Midwives' perspectives and perceptions in relation to perinatal psychotic-like experiences: A qualitative study

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Abstract

Background: Psychotic-like experiences (PLEs) refer to subclinical experiences consistent with psychosis that may include hearing, feeling or seeing things that others cannot, or experiencing unusual beliefs. These experiences appear to be more common during the perinatal period. There appear to be barriers which make it difficult for midwives to support mothers with mental health difficulties. However, it is important that midwives can provide support with PLEs. **Aim:** This study aimed to explore UK midwives' perspectives and perceptions relating to mothers' psychotic-like experiences in the perinatal period. **Methods:** A qualitative study using semi-structured interviews with ten midwives recruited online was conducted. Transcripts were analysed using thematic analysis. **Results**: Four themes were developed: (1) Identifying psychotic-like experiences would not be as easy as it sounds: making decisions on behalf of women; (2) Psychotic-like experiences can feel overwhelming; (3) This is my responsibility: I'll do what I can to support women even if it's hard; and (4) The system feels unsafe and insecure which makes the anticipated role in supporting psychotic-like experiences harder. **Conclusion**: Midwives described their motivation to support mothers with PLEs but articulated many factors that made this difficult. The results emphasise the importance of training and guidance for midwives to support them being able to offer support and information to mothers. The findings also highlight the importance of systemic safety for midwives alongside support through supervision and reflective practice.

Keywords Midwives; mothers; psychotic-like experiences; postpartum psychosis; perinatal mental health; thematic analysis

Introduction

Perinatal mental health (PMH) problems are those experienced during pregnancy or the 12 months following childbirth (NHS England, 2019). Of every 1000 women[1] who give birth, approximately one to two experience postpartum, or puerperal, psychosis (PP) (Vanderkruik et al., 2017). PP refers to a collection of experiences including mood changes, hearing, seeing or feeling things that others cannot (hallucinations) and unusual beliefs (delusions) (NHS, 2020).

Although PP is a specific diagnosis (Osborne, 2018), the 'continuum' concept of psychosis suggests that within the general population, experiences of psychosis range from 'subclinical' occurrences to clinical psychosis (Van Os et al., 2009). Subclinical experiences are referred to as 'psychotic-like experiences' (PLEs) and include unusual experiences consistent with psychosis that are below clinical threshold and may or may not cause distress (Van Os et al., 2009; Yung et al., 2009). PLEs appear relatively common in the general population, with Linscott & van Os, (2013) estimating the median population lifetime prevalence as 7.2%.

Although PP is relatively rare, subclinical perinatal PLEs appear common with 37.2% -93.3% of women surveyed perinatally endorsing at least one out of 33 PLEs including 'on occasions I have seen a person's face in front of me when no-one was in fact there' (Holt et al., 2018; Lu et al., 2022; Mackinnon et al., 2017; Mannion & Slade, 2014). Although PLEs may be transient and may not transition to psychosis, they can be distressing (Mackinnon et al., 2017) and women may not disclose them due to perceived consequences including having their baby removed (Jones, 2019).

[1] The use of the terms "women" and "mother" here are intended to be inclusive of individuals who are pregnant or have given birth but do not identify as women.

Women who experience PMH difficulties appear to experience difficulties with seeking professional PMH support (Schmied et al., 2016). This may be linked to multiple barriers including women's perceptions of healthcare professionals' lack of knowledge and ability to discuss PMH, and inadequate systemic resources (Sambrook Smith et al., 2019). However, most mothers will regularly see midwives during the perinatal period. In the UK, pregnant women will typically see midwives regularly from early in the antenatal period (NHS, 2023). During labour and birth, women are likely to be cared for by midwives who may be well placed to identify early mental health concerns such as experiences of psychosis. Midwives continue to see women in the early postnatal period, with care transferred to health visitors typically between 10 and 14 days after birth (NHS, 2022).

During these meetings, midwives' roles are to check the health of mother and baby, and provide information (NHS, 2023). The Maternal Mental Health Alliance, a UK charity supporting families affected by PMH difficulties, discuss midwives' important roles within informing women about PMH and supporting women with identifying difficulties and seeking support (Maternal Mental Health Alliance, 2013). The recent increase in Specialist PMH care provision, secondary care mental health support in the UK, (Howard & Khalifeh, 2020) further highlights the importance of midwives' roles in supporting women to access these specialist services. National Institute for Health and Care Excellence guidelines also stipulate that professionals should discuss PMH with women postnatally (NICE, 2014). Therefore, midwifery contacts provide invaluable opportunities for midwives to discuss PMH concerns (Alderdice et al., 2013), inform mothers about experiences such as PLEs or identify and support women with these experiences.

Midwives often recognise their important role within PMH but identify multiple barriers to discussing mental health, including low confidence and knowledge, and worries about offending women (Bayrampour et al., 2018; Carroll et al., 2018). The small body of

quantitative research exploring midwives' views towards PP reports that almost half of midwives never ask about psychosis, they feel less skilled in asking about psychosis than depression and rate their knowledge of psychosis as lower than depression (Carroll et al., 2018; Viveiros & Darling, 2019).

It is important that midwives can discuss PLEs with women, as distinguishing the 'typical' emotional impact of new motherhood from potential PMH difficulties can be difficult for women (Delaney et al., 2015). Mothers may experience shame when reporting unusual experiences or thoughts (Glover et al., 2014) and could benefit from a safe environment to discuss these.

Notably, a midwife's response to acute PP will likely require a vastly different approach to subclinical PLEs. PP is considered a 'medical emergency' due to rapid escalation of symptoms and potential risk (NHS, 2020). It is, therefore, treated urgently and midwives' roles may be to respond quickly and seek immediate support. In contrast, PLEs often do not transition to psychosis and are unlikely to escalate. Therefore, appropriate support may involve midwives providing normalising information and offering reassurance.

Many midwives do not feel confident in addressing women's perinatal experiences of psychosis (Carroll et al., 2018). Consequently, midwives may feel unable to initiate conversations and offer support for these experiences. To address this problem, an in-depth understanding of midwives' perspectives is required to understand potential barriers and facilitators to their roles regarding perinatal PLEs. The current study addressed this by exploring midwives' perspectives and perceptions regarding perinatal PLEs.

Methods

Design

This study utilised qualitative methodology for in-depth exploration of participants' perspectives and perceptions. Data collection used a vignette describing perinatal PLEs,

alongside a semi-structured interview to gain a deeper understanding of the topic area (Fylan, 2005). Previous studies have demonstrated that combining vignettes and open-ended questions can produce detailed and nuanced insights into participants' perspectives (Dixon et al., 2013). Ethical approval for this research was granted by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Participants

The anticipated sample size for this study was 10-20 participants, informed by literature (Clarke et al., 2015) and considering time and workload constraints. Data saturation was not an aim as Braun and Clarke (2021b) describe that this is inconsistent with RTA.

Recruitment took place through online advertisement, posted on the Royal College of Midwives (RCM) website and social media, namely X (formerly Twitter) and Facebook. Registered midwives currently working in the UK in a role which predominantly included direct contact with expectant or new mothers were eligible to participate. Midwives interested in the study emailed the researcher and were given further information. Midwives gave written informed consent following this information and provided demographic information (see Table 1).

Ten midwives were interviewed, all of whom currently lived and worked within the UK and worked in the public sector. Participants were recruited over nine months. Two further participants expressed interest in partaking however were excluded due to having previous experiences working as Registered Mental Health Nurses. These midwives were excluded due to expectations that they would have had extensive training and experience within mental health and therefore may differ considerably from the perspective of a midwife without this. The age range of participants was 27-49 and all participants identified as White British. Six were non-specialist midwives, and four were working as Specialist PMH Midwives.

Data Collection

All participants chose to be interviewed via Microsoft Teams. Interviews were recorded and transcribed and lasted between 44 and 70 minutes (average 58 minutes). Participants were interviewed using a semi-structured interview schedule which included a hypothetical vignette of 'Nina' experiencing PMH difficulties with a focus on PLEs. The vignette was developed using previous research (Anglin et al., 2014; Lee et al., 2016), measures to identify PLEs (Launay & Slade, 1981; Peters et al., 2004) and information from Action on Postpartum Psychosis (APP) charity's 'personal stories' videos (Action on Postpartum Psychosis, n.d.). This vignette allowed discussion of this topic, even if the participants did not have in-depth knowledge of psychosis and PLEs (Hughes & Huby, 2002).

Participants were asked semi-structured interview questions (Appendix A) about this vignette that explored their perspectives and sense-making. This schedule was developed based on a review of relevant literature (e.g., Downes et al., 2017; Hauck et al., 2015; Higgins et al., 2018; Noonan et al., 2018). During the interviews, the vignette provided a basis for discussion around PLEs with midwives, and corresponding semi-structured interview questions were used to further explore these views.

Participants were interviewed by the primary researcher who was a Trainee Clinical Psychologist. At the start of the research, the researcher had an interest in PMH due to a background working with children, but had not previously worked in this area. Towards the latter stages of the research, the researcher began a work placement in a PMH setting. The researcher noted reflections on this experience throughout to reduce any unconscious impact of this experience on the research.

Data Analysis

Thematic analysis was used to analyse the interview transcripts (Braun & Clarke, 2021). The flexible nature of thematic analysis was appropriate due to the heterogenous nature of the

participant sample. Additionally, thematic analysis allowed the exploration of perspectives without requiring participants to have lived experience of supporting women with PLEs. The analysis followed the following steps outlined by Braun and Clarke (2021) as detailed in Table 2.

The analysis involved moving from one transcript to the other whilst refining codes and noting their reoccurrence, to allow integration of ideas across the data set, consistent with Braun and Clarke's (2021) description of coding as an iterative process. Subthemes were not deemed necessary, per Braun and Clarke's (2021) guidance that subthemes should be used judiciously as they can create a fragmented analysis lacking analytical depth (Trainor & Bundon, 2021).

Results

The analysis generated four themes encapsulating participants' views which are described below alongside anonymised participant quotes.

Theme 1: Identifying psychotic-like experiences would be difficult

Midwives reported a willingness to discuss PLEs with women but described multiple complicating factors. The prospect of having these conversations evoked worries about causing harm, as participants perceived that questions about PLEs may scare or upset women.

This resulted in 'tiptoeing' around the subject, with vague questions being described by some, 'if there's any struggles, simply saying something like, "How are you?", will generate a response usually' (Sophie). Throughout this, there was a sense of midwives making decisions on behalf of women concerning appropriate questions or conversations.

Some participants perceived that asking about psychosis would require a 'rationale', otherwise it would be odd or inappropriate. Some midwives, therefore, felt it was only appropriate to ask these questions in the context of other identified concerns, indicating beliefs that questions about PLEs were particularly intrusive:

> […] hopefully you would have asked the Whooley and the GAD[2] questions and if they answer no to those and everything's fine, you wouldn't have any reason to ask those questions, those more probing questions. (Lucy)

Some participants perceived that asking women about unusual beliefs could be offensive or may indicate judgement, suggesting perceived shame around psychosis:

> Yeah, I think some people would kind of I dunno laugh at you […] or they might get offended […] if you ask them, you know are you hearing voices or seeing things they might think that you think they are... (Eleanor)

This narrative of psychosis as inappropriate to talk about highlighted disparities between the perception of psychosis and other difficulties, as most midwives reported regularly asking about depression and anxiety. This appeared to unintentionally result in the onus being on women to report unusual experiences. Information around PLEs was viewed as potentially distressing for women:

> I don't think the majority of women would have ever thought about anything like that [baby being possessed]. And they, if, they were already worried about lots and lots of things then giving them that scenario, or putting that idea into their head might cause some women distress. (Sarah)

This highlights an important factor that influences the information provided to women. Midwives described making decisions about what would be 'appropriate' to give women information about to prevent causing distress. However, these decisions were made without women's input or choice.

Some midwives' experiences of uncertainty around the prospect of identifying PLEs resulted in the pursuit of certainty. Midwives frequently discussed the concepts of 'normal'

[2] The Whooley questions are 2 questions used to screen for depression (Whooley et al., 1997). GAD refers to the General Anxiety Disorder screening tool (Kroenke et al., 2007).

and ‘abnormal’ regarding women’s experiences and commented that the significant transition to motherhood meant that this dichotomy was not clear:

> …intrusive thoughts, I think, are a very normal adaptation of becoming a parent that is never talked about and that people are really frightened of. So, you know, as a community midwife, I talked a lot about intrusive thoughts, but also felt a bit anxious about when that becomes abnormal. (Linda)

There was an implicit pull for clarity in midwives being able to distinguish and identify ‘abnormality’. This dilemma between the ‘normal vs abnormal’ dichotomy led to a desire for step-by-step instructions, guidance on questions to ask or structured questionnaires to reduce ambiguity:

> If midwives had a pro forma, […] the midwife could go, “OK, I'm seeing some signs of the psychosis here. Let me get my proforma or my app on my phone”. (Sarah)

Overall, midwives described that although they were not opposed to having a role in PLEs, multiple factors complicated this. This led to midwives making decisions about the best way to approach this, which often involved making decisions on women’s behalf about questions they were asked and information they received.

Theme 2: Psychotic-like experiences can feel overwhelming for women and midwives

Alongside difficulties identifying PLEs, midwives also articulated a perception that PLEs and psychosis were overwhelming to support, which presented barriers. PLEs appeared to be viewed and described in the same way as PP, highlighting that participants did not appear to distinguish these experiences. Midwives described their perception of PLEs as emergency situations which were sometimes conceptualised as overwhelming and feared:

> I've looked after ladies with postpartum psychosis as well and my first few experiences of it was kind of like really nervous, […] probably losing sleep at night myself, worrying you know, what were you going to find in the morning and […]

wanting to go into work but not wanting to go into work just to find out what was going on. (Joanne)

This sense of fear appeared to provoke differing responses in midwives, with some feeling cautious around women experiencing psychosis and PLEs and others being driven to learn more to reduce this fear, highlighting that this could be experienced as either a barrier or a driver.

Previous experiences of psychosis shaped some midwives' expectations and contributed to the narrative of PLEs as extreme experiences. For some midwives, this perceived lack of shared experience contributed to uncertainty about supporting women and resulted in a desire for other professionals to fulfil this role. This inadvertently appeared to reinforce the sense of psychosis as unknown and maintain the perception of this as overwhelming. However, for others, the acknowledgement of these difference in realities allowed them to hold in mind women's needs, even if this felt unrelatable:

> […] then you can understand that what she's seeing, or thinks she's seeing, isn't what you're seeing. And that's the most important thing for other practitioners to be aware of that her, you know, her reality, as it were, is not the same as what we're seeing. (Sarah)

Participant accounts highlighted how societal narratives had shaped their view of experiences of psychosis and contributed to worries around supporting this. This influence was named as having a conscious impact on personal perspective for some participants:

> I remember being giving a community call to go and see a lady that'd been diagnosed with schizophrenia […] and I was nervous going out there because I didn't know what I was gonna walk into. […] you read in the press, don't you, about schizophrenia, people being murderers and you know, they're the ones that need to be off the streets

and in asylums and God knows what. And I think we're framed like that from horror movies from things growing up. So, it is definitely a fear of the unknown […] (Linda)

However, for some midwives this appeared to be a more implicit shaping of their understanding of how PLEs may present:

I'd probably probe on my own, obviously I think I'd have to be careful, um. You know, she might be unpredictable; she could suddenly become angry. (Eleanor)

These narratives positioned people experiencing psychosis as dangerous and unpredictable. This appeared to frame some midwives' conceptualisations of what supporting women might look like, particularly as many reported limited experiences of encountering these experiences themselves. This highlights the power of societal narratives around PLEs and psychosis and the potential impact of this on interactions.

In summary, PLEs and psychosis were represented by midwives as potentially overwhelming experiences that came with additional narratives and considerations compared to other PMH concerns. For some midwives, these conceptualisations resulted in caution with supporting women experiencing this. However, for others, their identification and acknowledgement of this resulted in a conscious effort to change their perceptions.

Theme 3: This is my responsibility: I'll do what I can to support women even if it's hard

This theme represents the sense of responsibility, duty and care that midwives displayed for women. It captures the complexity of midwives' attempts at navigating their responsibilities alongside the previously discussed difficulties related to PLEs.

Several midwives described their sense of privilege within their role, and acknowledged their significant responsibility regarding their responses to mental health concerns:

> You can pull it apart a little bit and reassure women […] If you don't do that very well um, you just solidify their thought processes and you'll never get an opening into where they, their mind is at all. (Linda)

Within this responsibility, midwives described the importance of creating relational safety for women within the interpersonal relationship, which was perceived to significantly impact on conversations about PLEs and psychosis. Continuity of care was viewed as important for building these relationships:

> Continuity of care has proven to have positive benefits […] I know the women that I look after and I know if I've seen them all the pregnancy and towards the end if something's changed, I'm like, "You're, you're a bit different today" […] you get to know what people are normally like […]. And I would imagine that they're a little bit more likely to open up to somebody that they know... (Lisa)

Midwives also articulated the importance of a shared understanding and language with women as Sarah describes, 'it's about midwives having the words and understanding it'. Within this, they highlighted the importance of normalising women's unusual thoughts and the significant changes that can come with motherhood, as Sophie describes:

> It seems totally reasonable that you would have someone in that period of time in their life, you know, big experience, never gonna feel an experience like giving birth, […] it's such a massive change that I wouldn't be surprised by that at all.

At times, midwives acknowledged that even if women's experiences were unrelatable or incomprehensible, it was important to validate and believe them. This reflected the sense of 'duty' which included asking difficult questions around psychosis:

> It'd make me a bit worried about it, but I think it's important to ask it 'cause you wouldn't be doing your duties as a midwife if you didn't ask it. (Eleanor)

This willingness to ask about PLEs appeared to be increased by some participants' confidence and trust in their own initiative. These participants described the benefits of learning to ask difficult questions and tolerating the discomfort of not being an 'expert'. Although this feeling was not consistent across participants, those who did feel confident reflected on how experience and education had aided this:

> Certainly, in my very early years as a midwife, lack of experience […] you felt that possibly you didn't have the tools to equip yourself with the answer that you might have within asking a question. So that's definitely come with experience, I'm much more confident at asking the questions. (Joanne)

Within their sense of duty, some participants described that information was important for women, as Kate explains, 'I'm aware of what's come out […] around particularly women's experiences of puerperal psychosis, and really what they've been saying is that actually they've had no, no knowledge of that […] until they're actually in the throes of it.' This was related to beliefs that we cannot assume who may experience psychosis, and therefore all women should receive this information:

> [I talk about psychosis with] every single person, because I just think whilst there are some people it's more likely to happen to […] we're really missing a trick if we just assume it won't happen to them. (Lisa)

This was not a shared narrative across participants, however, as for some midwives, the responsibility to protect women led to withholding information to reduce distress, as highlighted in theme one.

Theme 4: The systems feel unsafe and insecure which makes the anticipated role in supporting psychotic-like experiences harder

This theme encapsulates midwives' perceptions that the systems they work in and with, e.g. maternity systems, PMH and the NHS as a whole, can feel unsafe, for both them

and women, and not secure enough to confidently support mothers with PLEs. They described that this complicated their responsibility to do their best for women.

Midwives described being part of a system that lets women down. They explained their busy, hectic roles, where aspects must be prioritised due to time and workload demands. Several midwives highlighted time as a barrier to conversations about PLEs and psychosis:

> Appointments are 15 minutes long, back-to-back in the clinic setting. Erm, so how much of a conversation are you able to have really? And if you do and there's a disclosure, what do you do with that when you've got women back-to-back every 15 minutes…? (Kate)

Midwives described perceiving that demand for mental health support outweighed service capacity, meaning identifying difficulties such as PLEs was redundant in the absence of subsequent support. This was described as extremely impactful for midwives' wellbeing and roles:

> […] you're identifying that, yeah, you know, I've got a mental health remit […] but if you're not able to deliver, if your working environment is so over stretched that you're not able to do those basic aspects of midwifery care […]. You're kind of in breach of your own basic morality and your own fundamental principles, it's kind of it's an assault to […] your professional integrity […] And I think that's a major, major factor in midwives just burning out…(Kate)

Therefore, midwives described feeling they were 'not doing enough' (Eleanor). Some described feeling they were letting women down or actively harming women by referring them to inadequate services.

Midwifery services were described as unintentionally causing harm through burnt out midwives struggling to support women with experiences like PLEs:

> …if we've got traumatised midwives, they're not going to be able to deliver compassionate care. And then the throughput is traumatised mothers. (Linda)

Several participant accounts also highlighted the importance of psychological safety for midwives, including being able to ask for help and learn from mistakes:

> It helps to have an environment where things are really treated as a genuine learning opportunity instead of you've done something wrong and it's just because you're just not good at your job. It's like […] let's look at what we could do next time and this is an opportunity to learn a bit more. (Lisa)

This sense of seeking safety was also articulated through midwives' ensuring they 'do the right thing'. In relation to PLEs, for some midwives this meant that the risk of underreacting to PLEs felt too unsafe due to possible severe consequences. Midwives described perceiving that they needed to assume the worst-case scenario and act 'just in case' (Olivia):

> I can't make that guarantee. […] I can't slap a study on that from a safeguarding point of view for mum and baby. I would be going option A yeah like this maybe could be psychosis and possible harm. (Sophie)

Consequently, some midwives described feeling unsafe to normalise unusual experiences due to fear around making the wrong decision:

> I'd be terrified not to refer, I can't imagine not referring if someone told me or if I witnessed those symptoms […] it'd feel like I'm gonna get struck off because surely that can't be- I'd be breaching my duty of care if I didn't. (Eleanor)

In summary, midwives described how multiple systemic difficulties complicated their anticipated role within supporting PLEs and psychosis, as they could not draw on adequate resources and support. These systemic difficulties also affected midwives' personal feelings of safety and security, which subsequently altered their responses to women.

Discussion

This is the first qualitative study exploring midwives' perspectives and perceptions towards perinatal PLEs. The overall results indicate a dilemma for midwives when considering PLEs, echoing Coates and Foureur's (2019) findings concerning general PMH. This dilemma involves midwives perceiving many barriers to identifying and supporting women with PLEs, whilst also recognising the importance of their role within this. Systemic barriers appeared to confound this dilemma, extending previous findings highlighting the impact of systemic barriers for midwives' roles in PMH (Bayrampour et al., 2018).

Participants described anticipating difficulties with identifying PLEs, supporting previous findings reporting professionals' fear of offending or upsetting women when asking questions about PMH (Higgins et al., 2018). The results presented extend these findings through illustrating how the additional influence of negative societal narratives around psychosis, reported in wider research (Burke et al., 2016; Wood et al., 2014), further impacted midwives' perceptions that asking about PLEs would be inappropriate.

McGrath et al. (2013) report mothers' perceptions of negative reactions to their unusual postpartum experiences. Therefore, if midwives feel unable to ask about these experiences, women may not report them due to self-stigma (Wicks et al., 2019). The role of stigma may hinder midwives' abilities to initiate conversations about PLEs with women. This highlights requirement for societal changes concerning the perception of psychosis. Increased understanding of PLEs and psychosis at a societal and maternity service level may facilitate increased discussion of PLEs, as women describe perceiving low PP knowledge in the public and health professionals which may prevent discussion of unusual experiences (Roberts et al., 2018).

The barriers for midwives discussing PLEs and psychosis appear to contribute to mothers receiving less information about PP. Women who experience PP report receiving

little prior information about this, which reportedly increases distress (Forde et al., 2020; Heron et al., 2012). The current findings increase understanding of midwives' decisions regarding the information women receive, which may contribute to interventions to increase collaborative maternity care (NICE, 2021).

Despite perceptions of PLEs being difficult to support, midwives conveyed their responsibility to support women, supported by wider research (Bradfield et al., 2019). Some participants described how experience and training increased confidence and reduced fear around PP, positively supporting suggestions that training for midwives could support PMH care provision (NHS England, 2021). Despite this sense of duty and responsibility, midwives described how the current systemic context complicated their anticipated role in supporting mothers with PLEs. These findings indicated a lack of psychological safety for midwives. Psychological safety is the belief that it is safe to take interpersonal risks and share opinions without the threat of punishment (Edmondson, 1999). Psychological safety can minimise error and improve professional wellbeing within healthcare (Grailey et al., 2021). This lack of safety appeared to be particularly impactful when considering PLEs and psychosis, as this elicited an increased sense of risk therefore increasing the need for systemic safety.

Additional systemic issues further complicated midwives' roles within PLEs, extending previous findings (Bayrampour et al., 2018). Recent research indicates increased workload and time pressures within UK midwifery, particularly due to the COVID-19 pandemic (Cordey et al., 2022). The RCM (2021) report that 67% of UK midwives felt unsatisfied with the current care they could deliver. International studies also indicate midwife burnout (Suleiman-Martos et al., 2020) and a global midwife shortage (Nove et al., 2021). Therefore, despite international interest in supporting women's PMH (Coates & Foureur, 2019), midwives experience systemic barriers to this.

Mellor's (2016) findings from a study of midwives' perspectives towards PMH echo current participants' views that inadequate PMH referral pathways and service provision can be frustrating for midwives. West et al., (2020) describe 'moral distress', caused by being unable to fulfil your professional duty (Whittaker et al., 2018). Current participants highlighted distress caused by systemic difficulties that impacted their perceived ability to support women experiencing PLEs. Systemic changes, therefore, appear crucial for midwives to support PMH.

Clinical Implications

Within midwives' accounts of anticipated difficulties in identifying PLEs, they described desiring structured tools to assess PLEs, echoing NICE guidelines calling for tools to identify women at high-risk for PP (NICE, 2014). However, midwives have previously reported uncertainty regarding the purpose of structured PMH questions (McGlone et al., 2016) and difficulties asking these questions (Williams et al., 2016). Therefore, training midwives to use these tools could increase confidence and reduce fear around upsetting women.

Training for midwives around the psychosis continuum, PLEs and midwives' roles within this could support their knowledge. Forde et al., (2020) highlight delayed support-seeking for women experiencing unusual experiences, therefore training for midwives to facilitate early recognition may support women's wellbeing. A current campaign aims to provide information about PP to women in antenatal classes (APP, 2022). However, training for midwives could support them in disseminating information about PLEs and PP to women. This would allow women at increased risk for PLEs, including those experiencing depression or post-traumatic stress symptoms (Holt et al., 2018), to be provided with information. Additionally, providing information to families about these experiences may support the emotional wellbeing of partners and other families who may feel concerned or worried about a mother experiencing PLEs.

Alongside providing training and tools to support midwives, systemic changes are evidently required. Supervision may be beneficial for increasing midwives' psychological safety (Carter, 2022) along with allowing exploration of internally held narratives about PLEs and psychosis. Rothwell et al. (2019) support the importance of supervision for discussing clinically relevant personal factors. Clinical psychologists may be well-placed to offer reflective practice and supervision, in line with the British Psychological Society's (2016) guidance.

Midwives evidently have a potential role regarding PLEs. This could include disseminating relevant information to families, monitoring women's experiences and related risk and, where indicated, onward referral to PMH services or family support.

Limitations and future research

The inclusion of Specialist PMH midwives may have influenced the findings as these participants held more general knowledge around PMH. This was considered during the analysis, and distinct differences between the perspectives of non-specialist and specialist midwives were not identified. However, future research should explore views of non-specialist midwives with larger sample sizes to continue to inform clinical implications.

The lack of sample diversity is a limitation as all participants identified as White British, female and NHS employees. Future research should explore the views of midwives from different ethnic, cultural and gender identities working in different settings, particularly considering the impact of cultural, societal, and systemic narratives described in this study.

This was an exploratory study focusing on a novel area, and was limited in size. This sample size was continuously reviewed to ensure its adequacy to generate detailed findings that met the study aims (Patton, 2015). Data saturation was also considered. However, although data saturation is commonly utilised within qualitative research (Guest et al., 2006; Hennink & Kaiser, 2022), Braun and Clarke (2021a) highlight problems with 'saturation'.

They suggest it is poorly defined and arbitrary and Low (2019) suggest data saturation is flawed, as new data insights are always possible if data collection and analysis continue. Additionally, Roller (2023) argues that reliance on data saturation risks ignoring the nuance of individual participant accounts by prioritising 'new data'. Therefore, instead of an in-depth data analysis, the drive for 'saturation' and larger sample sizes could lead to a shallow, and therefore less meaningful, analysis.

Considering these critiques, ideas around information power were utilised instead which involves considering aspects including the study aim, sample specificity and analysis strategy to inform the sample size (Malterud et al., 2016). The current study's aim was relatively broad, however the target sample was specific and the analysis aimed for an in-depth exploration of participant perspectives, therefore a smaller sample size was deemed appropriate. However, further research in this area with more non-specialist midwives working across different professional areas may be valuable to confirm and/or extend these findings.

Conclusion

This study indicates the complexity of midwives' involvement in supporting PLEs, highlighting the impact of individual, systemic and societal factors. Duty and responsibility were emphasised by midwives, however this was difficult to fulfil without systemic safety. Therefore, increased support through supervision, reflective practice and training appears crucial.

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Declaration of interest

The authors report no conflict of interest.

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Appendix A

Interview schedule

1. Perspectives and perceptions around the topic of perinatal mental health in general

The initial part of the interview focused on the participants' perspectives and experiences of perinatal mental health in general, which intended to get a broader sense of their perspectives and perceptions and slowly introduce the topic of psychotic-like experiences.

[Example prompt questions]

- Could you tell me a little bit about your experiences of assessing, discussing and supporting women experiencing mental health difficulties or concerns during the perinatal period?

- How would you describe your knowledge and understanding of mental health difficulties during this period?

- Could you tell me about what you would routinely ask women about their mental health?

- Are there any barriers that have made this role more difficult for you in the past? Or any difficulties/challenges you have encountered in this role?

2. Vignette

The next part of the interview asked questions in relation to the vignette presented to participants.

Nina is a 30-year-old woman who has just given birth to her first child. Nina experienced complications during labour and required an emergency C-section. Nina and her baby were kept in hospital for 7 days and then discharged home. At a check-up with a midwife a week after Nina and her baby were discharged from hospital, Nina mentioned that she thought that other people in her village were staring at her and watching her when she was out walking recently. She wondered if people had been talking about her behind her back. Nina said that she did not like them staring at her or talking about her and would like them to stop. Nina also told the midwife at the end of the appointment that she believed that someone was going to steal her baby as everyone knew that she was a bad mum. Nina asked the midwife if it was 'normal' to have a feeling that her baby was possessed by something, as she had felt this and wondered if this might explain why she was a bad mum.

Predicted responses:

[Example prompt questions]

- Could you tell me about what your thoughts would be at this point?

- Is there any other information you think you would like from the woman after hearing this? Would you ask the woman for any of this?

- Can you tell me about whether you would be thinking there was cause for any concern?

- How do you think you would view or understand the woman's experiences?

- What do you think would happen next in this situation?

- Do you think there would be any barriers to you supporting the woman in this situation? If yes, what?

- How do you think you would feel if you were faced with this situation?

- Is there any support that you would need to feel more able to support the woman in this situation?

a. **Perceptions and knowledge:**

[Example prompt questions]

- What is your current understanding of psychosis during the perinatal period?

- How common do you think the unusual thoughts, beliefs and experiences described in the story are for women?

- Could you tell me about your views about your role in relation to asking about experiences like this?

- Explanation of PLEs (subclinical experience, common in the population, some research suggesting they may be more common in perinatal period). Explore thoughts about this. Would this impact your perspective?

- Are unusual thoughts, beliefs, or experiences something you would generally ask women about during appointments/interactions? (Give an example – e.g. would you ask women about hallucinations/unusual beliefs) If yes, what would you ask? If yes, what was this like? What happened?

- If yes, is this something you ask all women or are there specific situations in which you would ask this (if yes, which situations)?

- If no, what do you think it would be like to ask specific questions about psychosis (give examples, e.g. beliefs that baby is possessed, mothers hearing voices)?

- How do you think women would feel and think if you asked more about these experiences?

- How would you feel about asking these questions?

- Could you tell me about your understanding and confidence in supporting someone who disclosed these experiences?

- How do you feel about the level of training you have had in relation to responding to situations like the one described in the example? Would you like this to be different in any way?

- Do you feel that there are any barriers or difficulties that prevent midwifes being able to ask about and discuss women's experiences of psychosis? If yes, what?

b. **Own experiences:**

- What would allow you to feel more supported in asking women questions about psychosis and having conversations with women about these experiences? E.g. training, management support, referral pathways

- Have you ever come across women experiencing anything similar to the situation described in the story? What happened in this situation?

c. **Anything else**

- Is there anything else you feel it would be important to discuss that I haven't asked about?

Table 1

Participant demographic information

Participant	Gender	Age range[3]	Years qualified as a midwife	Current area of work
1 - Olivia	Female	Between 45 and 50	0 – 5 years	Non-specialist
2 - Joanne	Female	Between 45 and 50	15 – 20 years	Specialist Perinatal Mental health

[3] Age and year range has been used to protect participant anonymity

3 - Eleanor	Female	Between 25 and 30	0 – 5 years	Non-specialist
4 - Hannah	Female	Between 35 and 40	10 – 15 years	Specialist Perinatal Mental health
5 - Linda	Female	Between 40 and 45	5 – 10 years	Specialist Perinatal Mental health
6 – Sarah	Female		15 – 20 years	Non-specialist
7 – Sophie	Female	Between 25 and 30	5 – 10 years	Non-specialist
8 - Lucy	Female	Between 45 and 50	10 – 15 years	Specialist Perinatal Mental health
9 - Lisa	Female	Between 25 and 30	5 – 10 years	Non-specialist
10 - Kate	Female	Between 45 and 50	10 – 15 years	Non-specialist

Table 2

Stages of thematic analysis
1 The lead researcher listened to the audio recordings of interviews, transcribed these and read transcribed interviews to familiarise themselves with the data and noted initial thoughts.

2 After familiarisation, initial codes were produced and identified alongside the transcript. Initial codes were discussed with the three other members of the research team to confirm that the analysis considered relevant information and that codes were warranted by the data. The initial coding highlighted that codes were too narrow with little repetition which prompted a broader coding approach, reducing the number of codes to a more pragmatic amount.

3 Codes were then reviewed, refined, and organised into possible themes. This initially involved grouping of codes that appeared to indicate similar understanding or concepts.

4 Initial themes were generated independently by the researcher and reviewed with the full research team. For example, theme one was initially named ‘choice around PLEs lies with midwives’, however discussion with the research team highlighted the ambiguity of this and the themes’ positioning from a third-person perspective rather than midwives’ perspectives. Therefore, this theme was re-examined to incorporate broader difficulties that midwives articulated when making decisions relating to PLEs.

5 Once final themes were determined, the themes were then named and defined. This stage involved considering themes individually in addition to consider how themes fit together to reflect the data.

6 Finally, the themes were written up to create a coherent story about the data. The research team supported this stage through providing feedback on how the themes fit together and the consistency of the analysis as a whole.
