of themes and sub themes, was developed (see Appendix 3 for table of preliminary themes), however this resulted in a large number of themes. The steps of analysis to this point were conducted by analysing the clinician's and mother's interviews separately, in line with the distinctive research questions for each group. However, when the themes and sub-themes from each group were compared, overlapping themes between the groups became apparent. This allowed for the dataset to be re-examined to identify common themes which were derived across groups and allowed for the initial

themes to be condensed and refined. Thus a final set of themes and subthemes relating to both clinicians' and mothers' experiences were identified. Lastly, the analysis was written up, with extracts from the data used to support each theme.

Credibility checks

In line with good practice guidelines (Barker & Pistrang, 2005), steps were taken to strengthen the credibility of the findings. Two second coders, both with post-graduate level experience of qualitative research, but novel to the field of perinatal research, reviewed a sample of the transcripts from both mothers and clinicians, prior to further steps in the analysis process being taken. The lead researcher then met with the second coders to compare codes and took a consensus approach to discussing any differences in the initial codes. Preliminary emergent themes were also discussed at this stage. The main researcher shared the thematic map with the second researcher prior to the final stages of analysis.

Disclosure of perspective

The lead researcher is a 29-year-old, white British, able-bodied, cisgender, heterosexual woman, who is not yet a parent and thus does not have lived experience of the perinatal period. She has experience working clinically in the area, specifically in an NHS PNMHS. Prior to designing the interview schedule or collecting any data for the present research, the lead researcher underwent a peer-facilitated bracketing interview, exploring preconceptions of the research questions, respondent sample and potential findings. This method was intended to support the lead researcher to retain a focus on her own perspectives and avoid omitting possible avenues of enquiry or understanding.

The epistemological stance of the lead research can be described as social constructionist, a framework which posits that researchers construct meanings and realities within the interaction process with both participants and the generated data (Cisneros-Puebla,

2007). This implies that the role of the researcher needs to become transparent in both data collection and subsequent analysis. This means that findings are not understood independently and objectively, but as a consequence of the subjective construction (Lock & Strong, 2010), which is a relevant and unique result of the moments of interaction between the researcher and the participants (Arce, 2005).

Ethical approval

Ethical approval was obtained from the UCL Research Ethics Committee (approval reference number 18737/001; see Appendix 4 for approval letter). Participants provided informed consent at the point of signing up for the study, prior to being contacted to arrange an interview, and were given a further opportunity to ask questions regarding the study and verbally re-consent at the beginning of the interviews.

Results

Participant demographic information

Thirteen mothers (age range = 21 – 42, mean = 32 years old) and the same number of clinicians, living and working in multiple regions across the UK participated in this study. All mothers were postpartum at the time of interview. Clinicians who took part were working in a range of PNMHS, including NHS services, perinatal charities or third sector organisations and independent practice. Their roles included trainee and qualified clinical psychologists, adult mental health practitioners, charity workers, a midwife and a perinatal yoga instructor.

Overview of findings

Seven themes relating to the research questions were extracted: (i) *the unique nature of the perinatal period*, (ii) *wide net, fine tools*, (iii) *right place, right time*, (iv) *starting conversations, keeping them going*, (v) *it takes a village*, (vi) *'nobody puts baby in the corner'*; *centring the parent-infant bond* and (vii) *silencing forces*. A further three contextual

themes, which overarch all other themes and were derived from the data and contain sub-themes were (viii) *dual identities (Many hats - mother-knowledge and cared for to caring)*, (ix) *contextual factors (COVID-19 pandemic; diversity and social-contextual factors)* and (x) *service-level, operational factors (information sharing; geographical area; service funding and resources and thresholds and service criteria)*.

Table 2.2

Contextual factors – list of themes and sub-themes

Theme	Sub-theme
8. Dual identities	8.1 Many hats – mother-knowledge 8.2 Cared for to caring
9. Contextual factors	9.1 COVID-19 pandemic 9.2 Diversity 9.3 Social-contextual factors
10. Service-level, operational factors	10.1 Information sharing 10.2 Geographical area 10.3 Service funding and resources 10.4 Thresholds and service criteria

Theme one: the unique nature of the perinatal period

Both mothers and clinicians described the unique nature of the perinatal period, distinct from other life stages. For some mothers, this period represented the first time they had come into contact with formal mental health services:

Prior to my most recent pregnancy, I never had any mental health issues, not other than the occasional down day or you know, occasional worries, but nothing to write home about as such. And then when I was pregnant, in my most recent pregnancy, I was definitely a lot like, anxious about a lot of things. I felt sure that something had to go wrong in this pregnancy, that you know, things are going too well the first time around so it must... something's got to happen this time. So it's constantly expecting, either to lose the baby or to be told some bad news or just things to go wrong (M3).

For others, who had previous experiences of longstanding mental health difficulties, they noted that difficulties in the perinatal period were different, often worse:

Having had difficulties before, I recognized how wrong this felt. It didn't just feel like 'oh, this is just anxiety or depression that I've coped with before and I can use my normal sort of coping mechanisms and you know, just kind of get on with my life and do things that make me feel good' and all this sort of stuff. It felt like quite a lot beyond that (M5).

Clinicians also noted that they worked with women with existing, sometimes complex mental health presentations but they would also see women for whom the perinatal period was the first time they had come into contact with services. Clinicians described the potential for rapid changes in mood and presentation in the perinatal period:

There can be quite sudden shifts of mood or shifts of concern. So a lot of women might be sort of anxious in the run up to birth and then euphoric immediately after birth, and then you know, their mood like dip again, you know, a couple months in (C12).

At times this was associated with a significant scope for change when working therapeutically in the perinatal period:

Although it was intensive emotive work, it meant that changes were fairly rapid as well (C1).

However it was also associated with clinicians' experience of managing risk and the unique nature of this when working with a mother-infant dyad:

Something that can be stressful is the risk involved in this period so, when mums are feeling quite hopeless and suicidal, you're not only worried about them, but of course, that tiny baby too (C10).

Theme two: wide net, fine tools

Mothers described the importance of clinicians at each level of care being sensitive to and detecting concerns. They described how they might report difficulties or concerns in a broad, indirect way for example, by reporting on their baby's physical health presentation such as issue with their feeding or sleep, when there were underlying concerns relating to emotional wellbeing or the bond, but this would be dismissed as a normal part of the perinatal period:

We had quite a lot of troubles with feeding and weight gain and all that kind of stuff and um... They got resolved, but at the beginning you know I was just told 'oh breastfeeding is hard', but actually [...] he didn't really sleep. I'm so, like it was a rocky start, looking back now [...] my mood wasn't great [...] but it did feel like that health visitor had been very dismissive of all of that and didn't really know how to handle the postnatal depression (M11).

Mothers described how difficulties in the bond could be very subtle and it took a highly attuned clinician to identify difficulties in the parent-infant relationship in order to facilitate conversations around this:

By the time I was discharged from hospital after having my son, I was breastfeeding and you know seemed to be holding him and breastfeeding. You know that ticks all the boxes for them [...]. So, instead of just because somebody is breastfeeding and holding their child and changing them, you know they need to not assume that everything is great (M10).

I think 95% of mums, new mums, especially when the baby cries do go to the baby [...]. So it sort of doesn't give a clear picture because although you're responding to your baby and although you're doing those things, if you're inside feeling very low, it doesn't matter, you're responding, but you're not necessarily there and doing it (M6).

Both mothers and clinicians commented on how time- and resources-restricted services were more likely to miss the subtler signs of perinatal mental distress and that lack of specialist training may result in indicators of this going undetected:

Is it 12 weeks? 6 weeks? 12 weeks? [...] I can't remember now, but I didn't get long enough, I don't feel [...] because I was, um, kind of quite coping outwardly know you, the midwives can only look after you for so long that they, 'cause they're really there for the pregnancy, and not so much afterwards (M10).

But I get the feeling it's a kind of quick conversation at the midwife might pick up mental health issues and then suggest a referral (C12).

Occasionally we would get a midwife, or health visitor who perhaps had a little bit better relationship with the client, or has, you know, a bit more in kind of knowledge of them or just was a bit more sensitive to mental health stuff in general or maybe pick things up slightly earlier stage (C6).

Theme three: right place, right time

Mothers and clinicians spoke to the importance of timely input, particularly pre-emptive support, but how difficulties often reached crisis point before a provision was offered. Several mothers shared experiences of feeling that if only they had had relevant support earlier, they could have avoided significant psychological distress:

I feel sad that I had to get to that point of having those thoughts and you know the distress that it caused, my husband in particular of hearing me say, you know, I didn't want to be alive anymore. You know and actually I think... you know, coming up with a plan of how I was gonna do that, how I was going to end it all and... but once you verbalise those things, things then seem to happen quite quickly. I'm just really sad that it got to that stage for things to happen quickly. [...] And would've been nice just to have something in place for after I had the baby, rather than having, again having to wait till you know afterwards and I reached that crisis point again, you know, and I felt like I'm saying 'hello, I'm here, [...] can someone help me?' (M12).

Unfortunately, it's still often at a point where most, it is at a point of crisis, I guess, to come into the kinds of services that we were offering because they are about complex and severe mental health problems. So I think there's still a huge gap at the level under that if you like. So early intervention isn't really still available, so yeah, [...] really intensity of experience and feeling very overwhelmed and often either suicidal or kind of yeah, at the end of the road, I suppose, in terms of crisis levels (C6).

Both groups also spoke of services for PNMH difficulties being delivered in a range of locations, with home-visits being frequently referred to as a facilitator of this and mothers being required to attend clinic appointments, particularly in the post-natal period, as a barrier:

We are still able to offer home visits [...] I think that feels really, really important that, particularly for women when they're feeling really overwhelmed, that going to see them at home, I mean obviously leaving the house with a young baby can be quite challenging anyway, so for home visits we're flexible (C5).

The best thing for me from both the crisis team and the perinatal mental health nurse that I saw was the fact that they came to your house. It was just... It made me feel... that I was important, that I mattered, that someone... it might sound like a little thing, but the fact that someone was coming to me because they genuinely cared about me rather than expecting me to, you know, go to them (M12).

It was kind of a hassle for me to get to the to the hospital where the treatment ended up being because I don't have a car [...] so I'd have this like really torturous journey on the bus. And that was really stressful (M5).

Theme four: starting conversations, keeping them going

How to start conversation about mental health concerns in the perinatal period and how to keep them going was associated with a range of factors for both mothers and clinicians. Women with pre-existing mental health difficulties often described this as a facilitator, either in that they were already linked in with service or they felt well-versed in discussing their mental health support needs:

So I had a really early referral to services because I was already with the community mental health team (M8).

I mean obviously I have accessed mental health support for a really long time, since probably about the age of 14, so I feel quite familiar with it (M13).

Clinicians described the importance of asking the right questions, having sensitive conversations and working in a gentle way in order to open up conversations about mothers' mental health and the parent-infant relationship:

It's such a massive life event for someone to have a baby that I think it feels important to give kind of space and time to that person and work in a very gentle way initially (C5).

I mean, I think you know, having to tread quite carefully. Because there's really, you know, there can be a very quick move to guilt or anxiety. So really, you know, just proceeding quite sensitively and focusing on strengths (C12).

This sensitive approach was echoed in the mother's descriptions of needing a safe, non-judgemental space in which to disclose difficulties they may be experiencing in the perinatal period, whether to do with their own mental health or concerns about their relationship with their baby:

She's been the biggest aid in all of this, she's really supported me through all of it. She's so non-judgmental (M10).

For somebody that is feeling those things, there should be the space that isn't judgmental for them to open up and say 'yes, I don't feel love for my unborn child yet' (M2).

A crucial factor noted by both groups for facilitating conversations around PNMH difficulties and the parent-infant bond, was the therapeutic relationship. It was noted that this was not only important within psychological therapies; women's relationships with care-providers at every level were deemed to be of key importance for disclosing difficulties and thus accessing support:

It is all about relationships, really. So I think those who've had a good relationship with either GP or midwife, or a health visitor have found there's a reasonably smooth path into services (C6)

I feel like you need to have a relationship with someone, like really build up a relationship with someone to be able to be as honest as you might need to be (M1).

I found that hard because I'd formed such a close relationship with my nurse, and the psychiatrist; I didn't find it as easy to talk to her. So it felt like there was maybe a missed opportunity for a bit more input that I might have benefited from (M13).

Theme five: It takes a village

This prominent theme relates to the social experience of the perinatal period and mothering. Both mothers and clinicians spoke about the importance of social support, whether that be informally via friends and family, formally via therapeutic groups, or a combination:

I was very lucky in that respect, 'cause obviously I had that group, I had my sister, I had family support. And I just do think you know, for people that don't have that, I mean, if I hadn't had that, I would have ended up in a much darker place (M13)

That would be family and my mum really and close friends. But then for my last pregnancy which was, by no means straightforward, professionals [...] And I suppose I kind of built up a community around me, 'cause there wasn't [...] I had to reach out and find a community that would understand, you know, without judgment [...] So it was a combination of professionals, family and making my own community to share thoughts with (M10).

It was helpful in the group that I attended because the other mums seemed to say the same thing and it was helpful (M5)

And for me, you know it's just about [...] and the longer I practice, the more I think it's true, [...] is that women need support groups. Not necessarily formally, they may be family or friends, but you know magic happens when women get together in groups (C11).

Clinicians also spoke of the importance of working alongside other disciplines and agencies to provide wrap-around support for families, including medical, practical, social and psychological input:

We're linking quite a lot with local services and that means that we're linking a lot with the children centres and that they can provide parents with practical support, so they can get support with housing, or [...] food vouchers, if the family [...] have that sort of needs. They can also get some support in regards to benefits, but as well as to [...] appropriate developmental toys for the child, 1-to-1 play sessions with the family worker [...] And then we know that in perinatal period it is good to have a network around the family, either that could be a social network, their own network and how do we kind of bring this network together to help the practical and emotional support that they need (C4).

Theme six: ‘nobody puts baby in the corner’; centring the parent-infant bond

Both groups spoke to the importance of centring the parent-infant bond within PNMHS. Problems with services related to when services focussed input on either the mother or the baby, but were not able to hold both in mind, as a unique dyad:

No, I don't remember that being spoken about. I don't know. I think it was more just on me really. It was all just on sort of how I was dealing with things rather than the bond (M6).

I remembered my midwife saying ‘I have a duty to look after the unborn’ and I thought ‘but you also have a duty to look after me’ (M4).

I remember thinking at the time like ‘this is... is it just me? Like, you can't take your baby with you to get support?’ (M11).

Clinicians noted how babies can get ‘side-lined’ in the conversations with mother, in the clinician’s thinking and even in service planning and provision:

It's difficult to bring the baby as a person into the work [...] and I guess that might be because it's not the focus of the work often, but it might also be that the baby is... can be a little bit side-lined (C8).

I think my sort of primary concern is how perinatal services are being set up within... without the baby, and how CYPIAPT perinatal training is set up without reference to the baby, how maternal mental health is somehow being separated from the fact that the baby exists. And I think that feels quite dangerous and I think it feels quite unhelpful [...] ‘Why isn't this mother being seen in adult mental health? She's not being seen in adult mental health because she has a baby’. So where is the baby in the conversation? (C13).

Mothers acknowledged that it could be difficult to have conversations about the parent-infant relationship, particularly if there were ambivalent or negative feelings within the mother towards the baby. However, they often expressed that by normalising this and having thoughtful, perhaps less formal conversations around this, these crucial conversations could – and should – be had:

It's hard because I can also totally appreciate that, as a new mum, the idea of that is probably quite scary. Because I do think that we have a tendency as a society to go ‘if I'm not coping, my baby is going to be taken away from me and I don't want people to see that’. So I think that it's something that would have to be very sensitively approached, but I do think it's really important (M13).

And so it wasn't a formal, you know, like assessment of our bond, but it was just sort of quite casual, gentle, reassuring-ness... reassurement? (M5).

I think just kind of, don't make a big deal out of it, just try and normalize it maybe? (M12).

Theme seven: silencing forces

Both mothers and clinicians described multiple barriers, or silencing forces, which may prevent women from disclosing difficulties and seeking support for their own mental health in the perinatal period and sharing concerns relating to the parent-infant bond. A barrier early in the journey to accessing support related to both mothers and clinicians not knowing what types of services and support are available:

I think practitioners quite often find it very frustrating because you know you want to do your best and you want to help, but it's like well, what's out there? (C11)

The thing I really took away from the perinatal mental health services was how little was known about them [...] And I think a lot of people would benefit a lot, you know, from already knowing there's that service available before they even get pregnant or before they even have the baby [...] If they were aware about that, that would have helped me anyway, I know that (M4).

Social emotions related to disclosing mothers own mental health difficulties or concerns about their relationship with their baby, including embarrassment; shame and guilt or the sense of feeling judged, were also noted by both groups:

I think it can be quite... quite difficult, actually, um, asking for help about your well-being when you're pregnant or when you have a baby seems quite difficult. I think it comes with quite a lot of shame (C8).

The kinds of thoughts and worries that I was having were really like shameful and really, you know, in the context of my experience now, I wouldn't put it that way.

But at the time it felt very like I couldn't tell anybody because it was so embarrassing and awful (M5).

Both groups also noted that broadly speaking, ambivalent feelings towards the baby are particularly hard to talk about:

I think that's the hardest bit for somebody to be honest about. I think how somebody feels about their relationship with their baby, and the ambivalence that they may feel, or at times their total hatred or upset at their baby or absence of relationship is I think that's the hardest thing for somebody to admit (C13).

I knew that I really wasn't enjoying it, but I didn't really know how to say that (M13).

A frequently raised theme by both mothers and clinicians, viewed as a major barrier for disclosing difficulties and seeking support was the fear of social services involvement, ultimately leading to the baby being removed:

Those fears of social services becoming involved and the child being removed (C1).

I think every mum's worst fear is of social services I guess. And if you say the wrong thing or people think the wrong thing that social services will have an involvement. [...] As a parent like I've never been more scared than when social services said they're gonna come round and talk to me about our situation. And I know that I'm a good mum [...] but in that moment you still think like 'oh, they are gonna find something out about me that means that they're going to take my child away there and then' (M2).

Overarching themes

Theme eight: dual identities

Throughout the interviews it became evident that whilst all respondents signed up to participate as either a mother with experience of accessing PNMHS or as a clinician working in that setting, many participants in fact had experiences of both of these identities. Many of the clinicians were also mothers and several of the mothers also worked in the field, for example as midwives or charity project workers.

8.1 Many hats - mother-knowledge. Shared experience seemed to be an important factor in relation to women's experiences of group support and the theme of 'mother-knowledge' was important for who women chose to speak to about their distress in the perinatal period. For example, peer support and the importance of clinicians also being mothers:

I got the sense that my therapist wasn't a mother and not that that means that there should be, you know, only parents in perinatal mental health teams, like they can only be mothers, no, that's not what I'm saying at all, but it seemed very obvious that she didn't understand what it was like to be a mother [...] I don't know, they just didn't seem to be in awareness or understand enough about being a mum (M4).

And drawing a lot on my experience as a mother, actually as well as my experience as a psychologist (C12).

8.2 Cared for to caring. Some of the women interviewed shared that their personal experience of perinatal mental health difficulties had led to them becoming advocates of PNMH and seeking professional roles in the field:

So I work for [name of mental health charity], but I also have my own practice as a maternity nurse and a sleep consultant and supporting mums who've got

perinatal mental health issues and need help with their babies and it's just something I'm hugely interested in personally because of my own background with perinatal mental health issues (C3).

I'm a perinatal mental health campaigner as well as obviously lived experience (M10).

I wanted to get involved is because of my own experiences when I had my children, accessing perinatal mental health services and that led me to obviously the midwife as well and that's led me to taking a greater interest in perinatal mental health as a as a whole and seeing where the gaps are. And I'm just really keen to do whatever I can to try and push those services forward and you know, do my bit really in kind of hopefully improving things for other women (M12).

Theme nine: Contextual factors

9.1 COVID-19 pandemic. The context of the COVID-19 pandemic was raised throughout interviews, often relating to the impact this had on social support across the spectrum from formal support groups being stopped or held online, to support from family and friends being diminished due to national lockdowns. The theme of isolation was referenced by both mothers and clinicians and the causal or compounding effect this had on perinatal distress.

But we're under massive pressure and there's lots of, with COVID, I think there's been a real flurry, an increase of referrals into the service because I think so many women that might have done OK pre-COVID, are struggling more because of the isolation and the lack of support (C10).

The pandemic was really kicking in and suddenly I had both of the kids at home. And I just didn't... And like, I just crumbled really. Like, you know, because I

didn't have what it took to look after the two of them. And I just yeah, I just... It was hard (M11).

9.2 Diversity. The theme of diversity came up in many interviews, both with mothers and clinicians, under many guises and in different contexts. Often, it was raised in relation to accessibility to services, for example cultural diversity (or lack thereof) within PNMH teams:

I would say that the sort of diversity issues quite big I think this is the least diverse and NHS I've worked in and I think, I don't know if people would feel that they meet people like them in the team. And maybe that's across the social divide as well, it's a sort of predominantly white, middle class team (C13).

For mothers, it presented in relation to how their diverse identities were considered (or not) by the services they accessed:

I think I had a really clear care plan to manage the fact that I find non-direct questioning quite challenging, that came from my community, but mainly around like specialisms in autism (M8).

Before when I was pregnant, I was seeing a lady face to face and she was really, really lovely. She was also like from an ethnic minority, so I think that helped as well. And another thing was and I found this issue kind of across the board is that I identify quite strongly with my religion and my beliefs and that's a big part of how I cope and deal with things, but I find often even when you explain that, it never really becomes incorporated as part of the support you get. Um, I don't know if that's a bit perhaps, because obviously the individual that... or sometimes individual that's supporting you isn't... doesn't understand your beliefs and draw upon that. So I understand that, but I think, I guess it would have been nice to have someone of the same faith background (M9).

9.3 Social-contextual factors. Social-contextual factors, relating to socioeconomic status, family composition, and housing issues, among others, were raised by both mothers and clinicians as being important contextual or even precipitating influences for coming into contact with PNMHS:

And then there's another whole cohort of women who've been completely stigmatized by society anyway, so they might be single mums, or they might be mums on benefits, or they might be mums who are struggling in other ways (C6).

The actual work that I'm doing daily with these women and kind of the more issues around like, a lot of the women that I see, their mental health is such, like so much a cause of social problems, um, particularly housing is like a massive, massive issue and so many women that I see that actually I think probably wouldn't be under our team if they had appropriate housing (C9).

I think so, anyway, that mental health is circumstantial and what's going on around you greatly affects it. But then there's no service that could change your social situation, so. Yeah, that's fairly difficult (M2).

Theme ten: Service-level, operational factors

Clinicians, but interestingly also mothers, spoke to service level and operational factors which originate at the level of service planning and commissioning, and ultimately impact the care available to women in the perinatal period at the point of service delivery.

10.1 Information sharing. Mothers described how information about their care was not shared with relevant professional, leading to delayed or inappropriate care being delivered and additional distress placed on mothers and their families:

I read my reports after, they're like 'did not engage'. Well, I wasn't very well so. It's just a little bit of thinking about how it's really important, really early on when you're accessing places in crisis to link with, I don't think it's always is family because it can be really challenging for family, even to be able to agree with how bad things get. But when you are under so many services which I was under quite a few different – I think under home treatment team, perinatal, CMHT, someone would have been available to share a bit of information (M8)

You just can't get into Rio. They can't get into it. So they have people turning up in ED with.... taking overdoses [...] and they can't access the information (C11)

10.2 Geographical area. Another service level barrier related to geographical area of services, whether that be one perinatal team covering a large area and thus mothers having to travel significant distances for outpatient support or, in the case of inpatient support being required, mothers being admitted to mother and baby units miles from their home and support network:

[The] geographical area meant that often mothers really struggled to attend appointments with me [...] so, there was no one in the whole of the county with perinatal experience; it was quite a shocking situation (C1).

We had to travel 100 miles to Winchester where, um, yeah, thankfully my mum lives so that's where I grew up. So my partner was able to live with my mum [...] but obviously we still were away from home and like miles away and so yeah, that was really... that made it so much harder, you know to be nowhere near you know my friends and my home and to just have to kind of leave like that in an emergency, you know was really literally quite traumatic (M7).

10.3 Service funding and resources. Both groups referenced issues with service funding and resources available, particularly in reference to the NHS services being under strain. Often respondents, particularly mothers, spoke about this with a real sense of compassion for a system under pressure:

So, I guess that relates to service commissioning and funding and the pressures that services are under from a more top down level that then trickles through and has an impact for the families that are accessing them (C7).

Yeah, so it's, I think, unsurprisingly, as is really with all mental health services, there are a lot of areas where the system is kind of groaning under the strain of not being able to cope (M13).

10.4 Thresholds and service criteria. A further service level factor which was reported as a barrier to mothers accessing PNMHS related to thresholds for receiving input and service criteria. Both mothers and clinicians described mothers falling or bouncing between services due to restrictive criteria or not meeting thresholds when they first sought support:

People might fall through the gaps in between different services, so they're not right for one in terms of that service's criteria, but then they're really not fitting into any criteria or service and you feel like you're going round in circles, and they've had a really elongated journey (C7).

So I reached out for help then and I can't remember how I did it, if I went to the GP or... but I remember there was a cock up basically and they did the referral and then I waited and waited and waited and waited and whichever team it was came back to me and said 'Oh no, we're not the right team. We didn't realise that you were pregnant. You need to go through, you need to be referred to perinatal'. So then I -

and by this point I was about 28 weeks pregnant - and then I had to wait for the referral to perinatal to go through. And by the time I got that, I think I was probably about 36 weeks pregnant and I was like, you know, 'I'm having this baby in a couple weeks.' (M12).

Discussion

The present study aimed to explore mothers' and clinicians' experiences of PNMHS, specifically relating to assessments of and interventions focussed on the parent-infant relationship. We also explored women's experiences of disclosing perinatal mental health difficulties and their experiences of accessing PNMHS, with a focus on how these services assess and more broadly address mother-infant relationship difficulties. We hoped to address the gap in the existing literature; between the qualitative research focussed on mothers' individualistic experiences of PNMHS and the quantitative studies which examine efficacy of assessments and interventions focussing on the parent-infant bond. Finally, we explored clinicians' experiences of working in PNMHS, with a focus on the experience of assessing and working with the parent-infant relationship. In essence we asked 'what is the experience of mothers coming into PNMHS and having their relationship with their baby assessed, and how do the assessing clinicians experience this process?'

Twenty-six semi-structured interviews with mothers who had accessed PNMHS (N = 13) and clinicians who work in the area (N = 13) were conducted and analysed using thematic analysis. From this analysis, seven themes relating to the research questions were extracted: (i) *the unique nature of the perinatal period*, (ii) *wide net, fine tools*, (iii) *right place, right time*, (iv) *starting conversations, keeping them going*, (v) *it takes a village*, (vi) *'nobody puts baby in the corner'*; *centring the parent-infant bond* and (vii) *silencing forces*. A further three contextual themes, which overarch all other themes and were derived from the data and

contain sub-themes were (viii) *dual identities (Many hats - mother-knowledge and cared for to caring)*, (ix) *contextual factors (COVID-19 pandemic; diversity and social-contextual factors)* and (x) *service-level, operational factors (information sharing; geographical area; service funding and resources and thresholds and service criteria)*.

Largely, the present findings concur with existing research in the field (e.g. Megnin-Viggars et al., 2015; Millet et al., 2017). The themes of *the unique nature of the perinatal period* and that of *'nobody puts baby in the corner'; centring the parent-infant bond*, related to previous findings of needing to better tailor mental health services to the perinatal context and holding the mother-infant dyad in mind as a distinct system. Problems with services according the women in the present study, often related to services focussing either the baby, or the mother, but not holding both in mind. The need identified in previous research for collaborative, integrated care, presents here through the theme of *it takes a village* and the subtheme of *information sharing* within *operational factors*, which speak to the need for services to provide person-centred provision, in collaboratively with mothers, the family system and inter-professionally, across disciplines and agencies. The themes of *starting conversations, keeping them going* and *silencing forces* reflect previous findings which highlight the importance of non-judgmental and compassionate support and fears of loss of custody. Whilst the sub-themes of *diversity and social-contextual factors*, within the theme of *contextual factors*, highlight the need for services to offer person-centred, culturally competence provisions, which can conceptualise perinatal mental health within its wider socio-cultural context.

The themes of *'nobody puts baby in the corner'; centring the parent-infant bond; starting conversations, keeping them going* and *silencing forces* also begin to provide a qualitative understanding which builds on quantitative research into assessment of and interventions for the mother-infant relationship (e.g. Newton et al., 2020). They describe the

importance of working with the mother-infant relationship, despite the emotive and sometimes difficult nature of these conversations, as expressed by both clinicians and mothers. They also describe how both groups experience assessment and intervention for this aspect of perinatal mental health care, as well as factors which facilitate or impede this.

The novel lens through which the present study explored women's experience of PNMHS was a relational one, focusing particularly on the parent-infant bond, from an attachment theory perspective. Not only did we find the importance of working with the parent-infant bond, which was emphasised by both mothers and clinicians, we learned that relationships across system levels are crucial in this time. A thread running through many of themes in the present study is the social nature of the experience of the perinatal period, as demonstrated in the theme of *it takes a village*, but also in the roles of relationships in and social emotions in facilitating mothers disclosing their difficulties and seeking support. The importance of social support is perhaps further highlighted by the overarching contextual theme of *the COVID-19 pandemic*, which has increased the risk of women experiencing isolation in the perinatal period, both through face-to-face offers being reduced by PNMHS and women having less support from family members, friends and peers due to national lockdowns.

A potential link between the role of relationships in the perinatal period and particularly in PNMHS and the theme of *find net, wide tools* may be that in order for clinicians to detect maternal mental health concerns and difficulties in the parent-infant bond, they need to have a relationship with the mother. An existing relationship not only allows clinicians to assess each individual's baseline presentation and deviations from this, but also it can support the safe, non-judgemental space that mothers described as so crucial to enabling them to disclose concerns. The themes of *right place, right time* and *thresholds and service criteria* are important in understanding what may prevent therapeutic relationships

developing. If mothers are bouncing or falling between services, leading to delays in receiving support or only accessing input at the point of crisis, it is unsurprising that collaborative, safe relationships with health care providers may not be developing.

Limitations

Whilst themes and shared experiences were certainly identified, it is important to note that a vast range of experiences were brought by both mothers and clinicians. The unique nature of the perinatal period means that each mother's journey is individual and the present study cast a wide net in inviting women who had accessed any kind of mental health service during their perinatal period. Whilst this gives a broad picture of experiences and furthers our understanding of barriers and facilitators to women seeking support for their mental health needs in the perinatal period, it cannot deepen our understanding of more specific forms of PNMH support, such as experience of inpatient admissions in the perinatal period. Anecdotally from the current data, it appeared that service provision varies across different regions of the UK. However this was not formally captured and thus is it not possible to draw empirical conclusions relating to this from the present findings.

Research Implications

Whilst the present study was designed prior to the COVID-19 pandemic, all recruitment and data collection was conducted in the midst of multiple national lockdowns. This had significant impacts on maternity and mental health services throughout the UK and on the day-to-day lives of the mothers and clinicians who so generously gave their time to participant in this research. Further research into the impact of the COVID-19 pandemic on mothers and their children born in this period will support a better understanding of the impact of the increased isolation and changes to services in this time. From an attachment theory perspective, further research might explore the effects of increased time at home

within family units, in both the ante- and post-natal period on the parent-infant relationship. For example, one respondent who was a practicing midwife shared that anecdotally, the trust in which she worked during the first national lockdown, the team observed a decrease in elective third trimester sonograms. Initially they hypothesised that this was due to women's anxieties around coming into hospital and contracting COVID-19 and may correspond with an increase in still births. However, the still birth rate maintained and the team's secondary hypothesis was that women had been at home and more attuned to their bodies and babies antenatally, so had noticed their babies' smaller movements and not felt the need to request additional sonograms or movement checks.

The importance of social support is highlighted throughout the present findings, particularly by the overarching contextual theme of *the COVID-19 pandemic*, which increased the risk of women experiencing isolation in the perinatal period, both through face-to-face offers being reduced by PNMHS and women having less support from family members, friends and peers due to national lockdowns. Further research into women's experiences of isolation during the perinatal period within the context of the COVID-19 pandemic is needed to better understand these experiences and their effects on both maternal bond and – perhaps subsequently – their relationships with their babies.

Clinical Implications

The present study took a UK-wide sample, which provides a national picture of how women and clinicians experience PNMHS and how these services assess and work with the parent-infant bond. Given how PNMHS are commissioned on a local, trust-by-trust basis, the themes which have emerged from the present study can be understood to be higher order and overarching of service-level differences. By interviewing both service users and providers (mothers and clinicians), the findings and their clinical implications have in some way been reality tested. That is to say, in interviewing only service users, researchers may run the risk

of developing ideal yet unattainable service standards and recommendations. By also developing an understanding of the constraints of services from a provider perspective, we are able to develop clinical implications which are informed by what is most desirable as well as what might actually be feasible.

Several mothers described how getting out of the house to a service, particularly in the early perinatal period, created a barrier to accessing PNMHS. It might be then, that services would be wise to continue a virtual offer, even as face-to-face services become more available again. A virtual offer may also go some way in remedying the issue of PNMHS covering large geographical areas, in that women may be able to access support virtually, rather than travelling significant distances. However, this only applies in the context of outpatient support and the need for more localised inpatient provisions, that is, Mother and Baby Units, remains unmet.

The theme of *dual identities* (including the sub-themes of *many hats – mother-knowledge* and *cared for to caring*) highlight the importance for mothers in being supported by others with lived experience of the perinatal period. This supports the need for peer-led provisions and for services to make use of the knowledge of women who are experts by experience in the field of perinatal mental health. The overarching thread of social relationships provides evidence for services to develop provisions focussed on supporting the family unit, as well as group and community-focussed interventions.

Conclusions

The findings are consistent with previous research exploring mothers' experiences of accessing mental health services in the perinatal period. Results highlight the social nature of the perinatal period and the key role of relationships within the time and in facilitating access to PNMHS. The results have implications for further research relating to the perinatal period

within the context of the COVID-19 pandemic. They can also inform service provision following the pandemic, with an emphasis on flexible, service-use lead treatment options, which hold the mother-infant relationship at their heart.

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Part III: Critical appraisal

Introduction

This chapter will present a critical reflection on the research process of the empirical paper in Part Two. The findings and interpretations of these will be further reflected on in relation to broader theoretical perspectives. Through personal reflexivity, the researcher will explore her own perspectives and positions, in relation to the impact on the research and that of the research on the researcher. The impact of the COVID-19 pandemic on the present research and lessons learned for future research and clinical practice are also presented.

Selection of a project

I came to this project through an existing interest in developmental psychology and attachment theory, with previous experience in qualitative research, focussing on service-users experiences of accessing mental health services and clinician experiences of providing these. Very early in the project planning phase, I spent time listening to radio programmes and podcasts which presented real-world accounts of women's experiences of perinatal mental health difficulties and the services they interacted with by way of seeking support. This began my study into the field of perinatal mental health not only through academic papers and scientific experts, but also through centring the voices of experts by lived experience. This process influenced the decision to interview women and clinicians and to adopt an exploratory approach, by using semi-structured interviews which were flexible enough for novel topics and themes to emerge through the data collection and be derived from the analysis processes.

From my clinical experience in perinatal mental health, I have a developing understanding of the frustrations women sometimes experience in relation to their perinatal health care – both in mental health and physical health settings. The minority stress theory

describes how individuals who hold stigmatised minority identities experience poorer outcomes in both physical and mental health and this is associated with exposure to increased stressors (Pascoe and Richman, 2009). In the perinatal context, these identities may include – but are not limited to – Black women and women of colour, women with learning disabilities or who are physically disabled and women whose first language is not English. I feel passionately that the voices of women must be not only heard and honoured, but amplified through the mechanism of empirical health research.

Position of the researcher and personal reflexivity

The process of reflexivity in qualitative research involves the researcher exploring their own position and the impact this has on each stage of the research (Finlay & Gough, 2008). Furthermore, the process involves reflecting on the impact of the research on the researcher. The purpose of reflexivity is to attempt to bring the researchers' biases and assumptions into conscious awareness, with the aim of remaining open to alternative interpretations and findings (Starks & Trinidad, 2007). Here I will present and reflect upon my own experiences, identities and perspectives which are likely to have impacted on this research, as well as how the research process has impacted me.

On reflection, the interaction between my personal background and context and the research I have been drawn to seems almost inevitable. I come from a family whose members all identify as socialist, social activists and feminists, and who hold a range of professions from health and social care, including maternity care. From this context, I would consider social justice and providing equitable, accessible mental health services as core values in my clinical practice and research ideals. As a white, well-educated, able-bodied woman (to name but a few of the privileged identities I hold), I believe I have a social, political, and even moral obligation to use the platform built for me by my privilege to amplify other, less

privileged voices by creating research which can influence services to better serve stigmatised and socially minoritised communities in the future.

This stance drove multiple decisions in the research, including ensuring I completed a bracketing interview prior to conducting any data collection, in service of becoming more aware of my assumptions, biases and what I anticipated I may find in the present research. It also influenced the decision to interview mothers alongside clinicians, with the aim of gathering a rich understanding of perinatal mental health care from both the service-user and provider perspectives. It also informed the selection of the thematic analysis method, in order to flexibly draw together a large amount of rich, idiographic data, rather than a more interpretive approach which may be more vulnerable to the influence of the researchers' own perspectives. The coding methods selected, including descriptive and in-vivo coding were intentionally chosen as coding methods which prioritise and honour the participant's voice (Saldaña, 2021). Lastly, by highlighting the barriers and facilitators which impact women's ability to disclose their difficulties, seek support, access services and benefit from therapeutic intervention in the perinatal period (PNP) from the data, the findings presented aim to inform service improvements in the future.

During the interviews, I was aware of the lack of shared identity with many of the women I interviewed, with participants alluding to – or in some instances directly asking – the question as to whether I was a mother myself. Given the theme of *dual identities*, particularly that of *mother-knowledge*, I often wondered if respondents may have felt I could not understand their experiences in a way that another mother could. Not holding this identity of 'mother', may have influenced multiple stages of the research, from formulating research questions, developing the interview guide, how the questions were approached and follow-up questions used in interviews, to how transcripts were coded and thematically analysed.

In several interviews, with both clinicians and mothers, I noticed respondents seeming to censor themselves or accompanying complaints relating to services they received or were able to provide, with caveats demonstrating a compassionate understanding of the resource restrictions within the NHS. This is represented within the theme of *service funding and resources* within the empirical paper, however it may be that this reticence to critique the NHS – particularly in the context of the COVID-19 pandemic – in fact somehow blocked getting to the true shortcomings of services. It may also represent a socialised behaviour found to be common in qualitative interviews focussing on sensitive subjects such as lived experience of mental illness, where there is a performative or self-censoring nature to respondents' accounts (Yanos & Hopper, 2008).

During the procedure of analysis, the opportunity to discuss initial codes in a sample of the transcripts with the second coders was a highly enriching process for me. Identifying concordance and differences in the codes we were drawing from the data not only provided an important credibility check at the point of coding but also reminded me to keep an open, flexible approach to the data at each stage of the analysis.

Impact of the research on the researcher

Several of the clinicians interviewed for the project noted how emotive perinatal work can be. This certainly resonated for me as a researcher; as someone who is not yet a mother, hearing about mothers' experiences of the darkest, most frightening moments of transitioning to motherhood, as well as the joys and delight involved in this important life stage was both inspiring and somewhat daunting. Hearing these stories was emotive, but also made me feel extremely proud to be a woman and empowered, but also humbled by the power of the women I was speaking to, both clinicians and mothers. It was not uncommon during the interviews for women, both those who were coming to the project as a mother who had

accessed perinatal mental health services (PNMHS) and those who came as clinicians, to be ‘mothering’ during the interview. This including interacting with, tending to, entertaining, comforting and on more than one occasion, breastfeeding their children. I felt so struck that not only had these women given their emotional energy and time to be involved in the project and share their – often difficult – experiences; they did so whilst also giving to their babies.

As a clinician-researcher, when hearing distressing content in interviews and when interviewees became upset, I found it difficult to stay within the research frame and felt drawn towards the role of the empathic therapist, to offer support and at times, intervention. However, participants in qualitative research often report benefits of participating in interviews, including the opportunity to tell their story in a neutral, non-judgemental space and in doing so, helping others in the future and thus deriving something positive from difficult or traumatic experiences (Donalek, 2005). It was reassuring to hear at the conclusion of these interviews, that women often found the process of telling their story in its entirety, with the potential for this to improve services for other women in the future, an overall positive and empowering process. In line with ethical practice guidelines in qualitative research relating to sensitive topics, information about relevant avenues of support and an opportunity to reflect on the process of the interview was also provided to respondents at the end of the interviews (Corbin & Morse, 2003).

I conducted all of my interviews whilst on placement in a PNMHS and this certainly influenced my role within the team. This included my clinical assessments and therapeutic work with women but also in team discussions around service provision, as I became aware of experiences of both service users and providers up and down the country and the frustrations and concerns shared by both parties.

Other reflections

It was during the planning stages of this research that George Floyd was murdered by police in Minnesota, United States of America (BBC News, 2020), which preceded a resurgence in focus on the Black Lives Matter movement world-wide. Whilst I would like to have considered myself actively anti-racist in my practice and my research prior to this, the renewed acknowledgement of institutional racism has refocussed for me the prevalence of this in health services, including and especially, mental health services in the United Kingdom (UK). Of the 13 women I interviewed, 12 identified as white. Evidence from physical perinatal health care shows that Black women are four times more likely to die in childbirth in the UK compared to their white counterparts (Knight et al, 2020). When we consider the statistics for maternal mortality in the UK, logic would follow that perinatal psychological distress would be as much an issue faced by Black women and women of colour– if not more so – as their white counterparts. This raises the question then, of why was the present sample so markedly biased in terms of racial demographics? The evidence demonstrates that Black women and women of colour are less likely to receive appropriate, good quality perinatal physical and mental health care (Huggins et al., 2020). Specifically within the mental health setting, research from primary care in the UK indicates that women of black Caribbean ethnicity are less likely to seek help for perinatal depression, than women from other ethnic groups (Edge, 2009; Templeton et al., 2003). Thus there are several explanations for the demographic make-up of the present sample, including that this is likely to be reflective of the inequities of the population accessing PNMHS. Additionally, for the Black women and women of colour who are accessing PNMHS, what is preventing them from getting involved in research which looks at their experiences? In her paper *It's leaflet, leaflet, leaflet then, "see you later"*, Edge (2011) explored black Caribbean women's perceptions of perinatal mental health care in the UK and found that barriers to consulting for depressive symptoms in particular, and health needs more generally, included perceptions of

practitioners' lack of compassion in delivering physical care and women's inability to develop confiding relationships with professionals during pregnancy and childbirth. It is an uncomfortable reflection to sit with, to consider how the present study may have unwittingly failed to create an inclusive recruitment campaign which resulted in a largely racially homogenous sample. This is likely to have been heavily influenced by the way in which we recruited for the study. In order to improve diversity in further research samples in this area, we would be wise to partner with online communities and organisations such as Black Perinatal Wellness, Black Mums Matter Too, Melanin Parents UK and Acacia Family Support, whose webpage has a page dedicated to information for professionals working with Black, Asian and Minority Ethnic families, and people of colour (Acacia Family Support, 2021).

Theoretic considerations

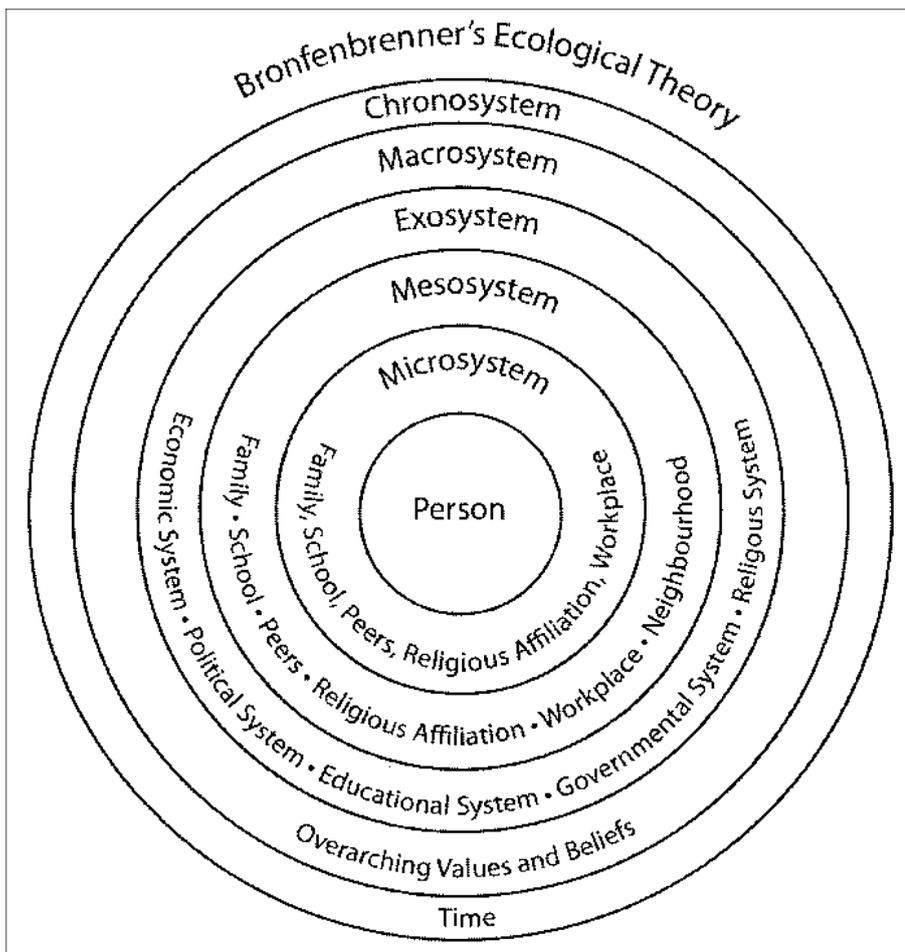
John Burnham's updated Social GRACES (2018) is a helpful tool for reflexivity in clinical practice but I have also reflected on how various social identities and the intersections between these have influenced and presented in the current thesis. Within the theme of identities, women raised how facets of the social identities interacted with their experiences of perinatal mental health problems and the care they received from services. This included respondents from both groups reflecting on class, geography, race, ethnicity, religion and gender.

A further theoretical framework which I have found helpful in making sense of the present findings, in particular the role of relationships across different systems, is Bronfenbrenner's Ecological Systems Theory (1992), which describes a complex system of relationships around an individual, affected by multiple levels of the surrounding environment. These include the individual's immediate family, to their close social circle and

community, through to broader cultural values and customs. The present findings touch on each level of Bronfenbrenner’s theory, from the intimate microsystem of the parent-infant dyad; to the mesosystem level relationships within and surrounding families around an infant; to the exosystem of community support around a mother and her infant; and the macrosystem, represented by socio-cultural contexts including socioeconomic status, housing and ethnicity. Lastly, the context and impact of COVID-19 may be understood through an ecological systems lens as a chronosystem level influence.

Figure 1.

An adapted illustrated model of Bronfenbrenner’s Ecological Theory



Note. (Cited by Stranger, 2011; adapted from Berger, 2007)

The COVID-19 pandemic

During the process of planning, conducting and writing up this research, the COVID-19 global pandemic arose and impacted every facet of the research and the lives of the researchers and participants involved in the project. In this section I will present reflections on some of the ways the pandemic effected the current research as well as the potential implications of this global event on future research and service provision in the perinatal context.

Impact on the research process

It was during the early research governance stages, whilst applying for NHS ethical approval that the COVID-19 pandemic hit the UK and the first national lockdown in England came into force. This impacted the research significantly as the trust we were applying for ethical approval within closed applications for any research not directly focussed on COVID-19. So, rather than applying for NHS ethics, embedding the research in three NHS PNMHS in an East London Trust and conducting the interviews face-to-face, the project required a significant redesign. We applied for UCL ethical approval and as recruiting via NHS channels was no longer an option, made the decision to recruit through social media. In my clinical practice during the COVID-19 pandemic, I was hearing that the mothers I was speaking to were using social media, in place of in person social supportive settings such as Children's Centres and baby groups, to connect with other mothers and seek support and information around their experiences. This knowledge enabled me to connect to a supportive, specialised network of individuals and organisations providing information, education, support and connection to women in this stage of their lives, within the context of the COVID-19 pandemic, which in turn supported the recruitment process. Moving to recruiting

via social media and employing video technologies to conduct the interviews also meant we could now look at a national sample (Hanna, 2012).

Impact on the findings

In comparison to previous research in the field of perinatal mental health and experiences of services, the present study found increased themes of isolation and the importance of the social network in the PNP. It is likely that the deprivation of social support, both formally through antenatal classes and mother and baby groups and informally, via support from family and friends due to the COVID-19 pandemic, emphasised the importance of these resources in the PNP. Both mothers and clinicians spoke to the theme of isolation, already a concern for women in the PNP, being exacerbated by the governmentally enforced lockdowns, quarantines and social distancing.

Implications for further research and clinical practice

There has now been an entire cohort of women who have experienced pregnancy, birth and the post-partum period within the context of a global disease pandemic. Further research into the impact of national lockdowns on women and their infants in the PNP is needed to better understand the psychological short- and long-term effects of this experience. In clinical practice, services would be well advised to incorporate the present findings into service planning and provision, particularly those which suggest the benefits of group and peer-led support and the need for flexible services offers in which mothers can opt for in-person – in a range of settings including home-visits – or digitally-delivered support. Further, services need to be alert to the subtle nature of difficulties in the parent-infant bond and as the present results suggest, relationships between care providers and service-users could be an instrumental mediating factor in this. Continuity of care and service planning which reduces the phenomena of women ‘bouncing between’ services and even clinicians within a service

may go some way to reduce the risk of relationships not developing and thus women not disclosing their difficulties or those relating to the bond.

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Appendix 1: Table I. Study characteristics

Study	Aim	Setting	Sample size	Data collection	Analysis
Abrams et al., 2016	To investigate knowledge and perceptions of perinatal mental disorders and their treatments at the community level in a rural, predominantly ethnic minority region of northern Vietnam.	Vietnam	14 perinatal women	Qualitative semi-structured interviews	Grounded Theory
Adeponle et al., 2017	To establish feasibility of Expanding Care of Perinatal Women with Depression (EXPONATE) with qualitative interviews prior to the EXPONATE research program, a mixed-methods study to assess the effectiveness of a stepped-care intervention program for perinatal depression in Nigeria.	Nigeria	14 women with perinatal depression	In-depth interviews (McGill Illness Narrative Interview)	Thematic content analysis
Andajani-Sutjahjo et al., 2007	To investigate women's own accounts of nonpsychotic depression pre- and postnatally, to explore whether culturally specific notions of postpartum depression exist in Indonesia.	Indonesia	41 women who scored above the cut-off score of 12/13 on the Edinburgh Postnatal Depression Scale (EPDS) during pregnancy, at six weeks postpartum, or on both occasions.	In-depth interviews	Thematic
Atif et al., 2016	To explore the facilitators and barriers to the acceptability of peer volunteers (PVs)—volunteer lay women from the community with shared socio-demographic and life experiences with the target population—as delivery agents of a psychosocial intervention for perinatal depression in a rural area of Pakistan.	Pakistan	21 depressed mothers	In-depth interviews and focus-group discussions	Framework Analysis

Bitew et al., 2020	To understand women and healthcare workers' perspectives of antenatal depression, their treatment preferences and potential acceptability and feasibility of psychological interventions in the rural Ethiopian context.	Ethiopia	8 women	In-depth interview	Thematic analysis
Clarke et al., 2014	To understand how mothers experience and manage distress in Dhanusha, a low-resource setting in rural Nepal. We also explored how distressed mothers interact with their families and the wider community.	Nepal	22 distressed mothers (GHQ-12 score ≥ 5)	Semi-structured interviews	Grounded Theory
Davies et al., 2016	To examine the experiences and explanations of depression amongst Xhosa-speaking pregnant women, mothers, and health workers in an urban township in Cape Town, South Africa. The study was conducted as part of formative research for a randomised controlled trial to develop and evaluate a task-sharing counselling intervention for maternal depression in this setting.	Cape Town, South Africa	12 depressed and 9 non-depressed pregnant women and mothers of young babies	semi-structured interviews	framework analysis
Fellmeth et al., 2015	To explore perceptions of mental illness among pregnant migrants and refugees and antenatal clinic staff living and working along the Thai-Myanmar border.	Thai-Myanmar Border	13 focus group discussions were conducted with pregnant migrants and pregnant refugees	Focus groups	Thematic analysis
Hanlon et al., 2010	To explore the sociocultural context of women's antenatal mental ill health in Ethiopia.	Ethiopia	Interviews with 2 pregnant women and 4 postnatal women plus focus group discussions were conducted	In-depth interviews plus focus group discussions	Inductive analysis

Kathree et al., 2014	To understand the explanatory models of illness held by women with maternal depression with the view to inform the development of an appropriate counselling intervention using a task sharing approach.	South Africa	with 11 postnatal women and 11 pregnant women 20 semi-structured qualitative interviews with mothers diagnosed with depression. Follow-up interviews were conducted with 10 participants.	Interviews	Thematic analysis
Lasater et al., 2018	To describe local idioms of distress and the socio-cultural contexts surrounding perinatal mental health to inform the development of locally-appropriate interventions.	Mali	26 perinatal women	Semi-structured interviews	Thematic analysis
Molenaar et al., 2020	To investigate perceptions and experiences of perinatal mental distress among women in a rural Ethiopian community, in an effort to advance understanding of cross-cultural experiences of perinatal mental distress.	Ethiopia	22 depressed women, according to their scores on a culturally validated assessment of perinatal mental distress (the Self-Reporting Questionnaire).	This study examined concordance and discordance between qualitative semi-structured interview data ('emic' perspective) and the layperson-administered fully-structured questionnaire data ('etic' perspective) of perinatal mental distress.	The questionnaire data was analysed using summary statistics and thematic analysis was applied to the qualitative data.
Mwape et al., 2012	To explore factors contributing to mental distress during the perinatal period of motherhood in Zambia.	Zambia	A total of 159 participants of various ages, and social backgrounds, both married and single, were purposively selected to participate in focus group discussions with 6–12 participants each. Among the 19 focus groups conducted were two groups of older women over the reproductive age, five groups of men, and 12 groups	Focus group discussions	Thematic analysis

Nakku et al., 2016	To explore the barriers and facilitators, as well as perceptions about the feasibility and acceptability of plans to deliver perinatal mental health care in primary care settings in a low income, rural district in Uganda.	Uganda	of younger women in antenatal and postnatal periods. Six focus group discussions comprising separate groups of pregnant and postpartum women and village health teams as well as eight key informant interviews.	Focus groups	Thematic analysis
Niemi et al., 2015	To provide an understanding of how perinatal depression is experienced, and how interventions targeting it should be adapted to suit a semi-rural context in Vietnam.	Vietnam	9 women who obtained high scores in a depression self-report measure during pregnancy	Interviews	Qualitative content analysis
Rodrigues et al., 2003	To use qualitative methods to investigate the cultural validity of the construct of postnatal depression (PND) and its social and cultural contexts.	Goa, India	In-depth interviews were carried out with 39 mothers (19 of whom were found to be suffering from PND as defined by a cut-off score on the EPDS)	Interviews	Iterative thematic analysis
Sarkar et al., 2018	To qualitatively explore multiple stakeholder perspectives on perinatal depression in rural Uganda	Uganda	32 perinatal women for in-depth interviews and 28 perinatal women within focus group discussions with various local health system stakeholders	Individual interviews plus focus groups	Emergent thematic analysis
Stewart et al., 2015	To investigate the thoughts and emotions experienced by women in pregnancy and the postnatal period, their expectations of support from husband and others, problems and difficulties faced and the impact of these on psychological wellbeing.	Malawi	11 focus group discussions with a total of 98 parous women.	Focus groups	Thematic analysis
Tang et al., 2020	This study explores how mothers in China understand the causes of	China (People's	38 mothers, both with and without PPD	Semi-structured interviews	Grounded theory

Tol et al., 2018	postpartum depression (PPD) and their preferred coping strategies To examine stakeholders' perspectives on mental health-related priorities, help-seeking behaviours, and existing resources to guide the development of a maternal mental health component for integration into non-specialized care in Soroti, eastern Uganda.	Republic of) Uganda	24 perinatal women	We employed rapid ethnographic methods (free listing and ranking; semi-structured interviews; key informant interviews and pile sorting)	Inductive thematic analysis. Smith's Salience Index was used for analysis of free listing data
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Appendix 2: Semi structured interview schedules

SEMI-STRUCTURED INTERVIEW TOPIC GUIDE FOR MOTHERS

Semi-Structured Interview Topic Guide

This guide is to be used flexibly in accordance with participant's responses. Each topic (1-6) should be covered (though the topics are not to be specifically asked of participants), but the questions asked (e.g., 1a, 1b etc) are there as guides and may not all need to be asked. The interviewer may use simple follow up prompts such as 'would you be able to tell me a bit more about that', in areas where the participant has given short or vague responses. However it is crucial to be mindful that this may be intentional and for the interviewer to respect the participants right to privacy (see introduction below).

Introduction: We are interested in finding out more about mother's experiences during pregnancy and after birth. Therefore we are using interviews (rather than questionnaires) in the hope we can paint a fuller picture. To this end, there are no right or wrong answers to the questions I ask you today and you can feel free to give as much detail about your experiences as you would like. If I ask any questions you would rather not answer, that's perfectly OK, you can simply say you would rather not answer. I might ask some follow up questions after you give some of your answers and with these, please also feel free to say you would rather not answer. For confidentiality, there is no need for you to name any specific services or professionals.

Do you have any questions for me before we start?

1. (Topic 1 - Warming up)
 - a) I am interested to hear about how you heard about this study
 - b) What drew you to contact us and being involved in the project
2. (Topic 2- Research question 1 - How do women seeking support for their mental health difficulties in the perinatal period experience and report their own mental health difficulties?)
 - a) It's quite common for people to experience emotional difficulties during pregnancy and the time after birth. Can you tell me, in as much detail as you feel comfortable with, how has it been for you?
 - b) Who did chose to speak to about these difficulties? Who would you be less likely to speak to? (Is there any differences within and between family, friends, and professionals)
 - c) How did you find speaking to others – family, friends, or professionals – about any difficulties?
 - d) What led you to seek support from services? What was going through your mind at the time/what kind of things were you thinking about?

- e) How did you go about it?
 - f) What was this like?
 - g) Did you have any worries about seeking support? What ultimately made you go for it?
 - h) So you reached out for some support, and what happened next? How did you find that?
 - i) What was helpful about the service you used?
 - j) And what were the challenges of the service?
 - k) And what elements of the service did not work well for you or were problematic?
 - l) What sort of service was it that you used? (make this a follow up Q if unclear from previous answers)
3. (Topic 4 – Research question 3 - How do women seeking support for their mental health difficulties in the perinatal period experience and report the relationship with their baby?)
- a) Can you tell me about your relationship with your baby after he/she was born? Do you feel that there been any difficulties in this relationship?
 - b) (Prompts: how do you feel you're getting along together? Have there been some good times and some more difficult times? Do you worry about your relationship or bond with your baby?)
 - c) Have you spoken to anyone – friends, family, or professionals – about your relationship with your baby?
 - d) How has that been for you?
4. (Topic 6 – Research question 5 - What are women's experiences of accessing and using perinatal mental health services – and specifically – the way services assess and more broadly address mother-infant relationship difficulties?)
- a) Did anyone from the service speak to you about your relationship with your baby? (If yes, go to next question. If no, got to question e)
 - b) How was that for you? (How did you feel this conversation was approached and managed?)
 - c) Did they use a questionnaire, an interview or take any video of you together to understand more about your relationship?

- d) If they did, what was this like for you?
 - e) If they did not, do you think this would be a helpful or important thing for services to do with new mums and babies?
 - f) Do you have any thoughts about how services could helpfully open up a conversation about the relationship with your baby? Should they? Do you have ideas about how best to do that?
 - g) And if you haven't experienced it, what do you think about using video for this?
 - h) Do you have any thoughts about how services could make it feel a bit more comfortable?
5. (Topic 7 – broadening out and ‘cooling down’)
- a) I'm aware I've asked you lots of questions, but the chances are there are elements of your experience of PNMHS which I haven't asked about. Is there anything else you want to share that will help us paint a fuller picture?
 - b) I'm also aware we've spoke about some very personal and difficult topics today and your wellbeing is very important to us. *(The interviewer will take time here to talk to the participant, check in with them about how they are doing and give them a moment to feedback and reflect on any issues that might have arisen, before sharing the debrief sheet with them).*
 - c) If this interview has brought up difficult thoughts and feelings, it is important that take care of yourself. If you are feeling worried about this, please contact your GP or PNMH professional. We have put together a debrief document with useful information and contacts on which we give to everyone who takes part in the study. A link to this information will be shared with you via MS Team now.

(For initial interviews only): Finally, you are one of the first to be interview for this study, using these questions – could I ask you for some brief feedback on how you found them?

SEMI-STRUCTURED INTERVIEW TOPIC GUIDE FOR CLINICIANS

Semi-Structured Interview Topic Guide

This guide is to be used flexibly in accordance with participant's responses. The interviewer may use simple follow up prompts such as 'would you be able to tell me a bit more about that', in areas where the participant has given short or vague responses. However it is crucial to be mindful that this may be intentional and for the interviewer to respect the participants right to privacy (see introduction below).

Introduction: We are interested in finding out more about clinicians' experiences of working in perinatal mental health setting and therefore using interviews (rather than questionnaires) in the hope we can paint a fuller picture. To this end, there are no right or wrong answers to the questions I ask you today and you can feel free to give as much detail about your experiences as you would like. If I ask any questions you would rather not answer, that's perfectly OK, you can simply say you would rather not answer. I might ask some follow up questions after you give some of your answers and with these, please also feel free to say you would rather not answer.

It is important that your responses are in line with your organisations confidentiality policy and to this end we ask you not to share any confidential, identifiable or personal information pertaining to either your clients, your colleagues or your organisation. If you mention any such information by mistake (e.g. such as names of people, places, services etc.), we will ensure these are redacted from the transcript of the interview.

Do you have any questions for me before we start?

- a) I am interested to hear about how you heard about this study
- b) What drew you to contact us and being involved in the project?
- c) Without naming the specific service, could I ask you which **type** of service you work in? (NHS, Inpatient, community, third sector)

(So thinking about the women who access support for their mental health in the perinatal period...)

- d) In your experience, what leads women to first come into contact with PNMHS? (What are the common routes in?)
- e) What is your sense of how they experience those first stages of seeking support?
- f) In your opinion, how accessible do you feel your service is to women experiencing mental health difficulties in the perinatal period?
- g) What elements of the service do you think are accessible, supportive or positive in other ways?

- h) And what were the challenges of accessing the service?
- i) And what elements of the service do you feel to not work well for women or are problematic?

(So thinking now a bit more about your experience of the work...)

- j) How did you find speaking to your clients about difficulties they experience in the perinatal period?
- k) What is your experience of mothers reporting their babies' difficulties in the perinatal period?
- l) What is your experience of mothers reporting on their relationships with their babies during the perinatal period?
- m) Do you use any formal measures which focus on the parent-infant relationship in your work?
- n) If so, which?
- o) And what is your experience of using this/these?
- p) If not, is there a particular reason for this? Is it something that is used by other professionals in your service?
- q) In not, do you use another means to assess this?
- r) What is your experience of discussing the parent-infant relationship with mothers seeking support for their mental health difficulties in the perinatal period?
- s) How do you approach these conversations?
- t) Lastly, do you have ideas about any tools or approaches that would improve conversations around the parent-infant relationship with mothers who access PNMHS?

I'm aware I've asked you lots of questions, but the chances are there are elements of your experience of working in PNMHS which I haven't asked about. Is there anything else you want to share that will help us paint a fuller picture?

Appendix 3: Table 2.1. Preliminary themes and sub-themes

Domain/theme category	Theme (initial analysis)	Sub-theme	Final themes
Research Question-Driven Domains	-	-	
Women's experiences of their own mental health difficulties and experiences of reporting these in the perinatal period (PNP)	<ol style="list-style-type: none"> 1. The PNP as a unique period 2. Experiences in the PNP 3. Barriers to reporting 4. Facilitators to reporting 	<ol style="list-style-type: none"> 1.1. Transition to becoming a parent 1.2. PNMH experiences worse than previous experiences of MH difficulties 1.3. First Contact with MHS in the PNP 2.1. Isolation 2.2. Pregnancy and birth experiences 2.3. Symptoms (Anger, Anxiety, Suicidality) 3.1. Fear of social care involvement/baby being taken away 3.2. Difficulties being dismissed as a 'normal' part of the PNP 3.3. Social emotions related to disclosing 4.1. Clinician 'catching' concerns 4.2. Therapeutic relationship 4.3. Existing mental health difficulties 	<p>The unique nature of the PNP</p> <p>Wide Net, Fine Tools</p> <p>Right place, right time</p> <p>Starting conversations, keeping them going</p>
Women's experiences of and experiences of reporting their babies' difficulties in the PNP	<ol style="list-style-type: none"> 5. Focus on physical presentation 	<ol style="list-style-type: none"> 5.1. Baby's health 5.2. Feeding difficulties 5.3. Sleeping difficulties 	<p>It Takes a Village (magic happens when women get together)</p>
Women's experiences and experiences of reporting on the relationship with their baby in the PNP	<ol style="list-style-type: none"> 6. Experiences of the relationship 7. Experiences reporting on the relationship 	<ol style="list-style-type: none"> 6.1. The relationship over time 6.2. No issues with the bond 6.2. Stories about the bond 6.2. Negative experiences 7.1. Subtle difficulties, wider conversations 7.2. Hard to talk about 	<p>Nobody puts baby in the corner – centering the parent-infant bond</p>
Views of women seeking support for their mental health difficulties in the PNP about how and to whom to share or disclose these experiences	<ol style="list-style-type: none"> 8. Professional support 9. Social support 	<ol style="list-style-type: none"> 8.1. Professionals 9.1. Husband or partner 9.2. Family 9.3. Friends 9.4. Community 	<p>Silencing forces</p>

<p>Women's experiences of accessing and using mental health services in the PNP</p>	<p>10. Getting in the Door – Seeking and Accessing Support 11. Key professionals and relationships 12. Timing on input 13. Treatment options 14. What's working 15. What needs to improve</p>	<p>10.1 Facilitators 10.2 Barriers 11.1 The role of primary care 11.2 The therapeutic relationship 11.3 Multidisciplinary or multi agency support 12.1 Pre-emptive support 12.2 Getting a service at the point of crisis 13.1 Face-to-face vs. virtual 13.2 Group support 13.3 Generic vs. Specialist PNMH support 13.4 Medical model vs. talking therapy 14. 1 Shared experiences 14. 2 Clinician of service holding baby in mind 14.3 Lifesaver 14.4 A safe space to be heard 14.5 Right place, right time 15.1 Feeling judged 15.2 Failing to see the family system 15.3 Knowing the options, having a choice 15.4 Wrong place wrong time</p>
<p>Women's experiences of the way services assess and more broadly address mother-infant relationship difficulties in the PNP</p>	<p>16. Assessing and working with the bond</p>	<p>16.1 Approaches and tools 16.2 Barriers to engaging in the work around the bond 16.3 Absence of conversations around the bond</p>
<p>Clinicians' experiences of working in PNMHS a</p>	<p>17. Experience of the work 18. The role of relationships 19. Systems 20. Time and place</p>	<p>17. 1 Complex emotions 17. 2 Perceived experience of mothers 17. 3 Approaches 17. 4 The perinatal period 18.1 Relationship to help 18.2 The therapeutic relationship 18.3 Group support and shared experiences 19.1 The family system around the baby 19.2 Systems around the family 20.1 Getting in the door 20.2 Timing of input</p>

		20.3 Getting support: when, where and how
Clinicians' experiences of assessing and working with the mother-infant relationship.	<p>21. The importance of the bond in PNMH</p> <p>22. Mothers reporting on the bond</p> <p>23. Working with the bond</p>	<p>21. –</p> <p>22. –</p> <p>23.1 Assessing the bond</p> <p>23.2 Interventions for the bond</p> <p>23.3 Barriers for clinicians talking about the bond</p> <p>23.4 Approaches to talking about the bond</p>
Data-Driven/Emergent Themes	Dual Identities	Many hats (Mother-Knowledge) Cared for to Caring
	Contextual Factors	COVID-19 Pandemic Diversity Social-contextual Factors
	Service-level/Operational Factors	Information sharing Geographical area Service funding and resources Thresholds and referral criteria

Appendix 4: Letter confirming ethical approval



21st August 2020

Professor Pasco Fearon
Research Department of Clinical, Educational and Health Psychology
UCL

Cc: Holly Summers

Dear Professor Fearon

Notification of Ethics Approval with Provisos

Project ID/Title: 18737/001: Women's and Staff's Experiences of Perinatal Mental Health Services (PNMHS): A Qualitative Investigation

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the REC until **21st August 2021**.

Ethical approval is subject to the following conditions:

Notification of Amendments to the Research

You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form'

<http://ethics.grad.ucl.ac.uk/responsibilities.php>

Adverse Event Reporting – Serious and Non-Serious

It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report

Office of the Vice Provost Research, 2 Tavilton Street
University College London
Tel: +44 (0)20 7679 8717
Email: ethics@ucl.ac.uk
<http://ethics.grad.ucl.ac.uk/>

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research: <https://www.ucl.ac.uk/srs/file/379>
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely



Professor Michael Heinrich
Joint Chair, UCL Research Ethics Committee

Appendix 5: Online recruitment posters

Perinatal Research at University College London

Have you accessed perinatal mental health services during the past 18 months? Is your baby below age 12 months? If so we would love to hear from you.

We are carrying out some research to better understand women's experiences of accessing perinatal mental health services and hope to use this understanding to improve services in the future.

We are looking for women who:

- Are aged 16 or over
- Have accessed perinatal services for a perinatal mental health difficulty during pregnancy or post-birth in the past 18 month
- (Whose) baby is currently aged below 12 months
- Speak English (English does not have to be your first language, however fluent English is required)



Taking part in this research would involve being interviewed for up to one hour by our lead researcher, Holly Summers, about your experiences using perinatal mental health services. All interviews will be completed via telephone or video call and you will be able to choose which of these methods you prefer.

Your participation will help shape services for women in the future.

If you are interested in participating in this study, please click the link in the post, which will take you to further information and, if you choose to take part, a consent form. In the interests of protecting your data, we ask that you do not contact the research team via social media.

The lead researcher for this study is Holly Summers (trainee clinical psychologist) and the Principle Investigator is Professor Pasco Fearon ([clinical psychologist](#)). The study has been approved by the UCL Ethics Committee, approval reference number 18737/001.

Thank you for considering taking part in this study!

Perinatal Research at University College London

Are you a professional currently working in a perinatal mental health service?
If so we would love to hear from you.

The department of clinical, educational and health psychology at University College London (UCL) is carrying out some research to better understand women's experiences of accessing perinatal mental health services and hope to use this understanding to improve services in the future.

We are looking for health visitors, midwives, nurses, psychologists, psychiatrists, family support workers and similar professionals, who currently work in a perinatal mental health setting. This might a community perinatal mental health team, an inpatient provision such as mother and baby units, or a third sector or charity perinatal mental health organisation.

Taking part in this research would involve being interviewed for up to one hour by our lead researcher, Holly Summers, about your experiences working perinatal mental health services. All interviews will be completed via telephone or video call and you will be able to choose which of these methods you prefer.



Your participation will help shape services for women in the future.

If you are interested in participating in this study, please click the link in the post, which will take you to further information and, if you choose to take part, a consent form. In the interests of protecting your data, we ask that you do not contact the research team via social media.

The lead researcher for this study is Holly Summers (trainee clinical psychologist) and the Principle Investigator is Professor Pasco Fearon (clinical psychologist). The study has been approved by the UCL Ethics Committee, approval reference number 18737/001.

Thank you for considering taking part in this study!

Appendix 6: Participant information sheets

Researchers: Lead researcher; Holly Summers (Trainee Clinical Psychologist), Principle investigator; Professor Pasco Fearon (Clinical Psychologist).

Email: h.summers.18@ucl.ac.uk

UNIVERSITY COLLEGE LONDON
Research Study - Participant Information Sheet
(August) 2020

Women's Experiences of Perinatal Mental Health Services

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully, and discuss it with friends and relatives if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part. Thank you for reading this.

What is the purpose of this study?

It is not uncommon for women to need support from a mental health service during their pregnancy and during their babies' early years. However, we have little information about how the women who use these services experience the process. We are interested in finding out, first hand from the people who use them, what it is like to be supported in a perinatal mental health service.

Why have I been invited?

We are looking for women who are aged 16 or over; have accessed perinatal services for a perinatal mental health difficulty during pregnancy or post-birth in the past 18 months; whose baby is currently aged below 12 months; who speak English (English does not have to be your first language, however fluent English is required). If you meet the above criteria, we would like to invited you to participate in the research. This study aims to recruit 15 women to share their experiences.

What will happen if I take part?

If you decide you would like to be involved, you will be contacted by the researcher, who will answer any questions you have about the research and, if you wish to go ahead, arrange a time to meet for an interview. The interview will either take place by phone or by video-conference (MS Teams). The interview will take up to one hour and will be audio recorded. You can decide whether you want to use video or audio only. The recording of your interview will be transcribed immediately after the interview and only the transcript will be securely stored for the research; the audio will be deleted. You will need to consent to this recording in order to participate in the research.

It is important to let you know that if you decide not to take part, nothing happens to your care or support from any clinical team you might be under, you will still receive all the same care and support provided by the team as usual.

What are the possible disadvantages or risks of taking part?

This interview will ask you to revisit your experiences of mental health services and some of this may be distressing for you to recall. If you decide to participate in the interview, we will make every effort to be sensitive to this and you will be able to stop the interview and withdraw from the project at any time.

What are the possible benefits for taking part?

Some people find sharing their experience of using service a helpful process. Additionally, by participating in this study, you will be helping with research that is trying to improve perinatal mental health services.

Expenses and payments

We are unable to offer payment for participation in this study but we can reimburse you for your travel expenses.

What do I have to do to take part?

After reading this information sheet, you may discuss the study with us or friends and family if you wish. If you are interested in taking part in the study we will ask you to provide informed consent, which means that you understand the purpose of the study and what is going to happen. After giving consent we will begin the study, but you will be able to leave the study at any point without having to give a reason.

What happens to the results of the research study?

All information will be kept strictly confidential. The audio recordings of your interview will be identified by a code number only and stored on password-protected devices. Your contact details (which allows access to the code) will be held on a password protected computer or locked filing cabinet at University College London. These records will be held for the duration of the study and the analysis of its results. We plan to publish the results in a scientific journal. We would also provide a copy of the published results upon request. In the event of an audit, responsible members of University College London may be given access to your data for monitoring and/or auditing of the study to ensure we are complying with regulations. University policy is to retain research information for 10 years. Please check the “What will happen to my data?” section for more information on this.

Voluntary Participation and Discontinuation

Your participation in this study is voluntary. If you agree to take part and then change your mind and wish to withdraw you may do so at any time without this decision affecting your future care. If you decide not to take part your treatment within the team will continue as normal. Your legal rights will not be affected by your giving consent to participate.

What will happen to my data?

Data protection regulations require that we state the legal basis for handling information about you. In the case of research, this is ‘a task in the public interest.’ University College London is known as the ‘data controller’ and is responsible for looking after your information and using it properly.

We will be using information from you, and will use the minimum personally-identifiable information possible. A password protected electronic document linking IDs with personal identifiable data (e.g. participant name, contact details) will be held securely on the UCL server (S: or N: Drive). A hard copy of this document will be kept at UCL premises in a locked filing cabinet. Only the study Chief Investigator (CI, Pasco Fearon) and Holly Summers (HS) will have access to this document to reduce risks to privacy. Both the electronic and hard copy of the document will be deleted promptly upon completion of the project and dissemination of results.

We will keep identifiable information (like names, contact details, audio-recordings) about you for 12 months after the study has finished. We will store anonymised research data and the consent forms securely at University College London for 10 years.

Data protection regulations provide you with control over your personal data and how it is used. When you agree to your information being used in research, however, some of those rights may be limited in order for the research to be reliable and accurate. Further information about your rights with respect to your personal data is available at <https://www.ucl.ac.uk/legal-services/privacy/ucl-general-privacy-notice-participants-and-researchers-health-and-care-research-studies>

You can find out more about how we use your information by contacting Holly Summers (lead researcher).

Who is organising, funding and monitoring the research?

The research is organised by University College London. Investigators will not receive money for recruiting you into this study.

Ethical Approval

This study has been APPROVED by the University College London Ethics Committee (reference number 18737/001).

Research Ethics Committee
Office of the Vice-Provost (Research)
University College London
2 Taviton St, London WC1E 6BT

Tel: 020 7679 8717 Extension: 28717, Email: ethics@ucl.ac.uk

What to do if something goes wrong?

University College London, as the Sponsor, has appropriate insurance in place in the unlikely event that you suffer any harm as a direct consequence of your participation in this study.

However, if you have a concern about any aspect of this study, you should ask to speak to Holly Summers (lead researcher), who will do her best to answer your questions.

However, if you feel your complaint has not been handled to your satisfaction (e.g. by the PR or the supervisor) you can contact the Chair of the UCL Research Ethics Committee – ethics@ucl.ac.uk

Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any ensuing reports or publications.

Safeguarding and Confidentiality

All information from this study will be kept strictly confidential. The only exception to this is if we become extremely concerned about your safety or the safety of others. Should this occur, we are legally obliged to make contact with a relevant authority to make sure you and others are safe. We would always try wherever possible to discuss this with you beforehand.

What will happen to the results of the research project?

We hope to publish the results of this research project in a scientific journal. Once the study is complete we will share a summary of the results with you via email and if the study is published we will share where you can obtain a copy of the published results. You will not be identified in any report or publication.

The data collected during the course of the project might be used for additional or subsequent research under UCL.

Local Data Protection Privacy Notice

Notice: The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This ‘local’ privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our ‘general’ privacy notice:

For participants in health and care research studies, click [here](#)

For participants in research studies, click [here](#)

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the ‘local’ and ‘general’ privacy notices.

The categories of personal data used will be as follows:

Name

Email Address

Telephone Number
Home Address

The lawful basis that would be used to process your personal data will be performance of a task in the public interest.

The lawful basis used to process special category personal data will be for scientific and historical research or statistical purposes.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

How to contact us:

If you would be willing to take part in this study, please complete the informed consent form at the bottom of this page.

If you would like to discuss the research further with someone, please contact Holly Summers (principal investigator) or Professor Pasco Fearon (chief investigator) at the following address/phone numbers:

Holly Summers
University College of London
Department for Clinical, Educational and Health Psychology
1-19 Torrington Place
London WC1E7HB
h.summers.18@ucl.ac.uk
Tel: 07708359685

Pasco Fearon
University College of London
Department for Clinical, Educational and Health Psychology
1-19 Torrington Place
London WC1E7HB
p.fearon@ucl.ac.uk

Thank you very much for considering taking part in this study!

Researchers: Lead researcher; Holly Summers (Trainee Clinical Psychologist), Principle investigator; Professor Pasco Fearon (Clinical Psychologist).

Email: h.summers.18@ucl.ac.uk

UNIVERSITY COLLEGE LONDON
Research Study – Participant Information Sheet
(August) 2020

Staff Experiences of Perinatal Mental Health Services

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part. Thank you for reading this.

What is the purpose of this study?

This study aims to better understand the experiences of people who access perinatal mental health services and the experiences of the clinicians who provide them. We are interested in finding out, first hand from the people who work in perinatal mental health services, what it is like to provide these.

Why have I been invited?

You have been invited to take part in this study as you currently work in perinatal mental health services. This study aims to recruit 15 clinicians to interview.

What will happen if I take part?

If you decide you would like to be involved, you will be contacted by the researcher, who will answer any questions you have about the research and, if you wish to go ahead, arrange a time to meet for an interview. The interview will either take place by phone or by video-conference (MS Teams). The interview will take up to one hour and will be audio recorded. You can decide whether you want to use video or audio only. The recording of your interview will be transcribed immediately after the interview and only the transcript will be securely stored for the research; the audio will be deleted. You will need to consent to this recording in order to participate in the research.

What are the possible disadvantages or risks of taking part?

We do not anticipate any risks to taking part in this research and you will be able to share as much or as little of your experience as you feel comfortable to. It is important to note that you will need to ensure you follow your organisations' confidentiality policy and do not disclose any identifiable information pertaining to your clients or colleagues during the interview.

What are the possible benefits for taking part?

By participating in this study, you will be helping with research that is trying to improve perinatal mental health services.

Expenses and payments

We are unable to offer payment for participation in this study but we can reimburse you for your travel expenses.

What do I have to do to take part?

If you are interested in taking part in the study we will ask you to provide informed consent, which means that you understand the purpose of the study and what is going to happen. After giving consent we will begin the study, but you will be able to leave the study at any point without having to give a reason.

What happens to the results of the research study?

All information will be kept strictly confidential. The audio recordings of your interview will be identified by a code number only and stored on password-protected devices. Your contact details (which allows access to the code) will be held on a password protected computer or locked filing cabinet at University College London. These records will be held for the duration of the study and the analysis of its results. We plan to publish the results in a scientific journal. We would also provide a copy of the published results upon request. In the event of an audit, responsible members of University College London may be given access to your data for monitoring and/or auditing of the study to ensure we are complying with regulations. University policy is to retain research information for 10 years. Please check the “What will happen to my data?” section for more information on this.

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Your participation in this study is voluntary. If you agree to take part and then change your mind and wish to withdraw you may do so at any time. Your legal rights will not be affected by your giving consent to participate

What will happen to my data?’

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We will be using information from you, and will use the minimum personally-identifiable information possible. We will keep identifiable information (like names, contact details, audio-recordings) about you for 12 months after the study has finished. We will store anonymised research data and the consent forms securely at University College London for 10 years.

Data protection regulations provide you with control over your personal data and how it is used. When you agree to your information being used in research, however, some of those rights may be limited in order for the research to be reliable and accurate. Further information about your rights with respect to your personal data is available at <https://www.ucl.ac.uk/legal-services/privacy/ucl-general-privacy-notice-participants-and-researchers-health-and-care-research-studies>

You can find out more about how we use your information by contacting Holly Summers (lead researcher).

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Research Ethics Committee
Office of the Vice-Provost (Research)
University College London
2 Taviton St, London WC1E 6BT

Tel: 020 7679 8717 Extension: 28717, Email: ethics@ucl.ac.uk

What to do if something goes wrong?

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However, if you have a concern about any aspect of this study, you should ask to speak to Holly Summers (lead researcher), who will do her best to answer your questions.

However, if you feel your complaint has not been handled to your satisfaction (e.g. by the PR or the supervisor) you can contact the Chair of the UCL Research Ethics Committee – ethics@ucl.ac.uk

Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential. You will not be able to be identified in any ensuing reports or publications.

Safeguarding and Confidentiality

All information from this study will be kept strictly confidential. The only exception to this is if we become extremely concerned about your safety or the safety of others. Should this occur, we are legally obliged to make contact with a relevant authority to make sure you and others are safe. We would always try wherever possible to discuss this with you beforehand.

What will happen to the results of the research project?

We hope to publish the results of this research project in a scientific journal. Once the study is complete we will share a summary of the results with you via email and if the study is published we will share where you can obtain a copy of the published results. You will not be identified in any report or publication.

The data collected during the course of the project might be used for additional or subsequent research under UCL.

Local Data Protection Privacy Notice

Notice: The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This ‘local’ privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our ‘general’ privacy notice:

For participants in health and care research studies, click [here](#)

For participants in research studies, click [here](#)

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the ‘local’ and ‘general’ privacy notices.

The categories of personal data used will be as follows:

Name
Email Address
Telephone Number
Home address

The lawful basis that would be used to process your personal data will be performance of a task in the public interest.

The lawful basis used to process special category personal data will be for scientific and historical research or statistical purposes.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

How to contact us:

If you would be willing to take part in this study, please complete the informed consent form at the bottom of this page.

If you would like to discuss the research further with someone, please contact Holly Summers (principal investigator) or Professor Pasco Fearon (chief investigator) at the following address/phone numbers:

Holly Summers
University College of London
Department for Clinical, Educational and Health Psychology
1-19 Torrington Place
London WC1E7HB
h.summers.18@ucl.ac.uk
Tel: 07708359685

Pasco Fearon
University College of London
Department for Clinical, Educational and Health Psychology
1-19 Torrington Place
London WC1E7HB
p.fearon@ucl.ac.uk

Thank you very much for considering taking part in this study!

Appendix 7: Consent forms

8. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any adverse consequences, by advising the researcher of this decision.

9. I understand that relevant sections of the data collected during the study, may be looked at by responsible individuals from University College London or from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to the information I provide.

10. I agree to the use of anonymised quotes in research reports and publications.

11. If you agree to take part in this study, please provide your email address and phone number so that we can contact you to organise an interview.

Email address *required

Home address * required

Phone number

*A copy of the information sheet and consent form will be emailed to you.

Thank you very much for taking part in this study!

8. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any adverse consequences, by advising the researcher of this decision.

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Thank you very much for taking part in this study!