

Doctoral Thesis

Women’s experiences of psychosis in the perinatal period: exploring the perspectives of couples and midwives

Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

March 2023

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**Statement of Total Word Count for the Thesis**

|  |  |  |  |
| --- | --- | --- | --- |
| Section | Main Text | Appendices, references, tables and figures | Total |
| Thesis Abstract | 297 | - | 297 |
| Literature Review | 8000 | 7,356 | 15,356 |
| Empirical Paper | 8000 | 11,073 | 19,073 |
| Critical Appraisal | 4000 | 1781 | 5781 |
| Ethics Section | 4819 | 8352 | 13,171 |
| Total | 25,116 | 28,562 | 53,678 |

**Thesis Abstract**

This thesis explores the perspectives of couples and midwives regarding postnatal distress, specifically postpartum psychosis and perinatal psychotic-like experiences. It consists of three sections, a systematic literature review, an empirical research paper and a critical appraisal. The systemic literature review used Thomas and Harden’s (2008) methods for thematic synthesis to synthesise 17 studies exploring experiences of postpartum psychosis (PP) from mothers’ and partners’ perspectives. The review research question focused on mothers’ and partners’ experiences of their relationship with each other and their baby during PP, in addition to the impact of PP on these relationships. Four themes were generated: (1) The process of learning to adapt together; (2) Navigating the impact of the uncontrollable experience on our relationships; (3) This experience can strengthen or strain relationships; and (4) The journey through PP is a relational experience. Recommendations for clinical practice highlight the importance of services supporting women’s close relationships, and offering systemic interventions for families. The empirical paper aimed to explore midwives’ perspectives and perceptions concerning psychotic-like experiences (PLEs) in the perinatal period. Thematic analysis was used to analyse data from semi-structured interviews with 10 midwives. 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. The results emphasise the importance of systemic safety for midwives, alongside training and guidance for midwives to support them in supporting women with PLEs. The critical appraisal summarises the research findings and discusses strengths, limitations and methodological decisions alongside the author’s personal reflections on the work.

**Declaration**

This thesis comprises of research submitted in March 2023 as a partial fulfilment of the requirements for the Doctorate in Clinical Psychology Programme at the Division of Health Research, Lancaster University. The work presented is my own, except where due reference is made. This work has not been submitted elsewhere for the award of any higher degree.

Name: Molly Turgoose

Date: 17th March 2023

**Acknowledgements**

Thank you to all the wonderful midwives who gave up their precious time to take part in this research. I was struck by your commitment to supporting women and your ability to continue to do this even within the trickiest of circumstances. Thank you to the Royal College of Midwives for their generous help with advertising my study and supporting the recruitment of participants. Thank you also to the midwives who reviewed the study materials and offered their valuable feedback.

Thank you to my supervisors, Craig Murray, Bill Sellwood and Libby Chamberlain for all the support, guidance and expertise during this project. Thank you to Will Curvis for the encouragement, reassurance and compassion throughout the entirety of the doctorate and for continually helping me chip away at the imposter syndrome!

To my wonderful friends in the 2020 cohort, thank you for being there throughout all the highs and lows of this experience, for all the laughter (and tears!) and unwavering encouragement and compassion. I couldn’t have asked for better people to do this with.

Thank you to my family for all their support, especially Mum and Iz for the patience and understanding throughout everything that this thesis has brought, including the codes laid out on the floor for months on end!

Finally, thank you to Dom for your constant support, encouragement and understanding, for making me laugh throughout it all and for always having faith that I could do this, even when I didn’t believe it – it turns out you were right!

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# Systematic Literature Review

Couples' experiences of their relationship with each other and their baby in the context of postpartum psychosis

Word count (excluding references, tables and appendices): 8000

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Declarations of interest: none

Prepared for submission to *Archives of Women’s Mental Health*

See Appendix 1-A for submission guidelines

### Abstract

**Purpose:** This review aimed to synthesise qualitative findings relating to mothers’ and their partners’ experiences of their relationship with each other and their baby within postpartum psychosis (PP). PP appears to have the capacity to affect relationships considerably, therefore this review was important due to the possible implications for women, partners, and babies.

**Methods:** A systematic search of four databases (PsycINFO, Medline, CINAHL, Web of Science) was undertaken in June 2022 and updated in March 2023. The results of 17 papers published between 2003 and 2022 were synthesised using Thomas and Harden’s (2008) thematic synthesis.

**Results:** Four themes were generated: (1) The process of learning to adapt together; (2) Navigating the impact of the uncontrollable experience on our relationships; (3) This experience can strengthen or strain relationships; and (4) The journey through PP is a relational experience.

**Conclusions:** The results offer an in-depth understanding of the varied ways that PP can impact relationships and the interpersonal processes that occur during PP. Clinical implications emphasise the importance of supporting relationships and offering systemic intervention for PP that considers the needs of women, partners, and babies.

*Keywords:* postpartum psychosis; relationships; parent-infant relationship, thematic synthesis

## Introduction

Of every 1000 women[[1]](#footnote-1) who give birth, approximately one to two receive a diagnosis of postpartum, or puerperal, psychosis (PP) (Vanderkruik et al., 2017). PP often includes sensory experiences (e.g., seeing, smelling, hearing or feeling things) that others do not experience (hallucinations) or strong beliefs that others perceive as unusual (delusions) (NHS, 2020). Women with PP may also feel suspicious towards others, experience unusual thoughts or behave in ways that are unusual for them (Kamperman et al., 2017).

PP is often described as an experience that can emerge quickly and unexpectedly (NHS, 2020). Without support, consequences can be severe for both women and babies, including suicide and infanticide (Brockington, 2017). With support, a considerable decrease in women’s distress can be seen relatively quickly (Burgerhout et al., 2017). However, the experience of PP, which can be frightening and unexpected for women and families (Twomey, 2009), may have longer lasting effects on women’s relationships.

Symptoms of PP are more likely to occur within the first two weeks after birth (NHS, 2020) and therefore may be identified by professionals in contact with mums during this period, including midwives and health visitors. Service provision to support mothers and families with PP is likely to involve referral to Specialist Community Mental Health Services and Mother and Baby Units if necessary. Currently, these services focus predominantly on the mental health needs of mothers, and the relationship between mum and baby. Recent guidelines (Darwin et al., 2021) indicate the need for increased involvement of partners and family members within these services. However, in order to ensure that services can provide appropriate and relevant family interventions, it is important to have a better understanding of how perinatal mental health difficulties like PP impact interpersonal relationships.

Broader postnatal mental health difficulties have been linked to changes in romantic relationships. Delicate et al’s (2018) qualitative review reported couples’ experiences of both negative and positive changes within their relationships after birth trauma. Quantitative findings relating specifically to PP also demonstrate adverse effects on couples’ relationships, with relationship breakdown occurring in almost one in five couples after PP (Blackmore et al., 2013). PP also has the potential to negatively impact maternal sensitivity and mother-infant bonding (Gilden et al., 2020; Rigby et al., 2016), which could have important implications for child development (Winston & Chicot, 2016). The potential negative impact of PP on parental relationships reported by Blackmore et al. (2013) may indirectly negatively impact their child, as Harold and Sellers (2018) indicate that parental conflict can contribute to emotional wellbeing difficulties and interpersonal difficulties.

To date, most research has focused on women’s experiences of how postnatal distress impacts their relationships. However qualitative research exploring partners’ experiences also highlights their perception of the negative impact of postnatal distress on their relationship and the varied impacts on their relationship with their baby (Atkinson et al., 2021). The interaction between mothers’ and partners’ emotional wellbeing is also frequently reported, with some studies demonstrating a relationship between maternal and paternal postnatal depression (Paulson & Bazemore, 2010; Thiel et al., 2020). Iles et al., (2011) report that couple’s perceptions of lower postpartum support from their partner was significantly associated with symptoms of posttraumatic stress and depression for both women and men. Don and Mickelson’s (2012) supporting finding indicates that the association between paternal and maternal postnatal depression was related to couple’s perceived partner support and relationship satisfaction. This, therefore, demonstrates the role of relationships within postnatal distress for both women and men.

Further research also supports a role for relationships within the experience of postnatal distress. Couples report perceptions that male partners have a role in monitoring women’s postpartum mood (Pilkington et al., 2016) and women express preference for emotional support from partners, rather than services, during this period (Rowe et al., 2013). Partners’ responses to distress may also impact women’s support-seeking (Letourneau et al., 2007) which may further impact emotional wellbeing.

Therefore, considering the role of relationships within postnatal distress, the exploration of the couple’s relationship with each other and their baby within PP is important, particularly as relational support appears important for maternal mental wellbeing (Balaji et al., 2007). These relationships may be important within recovery from PP, as positive family relationships are cited as an influential aspect of recovery from first episode psychosis (Hansen et al., 2020). Although earlier models of PP are predominantly biological (Boyce & Barriball, 2010), more recent research has highlighted the role of psychosocial factors in PP (Hazelgrove et al., 2021), indicating that relationships may be important to consider within PP interventions.

In the UK, National Institute for Health and Care Excellence (NICE, 2014) guidelines acknowledge the relational impact of postpartum distress and Action for Postpartum Psychosis (APP, 2014) highlight the potential impact of PP on relationships. It is therefore important to develop a better understanding of how couple and parent-infant relationships impact, and are impacted by, PP in order to inform appropriate support for the wellbeing of mothers, partners and babies.

The emphasis of qualitative research on exploring individuals’ first-hand experiences and perspectives facilitates a deeper understanding of phenomena. An increasing body of qualitative research has explored how women and partners experience close relationships during PP (Wass et al., 2022; Wyatt et al., 2015). However, qualitative studies exploring the broader experience of PP also include data around relationships and therefore could contribute important findings regarding this. The current thematic synthesis (Thomas & Harden, 2008), therefore, synthesises these findings and aims to strengthen the evidence base. Previous reviews have explored the experience of recovery from PP from women’s and family members’ perspectives (Forde et al., 2020). However, to date no reviews have specifically addressed the aim of this review which was to synthesise data relating to women’s and partners’ experiences of the couple and parent-infant relationship within PP and the impact of PP on these relationships. The synthesis of qualitative findings can offer an in-depth understanding of experiences, consequently providing beneficial findings with the potential to inform perinatal mental health (PMH) evidence-based practice and policy (Mays et al., 2005; Stevens, 2001). Therefore, the review findings will inform recommendations for services regarding relational support for couple and parent-infant relationships in families who are experiencing, or have experienced, PP.

## Method

The reporting of this review has followed guidance within the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) (Tong et al., 2012) and Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021).

**Search strategy**

Scoping searches by the author found limited research specifically exploring couples’ experiences of their relationships with each other and their baby within PP. The search strategy, therefore, intended to capture papers exploring the qualitative experience of PP from mothers’ or partners’ perspectives. These papers were screened to determine whether they contained ‘sufficient’ data on relationships. This was defined as at least two relevant direct participant quotes and author interpretations, which was sufficient to provide rich data and significant enough not to omit.

The search strategy was defined using the qualitative PICo concept (Population, Interest, Context) (Joanna Briggs Institute, 2014) which supports the identification of search terms to address the main concepts of a research question (Methley et al., 2014). A systematic search of four electronic databases was completed in June 2022 using the search terms (Appendix 1-B) and updated in March 2023. These terms were devised through consultation of previous similar reviews and discussion with the research team. The terms were refined over multiple searches from January 2022 – June 2022. PsycINFO (1920-2022)[[2]](#footnote-2), Medline (1963-2022), Web of Science (1983-2022) and CINAHL (1990-2022) were searched to capture literature from the full range of relevant disciplines. The search strategy was discussed with a specialist university librarian who offered guidance, e.g., to include ‘psychotic N4 disorder’ to capture papers using ‘disorder’. One further included paper published in July 2022 was identified through database search alerts.

**Inclusion criteria**

Studies meeting the following criteria were included: (1) available in English, (2) published within a peer reviewed journal (3) qualitative studies including first-hand accounts from the mother’s and/or partner’s perspective concerning the experience of relationships with their partner or baby during or after PP, (4) included analysis of participant data, (5) included ‘sufficient’ data relating to the experience of relationships (at least two direct participant quotes and author interpretations).

Studies were excluded if: (1) they explored experiences across several PMH difficulties and PP was indistinguishable, (2) partner perspectives were indistinguishable from other significant others.

**Search results**

The search results produced 1289 novel papers which were screened according to PRISMA guidance (Page et al., 2021). Paper titles and abstracts were screened by the main researcher against the inclusion criteria using online software (Rayyan, https://www.rayyan.ai/). If inclusion could not be determined from the title or abstract, full text versions were reviewed. Consequently, full text versions of 60 papers were sought for retrieval. One paper could not be retrieved and the author could not be contacted. Therefore, full text versions of 59 papers were reviewed in relation to inclusion criteria, and 17 papers were included in the review. No further papers were identified through forward and backward citation searching or web searching. This process and resulting outcomes are illustrated in Figure 1.

(INSERT FIGURE 1 HERE)

**Quality appraisal**

The Critical Appraisal Skills Programme tool (CASP, 2018) was used to assess study quality. This is commonly used within health and social care qualitative research (Hannes & Macaitis, 2012). The tool consists of ten questions intended to support the researcher’s quality appraisal. Two questions are eligibility screening items, after which eight items are used to determine quality. These items cover a range of research aspects including design, data collection and analysis. A three-point rating system (Duggleby et al., 2010) was used to rate the studies using the CASP, giving a maximum quality score of 24. Within this three-point system, three represented strong justification or explanation of an area, two represented moderate justification or explanation and one represented weak justification or explanation.

All studies met the screening criterion relating to stating research aims and appropriate choice of qualitative methodology. The scores given for the remainder of CASP items are summarised in Table 1, ranging from 14 to 20. Some domains varied considerably between papers, e.g., research design scores differed widely due to differences in the detail of justification for study design. Other domains, such as reflexivity and ethical issues, were consistently scored as moderate or weak due to lacking detail.

A subset of papers (n = 5) were peer rated to ensure inter-rater reliability. There was a high level of agreement between ratings (90%), and ratings that differed were discussed. Collaborative agreements were reached on all scores through discussion of score rationale. Studies were not excluded based on their CASP scores as, currently, little evidence demonstrates how the quality of study reporting relates to the study’s robustness (Dixon-Woods et al., 2007). However, the quality ratings were considered within the review to ensure that themes did not rest solely on studies rated as poorer quality.

**Analysis**

Some included studies undertook a predominantly descriptive approach to data analysis and reporting, therefore Thomas and Harden’s (2008) thematic synthesis approach was deemed appropriate for analysis as Booth et al., (2016) describe the use of this with descriptive, ‘thin’ studies. Thematic synthesis involves synthesising data from qualitative papers through coding primary data and grouping codes to develop descriptive themes. This approach then aims to develop analytical themes that ‘go beyond’ the content of the initial papers (Thomas & Harden, 2008). This was chosen rather than meta-ethnography, which is better suited to synthesising studies with conceptually ‘thick’ data (Sattar et al., 2021).

In accordance with Thomas and Harden’s (2008) approach, all text under the ‘results’ or ‘findings’ section of each paper was considered as data, and data relating to relationships were extracted. Additionally, new author interpretations in the ‘discussion’ section were considered as data. Extracted data were uploaded into NVivo for analysis. The data were analysed using line-by-line coding by the main researcher, and initial codes were identified alongside the relevant line of data.

Codes were reviewed, and codes that indicated similar concepts were grouped (Appendix 1-C). Inductive descriptive themes were developed through naming and defining these groups. These descriptive themes were then reviewed and interpreted with reference to the research question to develop ‘analytic’ themes, which went beyond the original data to generate further understandings and address the review aims (Appendix 1-D). These themes were discussed with the research team and subsequently refined.

## Results

**Study characteristics**

The characteristics of the 17 included papers are displayed in Table 2 and Table 3. Papers represented perspectives from varying countries, including the United Kingdom (n = 12), United States (n = 3) and Sweden (n = 2). Two included papers used the same sample at different time points with two different research questions (Engqvist et al., 2013; Engqvist et al., 2014). Two studies focused solely on male partners’ experiences, nine focused solely on mothers’ experiences and six explored the experiences of both. 16 studies collected data through semi-structured interviews, and one utilised internet narratives. Analysis methods used included thematic analysis (n = 5), interpretative phenomenological analysis (IPA) (n = 4), grounded theory (n = 4), content analysis (n = 3) and structural analysis (n = 1).

**Themes**

Four themes were generated: (1) The process of learning to adapt together; (2) Navigating the impact of the uncontrollable experience on our relationships; (3) This experience can strengthen or strain relationships; (4) The journey through PP is a relational experience. Each of these is presented below.

**Theme 1: The process of learning to adapt together**

Women and partners within 16 studies (Appendix 1-E) indicated a process of adaptation within their relationships during PP which was impacted by relational changes and disruptions. Couples described considerable changes in their relationship dynamics and roles which required collaborative adjustment in order to maintain their relationship.

Male partners described a role change within their relationship which, for some, involved moving into a ‘carer’ role: ‘…you sort of end up being a carer, full time…’ (Wass et al., 2022, p. 10, partner) or a professional role: ‘I needed advice on how to handle the illness […] information on the early signs of relapse to watch for and if it was to the point that I needed to get help.’ (Doucet et al., 2012, p. 241, partner).

For both mothers and partners, there was a shared sense of adjusting to something that felt ‘abnormal’ and contributed to the mother being unrecognisable: ‘…this was a person I really didn’t recognize.’ (Enqgvist & Nilsson, 2013, p. 85, mother). Due to these changes, many partners described having to adapt their interactions with mothers: ‘[…] I just talked about very simple topics. The conversations were not complex’ (Wass et al., 2022, p. 8, partner).

Women also experienced their partner’s role change: ‘he did a lot of interpreting to medical staff about my needs and what I was meaning, being an advocate really’ (Wass et al., 2022, p. 9, mother) and recognised the importance of their partners adapting into this role: ‘[…] I was going in and I was really chatty with them and I seemed as if I was coping with everything […] But my husband was like, that's not who she is, she's not that type of person.’ (Stockley, 2018, p. 154, mother). However, changes in couples’ intimacy were also noted: ‘it’s probably affected our sex life […] it took a while when I came home from hospital to have a normal relationship again in that way’ (Wyatt et al., 2014, p. 431, mother).

Women discussed adaptation within the mother-infant relationship due to the experience of PP: ‘I needed somebody with me at all times to be told what I had to do to take care of myself and my child […] I couldn’t trust my own judgment.’ (Doucet et al., p. 239, mother). Partners also noted the disruption in their adaptation to their lives as a family, which meant adjusting to a different start to their babies’ lives than they expected (Boddy et al., 2017) and feeling that they ‘missed out’ (Wyatt et al., 2014, p. 435, partner). For some, this was experienced as concurrent loss and gain: ‘Essentially, I had gained a child on one day and lost my partner on the next day.’ (Holford et al., 2018, p. 4, partner). This process of adaptation involved the integration of competing demands and changing priorities within relationships. Women described how adapting to their lives with their baby changed their romantic relationship: ‘it’s as if I didn’t have enough love to go round and so I gave it all to my son.’ (Robertson & Lyons, 2003, p. 421, mother).

Partners discussed having to take on a greater childcaring role than anticipated and adapting to their relationship with their baby: ‘…I’m literally the one left holding the baby and obviously, I was expecting her to do everything’ (Wyatt et al., 2014, p. 432, partner) which could put pressure on partners: ‘like he had to basically be in jail.’ (Posmontier & Fisher, 2014, p. 174, mother). Mothers echoed the adaptation to changes in expected parenting roles: ‘that traditional role that you think of as the woman’s, being the one that leads […] it just wasn’t how it was […]’ (Wass et al., 2022, p. 10, mother).

Loss was frequently articulated within descriptions of adaptation. Women described a loss of the normality in relationships, and male partners described a loss of their partner: ‘you couldn’t have a normal conversation…it was hard’ (Wyatt et al., 2014, p. 431, partner) and a loss of time with their baby: ‘you’ve got two weeks off from work, […] and suddenly that two weeks is gone. Because you’re in hospital. And then you…need to go back to work but we haven’t had time to bond...’ (Boddy et al., 2017, p. 405, partner). This adaptation to the loss of the anticipated parenting experience was also described by women: ‘I get upset particularly when I see women with their newborns outside, I get quite bitter about the fact that I couldn’t do that...’ (Robertson & Lyons, 2003, p. 420, mother).

Couples also described that adapting to physical separation from each other and their baby involved difficult emotions for mothers: ‘…it made me worse in retrospect being separated’ (Plunkett et al., p. 1104, mother) and partners: ‘…that sort of closeness is ripped apart...I felt I had lost not only my wife but my little one, he was in the MBU.’ (Holford et al., 2018, p. 4, partner).

In conclusion, there was a pervasive sense of relational adaptation and adjustment that was described by mothers and partners. This involved adapting to changes in relationship roles and dynamics, alongside adjustment to loss experienced during PP. This process of adapting throughout PP and integrating their baby into their relationship demonstrated an important aspect of couples living through the experience together.

**Theme 2: Navigating the impact of the uncontrollable experience on our relationships**

This theme, reflected in 16 papers (Appendix 1-E), captures the lack of control within the experience of PP, particularly concerning the uncontrollable impact on couples’ relationships.

For partners, the fear and confusion caused by seeing the mother in an uncontrollable and unknown situation caused distress: ‘I kept thinking, when is she going to snap out of it? Why is this happening?’ (Doucet et al., 2011, p. 241, partner). This experience coming ‘out of the blue’ (Wass et al., 2022, p. 6, partner) caused an unexpected disruption to couples’ relationships. One partner described this sudden impact on their relationship: ‘during it all there was no husband and wife relationship, which we had been having you know a week or so before [infant] was born.’ (Holford et al., 2018, p. 4, partner).

This uncontrollable impact on their relationship increased fear for some couples, due to the perceived unpredictability of the situation: ‘Fear of relapse and fear of me not sleeping, or having another dip ... the ups and downs were just hideous for him... And also... […] you know the fear for him of, ‘what is she going to do next’.’ (Heron et al., 2012, p. 162, mother). For some participants, the responses resulting from their lack of knowledge and control over the situation contributed to relationship difficulties: ‘He couldn’t understand at times why I just couldn’t pull myself together which annoyed me even more and there was always a cloud hanging over our relationship.’ (Robertson & Lyons, 2003, p. 421, mother). For others, this resulted in powerlessness within the relationship: ‘I felt a bit like... there’s nothing I can do for her, all I can do is go and visit for my own benefit not for hers.’ (Boddy et al., 2017, p. 404, partner).

For women, there also appeared to be an impact on their relationship with their baby caused by uncontrollable difficult thoughts and feelings about their baby: ‘Then I thought, ‘Well, I’ll kill them.’ I would give them something to eat so they would die, or I might strangle them. […] It sounds crazy now and of course it was.’ (Enqgvist et al., 2013, p. 86, mother).

Women and partners both described varying ways of coping with this uncontrollable impact on their relationship. For some partners, this involved increased protectiveness over their baby, due to uncertainty about women’s caregiving abilities: ‘I found it hard to walk that balance, showing her how to do things, making sure that she did them properly so my son didn’t get harmed’ (Wass et al., p. 10, partner). Women also spoke about seeking control in the relationship with their baby in order to protect them: ‘…although I knew my husband and the staff were very competent to take over I was protective of the baby and resented their involvement’ (Enqgvist et al., 2011, p. 380, mother). This appeared to be exacerbated by the perceived unpredictable impact of PP on the mother-infant relationship: ‘I was fearful, I was afraid of becoming psychotic and I was afraid that I would harm my baby.’ (Enqgvist et al., 2011, p. 380, mother).

Within this concept of PP having an uncontrollable impact on relationships, there was a pervasive sense of guilt for couples that they could not control this or prevent the impact on their family. Mothers reported blaming themselves as they perceived having let their baby down: ‘…it felt like I’d failed I suppose. I probably felt a bit guilty.’ (McGrath et al., 2013, p. 5, mother) and felt they caused emotional distress for their partner (Heron et al., 2012; Robertson & Lyons, 2003). Within this, aspects that were out of women’s control contributed to concerns about harm for baby: ‘I was actually given a leaflet on the emotional damage that you can inflict on your child by not breastfeeding […] I just kept thinking, what am I going to do?’ (Stockley, 2018, p. 156, mother).

Partners experienced guilt for not being able to prevent PP: ‘I suppose just feeling negative... that I let [the mother] down…’ (Holford et al., 2018, p. 6, partner), and for not physically being with their partner and baby: ‘...I probably felt if anything guilty that I wasn’t there in the Unit’ (Holford et al., p. 6, partner). For some this led to a search for controllable reasons for PP: ‘My hope is that, [difficult birth] caused it, because it’s something that... [is] not going to happen every day. […]’ (Boddy et al., 2017, p. 403, partner).

Both women and partners described guilt around the possible impact of PP for their baby, including a loss of future siblings: ‘she might never have a brother or sister... I’ve got a brother and he’s my best mate... My child won’t have that and I feel guilty about that, for her.’ (Boddy et al., 2017, p. 405, partner), and worry about their development: ‘I really, really worried about the impact on [my baby] because I’d read about mums who have mental health problems affecting their kids…’ (Heron et al, 2012, p. 158, mother).

In summary, women and partners experienced PP as an uncontrollable experience which impacted their relationships and led to a drive to increase control over this. Their accounts indicate the difficulty that couples experience when trying to navigate this uncontrollable event, and the relational guilt and self-blame that can consequently arise.

**Theme 3: This experience can strengthen or strain relationships**

Across all 17 studies, PP was described as having the potential to have a polarised impact on a couple’s relationship with each other and their baby. This was described as either strengthening relationships or causing relationship strain.

Both women and partners articulated this sense of strain. Partners communicated experiencing the mother as a different person: ‘It was somebody else in her body I suppose…’ (Boddy et al., 2017, p. 405, partner) which could become overwhelming: ‘…you have to snap out of things, and if you don’t I’m out of here because I can’t cope with this’ (Holford et al., 2018, p. 5, partner).

For some women, their detachment from reality disrupted relationships, with partners: ‘When my husband left me I soon forgot his appearance.’ (Engqvist et al., 2011, p. 382, mother) and babies: ‘He was not my child. […] I thought, ‘Who is this strange person?’’ (Engqvist et al., 2013, p. 85, mother). Unusual thoughts also exacerbated relationship difficulties: ‘…I thought the baby was the devil and by feeding her she was sucking my life blood away.’ (Glover et al., 2014, p. 260, mother).

Some mums reported having to re-prioritise during PP, meaning that the couple’s relationship received less attention: ‘…my focus was on looking after [daughter], but I wasn’t actually taking much notice that my relationship was sort of drifting apart..’ (Robertson & Lyons, 2003, p. 421, mother). Conversely, other mums felt that their baby was not prioritised: ‘My interest maybe in her [was lessening]. I was just so busy with myself worrying about this and that.’ (Posmontier & Fisher, 2014, p. 172, mother).

For both women and partners, distrust resulting from PP created further relationship difficulties. PP symptoms could create distrust: ‘…I told [my husband] ‘Why are you disconnecting the phone? You don’t want me to speak to anyone?’’ (Posmontier & Fisher, 2014, p. 173, mother). However, for others, interactions during the experience created longer-term distrust: ‘I’ll never forgive him, a little part of me will always remember and think you weren’t there for me the way he should have been’ (Wass et al., 2022, p. 11, mother).

Partners expressed less strain in their relationship with their baby, however their prioritisation of baby’s safety fostered distrust towards their partner: ‘She picked up the baby in quite a…I wouldn’t say aggressive manner, but not in a soft manner […] At that point I took her off her and I felt a little bit uneasy to...leave the baby alone.’ (Boddy et al., 2017, p. 404, partner). This distrust required a long process of repair: ‘They don’t trust you because you have done all these strange things and you don’t trust them because you think they will take you back to hospital. It’s taken many, many, many months to solve.’ (Heron et al., 2012, p. 162, mother). Additionally, partners expressed discomfort with their partner’s feelings towards their baby: ‘I would never have thought that a mother could be so rejecting, insensitive, angry, and irritable towards her child…’ (Enqgvist et al., 2013, p. 86, partner).

Conversely, many couples described that the experience of PP contributed to the long-term strengthening of their relationships. For partners, their parent-infant bond was strengthened through the experience (Holford et al., 2018), and mothers experienced increased gratitude for their child (Forde et al., 2019). For some mothers, PP resulted in subsequent increased effort with their baby: ‘he was spoilt in some respects because I felt guilty about missing out on the first four or five months of his life…’ (Plunkett et al., 2017, p. 422, mother).

Some couples acknowledged a re-appreciation for their partner: ‘I think I’ve got a lot more respect for Dan […] I think he’s...a really strong person which maybe I didn’t appreciate enough before.’ (Wyatt et al., 2014, p. 434, mother). This allowed a renewed focus on positive aspects of their lives: ‘…I look at life a lot differently now. […] I value what my husband’s done for me.’ (Robertson & Lyons, 2003, p. 422, mother). Others described positive changes in their interactions: ‘I think we talk more about feelings and emotions’ (Wass et al., p. 9, mother) and increased understanding: ‘I think I am far more aware of how […] I perceive [the mother] to be feeling’ (Holford et al., 2018, partner).

There was a sense that having experienced PP as a united team strengthened the relationship: ‘We’ve lived through something and dealt with it as a couple, that a lot of people maybe haven’t or couldn’t so […] it has, a small, you know positive in it’ (Forde et al., p. 9, partner). Couples also described a reciprocal increase in empathy: ‘we are both very supportive of each other in life...when one seems exhausted and drained then we give each other a break, but then we kind of more sympathetic than before.’ (Holford et al., 2018, p. 7, partner).

Couples described aspects that supported their relationship with each other and their baby. This included support from Mother and Baby Units (MBU): ‘so they [MBU staff] spoke to him about how he was […] that meant a lot […] it stops me worrying’ (Forde et al., 2019, p. 8, mother) and understanding their partner’s perspective: ‘…to get some insight into what my family and what my partner would have been going through...I think it certainly made me have more empathy...’ (Roberts et al., 2018, p. 80, mother).

In summary, women and partners described the drastic relational impacts that PP can have, resulting in strengthening or strain within relationships. This was also highlighted within the mother-infant relationship, whereas partners described the indirect effect of changes in their romantic relationship for the parent-infant relationship.

**Theme 4: The journey through PP is a relational experience**

Both mothers and partners described that the experience of PP was not an individual journey, but instead was reliant on relational processes and factors. For some couples, this was described as a journey to recovery, however for others this was described simply as managing the experience. This theme was expressed within 12 papers (Appendix 1-E).

For women, the couple relationship was viewed as a protective factor that supported their ability to manage the experience of PP. Mothers discussed their partner as a source of support and safety (Doucet at al., 2012; Engqvist et al., 2011; Engqvist et al., 2014; Posmontier & Fisher, 2014; Wass et al., 2022; Wyatt et al., 2015). This was articulated through descriptions of emotional support: ‘...Rich has always known the kind of things to do to make me feel better’ (Wyatt et al., 2015, p. 436, mother) as well as physical support: ‘I’d want him to hold me, hold my hand […]’ (Wass et al., 2022, p. 12, mother).

Partners also reflected this relational support, however this was articulated through their perceived roles to support mothers: ‘my role was to act as a rock, to know that I was always going to be there if she needed someone to talk to, or someone to help’ (Wass et al., 2022, p. 9, partner). Partners also communicated a protective element of physically being with the mother and baby which facilitated relational recovery: ‘And it was the first time we felt good. We had time together, to just be. And it was very nice…’ (Engqvist et al., 2014, p. 12, partner).

Alongside the partner relationship, women described their relationship with their babies as an influential aspect of living through PP. The parent-infant relationship was described, by some, as a constant positive throughout PP: ‘throughout the experience I always felt strongly bonded to my baby and never had any negative feelings towards him’ (Engqvist et al., 2011, p. 381, mother) and as a motivator for recovery: ‘he was definitely […] he was the reason I wanted to get better…’ (Plunkett et al., 2017, p. 1102, mother).

Fathers also spoke about their positive appraisals of their relationship with their baby throughout the experience of PP: ‘He just started laughing at me…At the time it can be stressful but…it makes you laugh…I love being father.’ (Boddy et al., 2017, p. 405, partner). Partners also reported their perspective of the importance of the mother-baby relationship and discussed their role in facilitating that: ‘I brought our son in and you could see her go ahhhhhhhhhhh (breathing out). It was tangible that change in her…’ (Wass et al., 2022, p. 12, partner).

Couples described a united approach to the experience of PP which was reflected by some partners through collective descriptions: ‘...we thought something was wrong but we didn’t know what.’ (Holford et al., 2017, p. 5, partner). For partners, their inclusion in this experience was important: ‘[On acute psychiatric unit] They wouldn’t really give me any information. They wouldn’t talk to me […] [On MBU], totally different story. Everybody knew what was going on.’ (Boddy et al., 2017, p. 403, partner). In addition to helping their partner through, some partners also noted how the experience of PP impacted them: ‘I think I’m better, it was having to re-learn how to live my own life once she got better’ (Wass et al., 2022, p. 8, partner), further indicating the relational nature of PP.

Pre-existing positive relationship characteristics supported couples within their experience of PP. For mothers, this was reflected through unwavering trust in their partner: ‘I telephoned my husband as the only person I felt I could trust’ (Engqvist et al., 2011, p. 382, mother), perception of the couple relationship as a crucial supportive relationship: ‘support of my family helped more than anything. My husband was fantastic’ (Heron et al., 2012, p. 161, mother) and a secure sense of partner support: ‘[to partner] you would love me through anything’ (Wyatt et al., 2015, p. 431, mother). Other couples described a conscious effort to sustain their relational patterns throughout the experience: ‘The way we communicated very much remained the same, that didn’t change, even when she was really unwell…’ (Wass et al., 2022, p. 8, partner).

For some couples, this relational journey through PP was described as difficult at times: ‘One of the things that was really bothering me, was when [partner] would say things like ‘are you feeling ok?’ […] or you know, just look at me, really concerned, […] I’d be like ‘oh gosh, am I not ok?’ (Forde et al., 2014, p. 11, mother). However, for others, this support from their partner was crucial: ‘…her husband reassured her by saying, ‘People go through things and, you know, David HaMelech (King David) had these kinds of tests and trials.’’ (Postmontier & Fisher, 2014, p. 173, mother).

In summary, couples described that their journey through the experience of PP was heavily influenced by their relationship with each other and their baby. For mothers, relationships were a source of support and motivation, and for partners there was a prioritisation of relationships and a focus on being united with the mother and baby. This appeared to have a considerable impact on how PP was experienced, with relationships cited as a factor for improving the experience.

## Discussion

This review aimed to achieve an in-depth exploration of women’s and partners’ experiences of their relationship with each other and their baby within the context of PP. 17 papers were synthesised, which utilised a varying range of methodologies and approaches including IPA, thematic analysis, grounded theory and content analysis. The papers ultimately highlighted the profound impact of the experience of PP for families and illustrated the considerable relational changes this can create. The resulting themes indicated that relationships impact the experience of PP and are also impacted by PP in contrasting ways. These findings provide an in-depth conceptualisation of the processes that occur within relationships during PP, and how relationships impact the experience of PP.

The results highlighted changes in relationship dynamics, consistent with wider research reporting partners’ experiences of rejection and hostility from women experiencing postnatal distress (Lever Taylor et al., 2019) and mothers’ experiences of relational changes during postnatal distress (Enlander et al., 2022). The current review offers a deeper insight into these changes within PP, including the contributing factors to this, therefore providing a valuable basis to inform couple interventions. Other research has described new parents’ prioritisation of a ‘parenting role’ over their role as a partner (Lévesque et al., 2020), however the current findings suggest an additional introduction of ‘carer’ and ‘cared for’ roles during PP. Therefore, couples may benefit from support with regaining their identity and ‘normality’ within the relationship. Having a baby is often a significant period of change for new parents (Leonhardt et al., 2022), however these findings offer a novel insight into the additional adjustment required for couples impacted by PP.

Additionally, the review findings illustrate how the process of adaptation and adjustment within PP can disrupt parent-infant relationships. For some couples, this was impacted by physical separation from their baby, supporting other research (Marrs et al., 2014), however the review also identifies the stressful process of adapting to the parent-infant relationship within the context of PP. Interestingly, this appeared to be influenced by the perception that PP caused a deviation from the perceived western societally ‘expected’ roles of mothers and fathers (Katz-Wise et al., 2010). Deviation from these societal expectations and narratives have been reported to play a role in postnatal distress for couples (Hambidge et al., 2021; Law et al., 2021), however the review offers a novel finding of the role of this within PP.

Both mothers and partners highlighted the relational impact of the uncontrollable nature of PP. Many participants described powerlessness and confusion, a common theme within postnatal distress (Atkinson et al., 2021) however this appeared to be particularly prevalent in PP due to the sudden onset of symptoms (Heron et al., 2008). The review indicated the particular impact of the ‘fear of the unknown’ for relationships, indicating that prior knowledge of PP may reduce relational difficulties. The findings, therefore, offer an important rationale for providing couples with prior information about PP, which may help to reduce the consequent sense of unknown and threat.

Feelings of guilt and inadequacy created additional pressure within relationships, which appears to be widely experienced within perinatal distress (Coates et al., 2014; Law et al., 2021). Perinatal distress can also contribute to increased protectiveness over baby and parental guilt about the impact for their baby (Johansson et al., 2020; Ruffell et al., 2019). The review indicated that, within PP, this protectiveness and guilt was particularly prevalent due to the perception of the baby being introduced into an uncontrollable, unknown situation. Considered in relation to compassion-focused theory (Gilbert, 2014), these feelings of guilt and inadequacy for couples may activate the internal threat system and disrupt the soothe system which can disrupt attuned relationships (Cree, 2010; Gilbert, 2009), indicating the importance of supporting couples with this.

The review findings indicate the significant impact of PP on a couple’s relationship, which was conceptualised as ‘strengthen or strain’. Individual studies have demonstrated varying impacts of PP for relationships, however this review offers a richer understanding of what may contribute to the ‘strengthening or ‘straining’ of relationships. This polarised impact of postnatal distress on relationships has also been reported within birth trauma (Delicate et al., 2018) and postnatal depression (Blanchard et al., 2009). Supporting research indicates that postnatal distress can create new strains in relationships (Johansson et al., 2020) with wider research highlighting that psychosis can increase distrust within relationships (Redmond et al., 2010). The current review highlights that distrust between couples after PP may contribute to long-term relationship difficulties, indicating the potential value of relational interventions for couples after PP focused on rebuilding trust and connection.

The current review supports the post-traumatic growth theory which refers to positive changes following highly distressing events (Tedeschi & Calhoun, 2004) which can positively impact relationships (Henson et al., 2021). The review findings indicate that aspects of the PP experience allowed growth and appreciation within relationships, which consequently supported them. This indicates a novel finding relating to the reciprocal role of supportive relationships within PP, of both promoting post-traumatic growth and being strengthened by this. External factors, such as MBU support, supported the strengthening of relationships therefore reinforcing the importance of early identification and support for PP (Doucet et al., 2011).

Women and partners discussed how the experience of managing PP was influenced by their relationship with each other and their baby. The findings offer a comprehensive overview of how these relationships offer safety and comfort throughout PP. This extends previous research indicating the importance of partner support within postnatal distress for both women and baby’s wellbeing (Antoniou et al., 2021; Stapleton et al., 2012), and supports studies indicating women’s preference for informal partner support for perinatal distress rather than formal support (Fonseca & Canavarro, 2017). These findings may support suggestions in Mauthner’s (1994) relational theory which suggests that postnatal depression occurrence is impacted by disconnection in interpersonal relationships, which Enlander et al., (2022) supports within wider perinatal distress. The current review extends this theory through demonstrating that, in addition to interpersonal disconnection contributing to postnatal distress such as PP, relational connection can be fundamental within managing the experience of PP.

Previous research supports the review finding that the mother-infant relationship can support recovery from postnatal distress (Wright et al., 2018). Additionally, Ruffell et al., (2019) suggest that a positive father-baby relationship can distract from difficult emotions relating to their partner’s perinatal distress. Increased oxytocin levels are observed in parents during interactions with their baby which can facilitate parent-infant attachment (Scatliffe et al., 2019) and the soothe system (Cree et al., 2010). Considering this, the current review indicates that this parent-infant relationship may be a soothing and protective aspect of PP for parents, supporting the importance of facilitating new parent-infant relationships.

**Clinical implications**

Evidently, within PP, it is important that relationships are supported, consistent with the NHS Long Term Plan (NHS, 2019) which recommends that specialist PMH services include couple and parent-infant interventions. This may involve admitting mothers to local MBUs where possible (NHS, 2016a), and supporting the maintenance of the father-infant relationship, particularly as fathers report difficulties with this when their baby is in an MBU (Marrs et al., 2014).

The findings demonstrate the impact of PP for parent-infant relationships, alongside the importance of ongoing support for parent-infant relationships within PMH services (NHS, 2019). Mothers and partners within the review described guilt relating to the impact of PP on their baby, therefore compassion-focused therapy approaches (Gilbert, 2014) may reduce the impact of maternal guilt and shame on mother-infant bonding (Cree, 2010). Despite the importance of the father-infant bond (Rempel et al., 2017), interventions focused on this relationship remain limited, however some evidence demonstrates the value of video-feedback interventions to support this relationship (Lawrence et al., 2013).

The findings indicate that considering the emotional needs of partners is important. NHS guidance indicates that partners should be offered emotional and parent-infant bonding support (NHS, 2016b; NHS, 2019). However, fathers continue to report a perceived lack of support during their partner’s perinatal distress, indicating a remaining gap in service provision (Mayers et al., 2020). Recently published guidelines may support the continued increase of perinatal relational support (Darwin et al., 2021).

Due to the potential impact of PP on relationships, and the subsequent impact for couples’ wellbeing, therapeutic intervention for PP should consider partners and relationship support. Relationship support involving systemic therapy principles is recommended in some services (O’Mahen & Healy, 2021), which can support couple communication and connection (Carr, 2009). Despite research into couples therapy and partner-inclusive interventions within postnatal depression and anxiety (Alves et al., 2018; Hunt, 2006), a lack of research explores this within PP. This may reflect the dominant biological understanding of PP (Davies, 2017) however the current review findings indicate a considerable need for relational support, particularly due to the potential impact of parental emotional wellbeing difficulties for children’s development and wellbeing (Kamis, 2021).

**Limitations and future research**

Although there was sufficient literature for this review, many primary papers did not focus solely on relationships and may have had a limited focus on collecting related data. Evidently, further qualitative exploration of the role of relationships within PP is important, particularly regarding their impact on the inherent experience of PP. Additionally, due to time and financial limits for this review, grey literature and non-English papers were excluded which may limit the results, therefore future research should explore this.

The primary review papers utilised a range of analysis methods, ranging from more descriptive methods (e.g., content analysis) to more interpretative methods (e.g., IPA). Although papers shared a similar phenomenological focus, the varying methodologies may reflect differences in the authors’ underlying individual positions, e.g., theoretical, philosophical, or social positions (Sandelowski et al., 1997). For example, authors utilising grounded theory are likely to focus on data which will facilitate the development of a theory, whereas authors using IPA are likely to place more emphasis on developing themes that focus on meaning-making and the unique experience of participants which may not be a core feature of other methodologies. Additionally, more interpretative papers may report thicker, more detailed descriptions of participants’ perspectives, which may have had a greater influence on the review themes. Consequently, it is important to acknowledge that the current synthesis is likely influenced by the inherent variations in emphases within different methodological approaches utilised in the synthesised papers.

Synthesised papers included those that explored partners’ or women’s perspectives or a combination of both. This allowed identification of parallels and differences within perspectives, alongside clinical recommendations for both women and partners. However, most papers focused on either women’s perspectives or a combination, with a minority focusing solely on partners’ experiences (Boddy et al., 2017; Holford et al., 2018). Findings from these studies indicated many similarities with women’s accounts, however the findings indicated some differences (e.g., increased childcaring role, monitoring partner) which future research should explore.

Finally, all studies were conducted in western countries with individualist cultures (Eckersley, 2006). Research in non-western countries with collectivist cultures may reveal differences within relationships during PP. However, although Kazim and Rafique (2021) noted some marital relationship differences between individualistic and collectivist cultures, they also highlighted several similarities. Therefore, although the review findings may be applicable to non-western cultures, further research would be valuable.

**Conclusion**

This review highlights the considerable role of the couple and parent-infant relationships within PP, alongside the profound impact of PP on these relationships. This emphasises the important role of relational support within therapeutic interventions for both women and partners which is likely to support the wellbeing and relationship of couples, along with infant development.

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## Figure 1

### *PRISMA Flowchart demonstrating the process of identification and screening of papers for the review*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Study Table 1*Critical Appraisal Skills Programme (CASP) ratings for included studies* | Research Design | Sampling | Data Collection | Reflexivity | Ethical Issues | Data Analysis | Findings | Value of Research | Total Score |
| Boddy et al (2017) | 2 | 2 | 3 | 2 | 2 | 2 | 2 | 2 | 17 |
| Doucet et al (2012) | 2 | 3 | 2 | 1 | 1 | 2 | 2 | 2 | 15 |
| Engqvist et al (2011) | 2 | 3 | 3 | 2 | 2 | 2 | 3 | 2 | 19 |
| Engqvist & Nilsson (2013) | 2 | 2 | 3 | 1 | 2 | 2 | 1 | 2 | 15 |
| Engqvist & Nilsson (2014) | 2 | 3 | 3 | 2 | 2 | 2 | 2 | 2 | 18 |
| Forde et al (2019) | 3 | 3 | 3 | 2 | 2 | 2 | 2 | 3 | 20 |
| Glover et al (2014) | 1 | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 14 |
| Heron et al (2012) | 1 | 2 | 2 | 2 | 2 | 2 | 2 | 1 | 14 |
| Holford et al (2018) | 3 | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 18 |
| McGrath et al (2013) | 3 | 2 | 2 | 2 | 2 | 2 | 3 | 2 | 18 |
| Plunkett et al (2017) | 3 | 2 | 2 | 1 | 2 | 2 | 2 | 3 | 17 |
| Posmontier & Fisher (2014) | 3 | 1 | 2 | 2 | 1 | 3 | 2 | 2 | 16 |
| Roberts et al (2018) | 1 | 2 | 2 | 2 | 1 | 2 | 3 | 2 | 15 |
| Robertson & Lyons (2003) | 2 | 3 | 3 | 1 | 1 | 2 | 2 | 2 | 16 |
| Stockley (2018) | 3 | 2 | 2 | 2 | 3 | 2 | 2 | 3 | 19 |
| Wass et al (2022) | 2 | 2 | 3 | 1 | 2 | 2 | 2 | 2 | 16 |
| Wyatt et al (2015) | 3 | 2 | 2 | 2 | 2 | 2 | 2 | 3 | 18 |

## Table 2

### *Characteristics of the studies included within the review*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Author (year)** | **Country** | **Study aims** | **Participants (number, age, sex, ethnicity)** | **Data collection/**  **analysis** |
| Boddy et al (2016) | UK | To explore fathers’ experiences during their partner’s MBU admission for first episode PP, focusing on their experiences of early fatherhood and relationships during this time. | 7 fathers aged 23-42, mean age 31.3 years. White British = 5, Black/African/Caribbean/Black British = 1, Mixed race = 1 | Semi-structured interviews / Interpretative Phenomenological Analysis |
| Doucet et al (2012) | Canada and United States | To explore the support needs, preferences, accessibility to resources, and barriers to support of women and their partners affected by PP. | 9 mothers (Canada, n = 7, United States, n = 2), mean age 34 years. White = 7, Other = 2. 8 male partners or ‘fathers’ (Canada, n = 7, United States, n = 1), mean age 36.25 years. White = 8 | Semi-structured interviews / Thematic Analysis |
| Engqvist et al (2011) | Conducted in United States, data source location unknown | To explore women's experience of postpartum psychosis described in narratives published on the Internet. | 10 internet narratives written by women, ages not specified. | Internet narratives / Content Analysis |
| Engqvist & Nilsson (2013) | Sweden | To explore descriptions of the first days of postpartum psychosis from different perspectives, namely that of the women and the next of kin. | 7 mothers, aged 39 to 60 years. 2 partners, 4 next of kin. | Semi-structured interviews/ Content Analysis |
| Engqvist & Nilsson (2014) | Sweden | To explore the recovery process of postpartum psychosis from the perspective of the women, the women’s partners and their next of kin, with regard to their experiences of the process at the conclusion of hospital care and after discharge. | 7 mothers, aged 44-62 years. 2 partners, aged 39-48 years. 4 next of kin, aged 59-72 years. | Semi-structured interviews/ Content Analysis |
| Forde et al (2019) | England and Wales | To explore and understand the psychological needs of women with postpartum psychosis, from the perspective of women and family members and to investigate their experiences and preferences for psychological intervention. | 13 women, aged 25-44 years. 8 family members aged 35 to 65+ years. All White British. | Semi-structured interviews / Thematic Analysis |
| Glover et al (2014) | England | To gain further insight into women’s individual experiences of PP and the context in which they make sense of it. | 7 women, aged 25-45 years. | Semi-structured interviews / Thematic Analysis |
| Heron et al (2012) | England | To explore women’s experiences of the process of recovery and their beliefs about the services needed to support recovery | 5 'service user researchers'. White British = 4, 1 = White European, ages not specified. | Semi-structured interviews / Grounded analytic induction approach |
| Holford et al (2018) | UK | To consider the lived experiences of partners of women who have had Postpartum Psychosis, and the impact that it has had on their lives and relationships. | 8 males, aged 30 to 49 years. | Semi-structured interviews / Interpretative Phenomenological Analysis |
| McGrath et al (2013) | England and Wales | To develop a theoretical understanding of recovery from psychosis following childbirth. | 12 women, aged 26 to 45 years, mean 35.6. All White British. | Semi-structured interviews / Grounded theory |
| Plunkett et al (2015) | England | To explore the role of the baby in recovery from postpartum psychosis. | 12 women, aged 23 to 56 years, mean 39.5. White British = 10, British mixed race = 1, Latin American = 1. | Semi-structured interviews / Thematic Analysis |
| Posmontier & Fisher (2014) | United States | To describe the experience of PPP in an Orthodox Jewish woman using a case-based narratology method. | 1 woman, age not specified | Semi-structured interviews / Structural analysis |
| Roberts et al (2018) | UK | To explore how the EastEnders postpartum psychosis storyline and the concomitant increase in public awareness were received by women who have recovered from the condition. | 9 women, aged 28 to 65 years. All White British. | Semi-structured interviews / Thematic Analysis |
| Robertson & Lyons (2003) | UK | To explore women’s experiences of puerperal psychosis and gain some understandings about living with that experience following the illness. | 10 women, aged 28 to 44 years, mean 34. | Semi-structured interviews / Grounded theory |
| Stockley (2018) | England and Wales | To examine women's experiences of postpartum psychosis during the onset and early days. Since the aim of the research is to examine women’s experiences, according to their own perspectives | 7 women, ages not specified | Semi-structured interviews / Interpretative Phenomenological Analysis |
| Wass et al (2022) | UK | To build on current literature using grounded theory to understand the impact of postpartum psychosis on the couple’s relationship, from the perspectives of both the woman and her partner. | 14 participants - 8 women, 6 men. 6 couples took part and an additional 2 women. Ages not specified. | Semi-structured interviews / Grounded theory |
| Wyatt et al (2015) | UK | To explore how women and their significant others make sense of their experience of postpartum psychosis, their relationships, and the mutual influence of these. | 7 women, aged 28-33 years, 7 significant others aged 29-39 years (5 partners, 1 sister and 1 friend) | Semi-structured interviews / Interpretative Phenomenological Analysis |

## Table 3

### *Original themes from studies included in the review*

|  |  |
| --- | --- |
| Study | Themes |
| Boddy et al (2016) | 1. What the f\*\*\* is going on 2. Time to figure out how your family works |
| Doucet et al (2012) | Mothers:   * Generic parenting needs * Serious mental illness needs * Informational support from professionals * Emotional, affirmational, & instrumental support from informal network * No specialized support * Limited community support * Family provided the majority of support * Health service barriers * Lack of knowledge about PP   Fathers:   * Support needs to support partner * Support needs to support themselves * Informational support from professionals * Instrumental support from informal network * Limited professional support * Limited community support * Family provided the majority of support * Health service barriers * Personal barriers |
| Engqvist et al (2011) | 1. Unfulfilled dreams, 2. Enveloped by darkness, 3. Disabling symptoms, 4. Feeling abandoned |
| Engqvist & Nilsson (2013) | 1. Loss of sleep, 2. Being in an unreal world, 3. From a wanted baby to an unwanted baby, 4. Infanticidal ideation, 5. Suicidal ideation - a complete darkness |
| Engqvist & Nilsson (2014) | 1. The recovery, 2. Supporting circumstances |
| Forde et al (2019) | 1. Seeking safety and containment, 2. Recognising and responding to the psychological impact and 3. Planning for the future. |
| Glover et al (2014) | 1. ‘The path to puerperal psychosis’, 2. 'Unspeakable thoughts and unacceptable self’, 3. ‘Snap out of it’ |
| Heron et al (2012) | 1. Unmet expectations, 2. Ruminating and rationalising, 3. Social recovery, 4. Medical support, 5. Information needs, 6. Family functioning, 7. Giving recovery time |
| Holford et al (2018) | 1. Loss, 2. Powerlessness, 3. United vs Individual Coping, 4. Hypothesising and Hindsight, 5. Barriers to Accessing Care and Unmet Needs, 6. Managing Multiple Roles, 7. Positive Changes from Postpartum Psychosis |
| McGrath et al (2013) | 1. The process of recovery, 2. Evolving an understanding, 3. Strategies for recovery, 4. Sociocultural context. |
| Plunkett et al (2015) | 1. The baby has a role in recovery, 2. The baby is a barrier to recovery, 3. The baby facilitates recovery |
| Posmontier & Fisher (2014) | 1. Birth and Shavuos, 2. The Symptoms Begin, 3. Coming Home, 4. Shabbos Psychosis, 5. Making Sense of the Experience |
| Roberts et al (2018) | 1. Public education, 2. Stigma, 3. Disclosure, 4. Reassurance, 5. Family relationships |
| Robertson & Lyons (2003) | 1. A separate form of mental illness, 2. Loss, 3. Relationship and social roles |
| Stockley (2018) | 1. What's happening? Lack of recognition of the seriousness, 2. Breast is best?, 3. Trauma |
| Wass et al (2022) | 1. Our relationship before, 2. Relationship test, 3. Picking up the pieces, 4. Discovering the new us |
| Wyatt et al (2015) | 1. ‘She wasn’t herself’: threatened relationships through loss of ‘normal’ self, 2. Invalidation and isolation: relational dynamics in seeking, receiving and providing support, 3. ‘the worst life can throw at us’: shared perceptions of trust and respect following PP, 4. A double-edged sword: understanding the influence of relationships on PP experience |

## Appendix 1-A

### Instructions for authors submitting to Archives of Women’s Mental Health

**Instructions for Authors**

Types of papers

**Original Contributions/Research Articles**

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

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

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

**Reviews/Meta-analyses:**

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

**Please note:**

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

**Manuscript Submission**

Submission of a manuscript implies: that the work described has not been published before; that it is not under consideration for publication anywhere else; that its publication has been approved by all co-authors, if any, as well as by the responsible authorities – tacitly or explicitly – at the institute where the work has been carried out. The publisher will not be held legally responsible should there be any claims for compensation.

**Permissions**

Authors wishing to include figures, tables, or text passages that have already been published elsewhere are required to obtain permission from the copyright owner(s) for both the print and online format and to include evidence that such permission has been granted when submitting their papers. Any material received without such evidence will be assumed to originate from the authors.

**Title Page**

Please make sure your title page contains the following information.

**Title**

The title should be concise and informative.

**Author information**

* The name(s) of the author(s)
* The affiliation(s) of the author(s), i.e. institution, (department), city, (state), country
* A clear indication and an active e-mail address of the corresponding author
* If available, the 16-digit [ORCID](https://orcid.org/) of the author(s)

If address information is provided with the affiliation(s) it will also be published.

For authors that are (temporarily) unaffiliated we will only capture their city and country of residence, not their e-mail address unless specifically requested.

**Abstract**

Please provide a structured abstract of 150 to 250 words which should be divided into the following sections:

* Purpose (stating the main purposes and research question)
* Methods
* Results
* Conclusion

*For life science journals only (when applicable)*

* Trial registration number and date of registration for prospectively registered trials
* Trial registration number and date of registration followed by “retrospectively registered”, for retrospectively registered trials

**Keywords**

Please provide 4 to 6 keywords which can be used for indexing purposes.

**Statements and Declarations**

The following statements should be included under the heading "Statements and Declarations" for inclusion in the published paper. Please note that submissions that do not include relevant declarations will be returned as incomplete.

* **Competing Interests:** Authors are required to disclose financial or non-financial interests that are directly or indirectly related to the work submitted for publication. Please refer to “Competing Interests and Funding” below for more information on how to complete this section.

Please see the relevant sections in the submission guidelines for further information as well as various examples of wording. Please revise/customize the sample statements according to your own needs.

**Important note:**

Please ensure your authorship is correct, check spelling of authors' names, line up, etc.

**No changes can be made** once copyright has been transferred to us.

Text

**Text Formatting**

Manuscripts should be submitted in Word.

* Use a normal, plain font (e.g., 10-point Times Roman) for text.
* Use italics for emphasis.
* Use the automatic page numbering function to number the pages.
* Do not use field functions.
* Use tab stops or other commands for indents, not the space bar.
* Use the table function, not spreadsheets, to make tables.
* Use the equation editor or MathType for equations.
* Save your file in docx format (Word 2007 or higher) or doc format (older Word versions).

**Headings**

Please use no more than three levels of displayed headings.

**Abbreviations**

Abbreviations should be defined at first mention and used consistently thereafter.

**Footnotes**

Footnotes can be used to give additional information, which may include the citation of a reference included in the reference list. They should not consist solely of a reference citation, and they should never include the bibliographic details of a reference. They should also not contain any figures or tables.

Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.

Always use footnotes instead of endnotes.

**Acknowledgments**

Acknowledgments of people, grants, funds, etc. should be placed in a separate section on the title page. The names of funding organizations should be written in full.

**Important note:**

Authors are requested to use **automatic continuous line numbering** throughout the manuscript and in double space.

References

**Citation**

Cite references in the text by name and year in parentheses. Some examples:

* Negotiation research spans many disciplines (Thompson 1990).
* This result was later contradicted by Becker and Seligman (1996).
* This effect has been widely studied (Abbott 1991; Barakat et al. 1995a, b; Kelso and Smith 1998; Medvec et al. 1999, 2000).

**Reference list**

The list of references should only include works that are cited in the text and that have been published or accepted for publication. Personal communications and unpublished works should only be mentioned in the text.

Reference list entries should be alphabetized by the last names of the first author of each work. Please alphabetize according to the following rules: 1) For one author, by name of author, then chronologically; 2) For two authors, by name of author, then name of coauthor, then chronologically; 3) For more than two authors, by name of first author, then chronologically.

If available, please always include DOIs as full DOI links in your reference list (e.g. “https://doi.org/abc”).

Tables

* All tables are to be numbered using Arabic numerals.
* Tables should always be cited in text in consecutive numerical order.
* For each table, please supply a table caption (title) explaining the components of the table.
* Identify any previously published material by giving the original source in the form of a reference at the end of the table caption.
* Footnotes to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data) and included beneath the table body.

**Figure Numbering**

* All figures are to be numbered using Arabic numerals.
* Figures should always be cited in text in consecutive numerical order.
* Figure parts should be denoted by lowercase letters (a, b, c, etc.).
* If an appendix appears in your article and it contains one or more figures, continue the consecutive numbering of the main text. Do not number the appendix figures,"A1, A2, A3, etc." Figures in online appendices [Supplementary Information (SI)] should, however, be numbered separately.

**Figure Captions**

* Each figure should have a concise caption describing accurately what the figure depicts. Include the captions in the text file of the manuscript, not in the figure file.
* Figure captions begin with the term Fig. in bold type, followed by the figure number, also in bold type.
* No punctuation is to be included after the number, nor is any punctuation to be placed at the end of the caption.
* Identify all elements found in the figure in the figure caption; and use boxes, circles, etc., as coordinate points in graphs.
* Identify previously published material by giving the original source in the form of a reference citation at the end of the figure caption.

## Appendix 1-B

### Search Terms

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Search term type** | **Population search terms: Parents where the mother has/is experiencing postpartum psychosis** | | |  | **Interest:**  **Experiences of relationships** |  | **Context:**  **Perinatal period** |
| Free text | mother\* OR women\* OR woman OR mum OR maternal OR mom OR father OR men\* OR man OR dad OR parent\* OR couple\* OR partner\* | AND | (psychotic N4 disorder) OR psychotic OR psychosis OR hallucination\* or delusion\* or paranoi\* or mania or hypomania | AND | experience\* OR qualitative OR perspective\* OR impact OR interview\* OR narrative OR thematic OR ‘grounded theory’ OR perception\* OR interview OR ‘focus group’ OR ‘thematic analysis’ OR phenomolog\* OR ‘Interpretative Phenomenological Analysis’ OR ‘content analysis’ | AND | perinatal OR postnatal OR postpartum OR peripartum OR pregnan\* OR puerperal OR birth OR childbirth |
| Subject headings (PsycINFO) | DE ‘Husbands’ OR DE ‘Wives’ OR DE ‘Couples’ OR DE ‘Parental Role’ OR DE ‘Parent Child Relations’ OR DE ‘Fathers’ OR DE ‘Parenting’ OR DE ‘Spouses’ OR DE ‘Mothers’ OR DE ‘Parents’ |  | DE ‘Psychosis’ |  | DE ‘Focus Group’ OR DE ‘Grounded Theory’ OR DE ‘Phenomenology’ OR DE ‘Qualitative Measures’ OR DE ‘Interviews’ OR DE ‘Semi-Structured Interview’ OR DE ‘Interpretative Phenomenological Analysis’ OR DE ‘Narrative Analysis’ OR DE ‘Qualitative Methods’ OR DE ‘Thematic Analysis’ |  | DE ‘Labor (Childbirth)’ OR DE ‘Perinatal Period’ OR DE ‘Birth’ OR DE ‘Postnatal Period’ OR DE ‘Pregnancy’ |
| Subject headings (Medline) | (MH ‘Parents’) OR (MH ‘Mothers’) OR (MH ‘Fathers’) OR (MH ‘Spouses’) OR (MH ‘Parent-Child Relations’) OR (MH ‘Parenting’) |  | (MH ‘Psychotic Disorders’) |  | (MH ‘Qualitative Research’) OR (MH ‘Grounded Theory’) |  | (MH ‘Postpartum Period’) OR (MH ‘Peripartum Period’) OR (MH ‘Perinatal Care’) OR (MH ‘Pregnancy’) OR (MH ‘Parturition’) |
| Subject headings (CINAHL) | (MH ‘Parenting’) OR (MH ‘Maternal Behavior’) OR (MH ‘Paternal Behavior’) OR (MH ‘Patient-Family Relations’) OR (MH ‘Mothers’) OR (MH ‘Fathers’) OR (MH ‘Parents’) OR (MH ‘Spouses’) |  | (MH ‘Psychotic Disorders’) |  | (MH ‘Qualitative Studies’) OR (MH ‘Grounded Theory’) OR (MH ‘Phenomenological Research’) OR (MH ‘Ethnographic Research’) |  | (MH ‘Postnatal Period’) OR (MH ‘Pregnancy’) OR (MH ‘Childbirth’) or (MH ‘perinatal period’) |
| Subject headings (Web of Science) | KP=(parents) OR KP=(parenting) OR KP=(mothers) OR KP=(fathers) OR KP=(spouse) OR KP=(parent-child relations) |  | KP=(‘psychosis’) |  | KP=(qualitative) OR KP=(interview) OR KP=(phenomenology) |  | KP=(postpartum period) OR KP=(perinatal period) OR KP=(pregnancy) |

## Appendix 1-C

### Example of development of theme three

|  |  |  |  |
| --- | --- | --- | --- |
| **Theme Title** | **Study** | **Codes** | **Participant quotes** |
| This experience can strengthen or strain relationships | Boddy et al., 2017 | Distrust of partner | ‘I guess there is a level of trust that kind of needs to be rebuilt... with how she is around the baby’ |
|  | Doucet et al., 2012 | Baby as inconvenience | ‘Holding him was an inconvenience to getting my house cleaned and totally organized.’ |
|  | Engqvist et al., 2011 | Distrust of partner | ‘For in my paranoia I was certain that my husband (who really is one of the world's greatest men and husbands) was out to get me. I thought he wanted to divorce me and take our child. I thought he was probably sabotaging our efforts to get help.’ |
|  | Engqvist et al., 2013 | Regret of having baby | ‘I regretted it all the time, all the time, all the time—THAT I HAD THIS BABY! I would have done anything to undo it. I wished that he would go back into my womb, so I could have my life back.’ |
|  | Engqvist et al., 2014 | Recovery can strengthen relationship with baby | ‘So there was much joy in taking care of my baby, but it was ... well, it was probably at around six months that it began to turn a little.’ |
|  | Forde et al., 2019 | Experience strengthened relationship | ‘I guess in some ways, we’ve... come out a bit stronger as well’ |
|  | Glover et al., 2014 | Fear of baby | ‘At one point I thought the baby was the devil and by feeding her she was sucking my life blood away.’ |
|  | Heron et al., 2012 | Relationship difficulties | ‘…it did affect our relationship in some ways. Um to be honest, I don’t think he ever thought I would be the same again’ |
|  | Holford et al., 2018 | Experienced strengthened relationship | ‘I’ve always said that it has got better. It’s got stronger, that sounds really odd... I always say that we are actually stronger for it.’ |
|  | McGrath et al., 2013 | Experienced caused positive changes in relationships | No direct participant quotes reported. Author interpretation: Women discussed a renewed appreciation for positive things in their lives...They discussed positive changes to relationships… |
|  | Plunkett et al., 2017 | Fear of baby | ‘I didn't want to be on my own with [baby's name] you know all the time, I said mum you've got to be with me ... all the time’ |
|  | Posmontier & Fisher, 2014 | Distrust of partner | ‘So I started pushing [my sister-in-law and husband] and I [shouted] ‘Get out get out! Get out! Get out!’ . . . ‘cause I thought they were ganging up against me and I don’t know what they were doing’ |
|  | Roberts et al., 2018 | Lack of shared experience | ‘... I didn’t think his side of it, and he actually admitted to me how frightened he was for me. I had no idea he was even the slightest bit concerned about me at the time.’ |
|  | Robertson & Lyons, 2003 | Increased valuing of relationships | `It’s made me stronger, I look at life a lot differently now. I value things better, like my mom, I value friendships I value what my husband’s done for me.’ |
|  | Stockley, 2018 | Difficulties caring for baby | ‘I'd be downstairs cleaning, writing myself instruction manuals on how to look after him.... I would sit and write instructions’ |
|  | Wass et al., 2022 | Experienced strengthened relationship | ‘It kind of made us closer really’ |
|  | Wyatt et al., 2015 | Experience strengthened relationship | ‘And I think, yeah the fact that we got through such a horrible period together, it probably made us stronger.’ |

## Appendix 1-D

### Development of analytical themes from initial descriptive themes

|  |  |
| --- | --- |
| **Analytical themes** | **Initial descriptive themes** |
| **The process of learning to adapt together** | Changes in relational dynamics and roles |
|  | Loss |
|  | Competing demands within relationships |
|  | Perceiving it as an abnormal experience |
|  | Finding ways to cope |
| **Navigating the impact of the** | Lack of control over what’s happening |
| **uncontrollable experience on our** | Experience of guilt and self-blame |
| **relationships** | Protectiveness over baby |
| **This experience can strengthen or strain** | Experience can cause strain on relationships |
| **relationships** | Recovery strengthened relationships |
|  | Lack of trust and connection |
|  | External facilitators of relationships |
| **The journey through PP is a relational** | Relationships can be a protective factor |
| **experience** | Perception of being in it together |
|  | Consistent protective aspects of relationship |

## Appendix 1-E

### Studies that contributed to each theme

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Study | The process of learning to adapt together | Navigating the impact of the uncontrollable experience on our relationships | This experience can strengthen or strain relationships | The journey through PP is a relational experience |
| Boddy et al., 2017 | X | X | X | X |
| Doucet et al., 2012 | X | X | X | X |
| Engqvist et al., 2011 | X | X | X | X |
| Engqvist et al., 2013 | X | X | X |  |
| Engqvist et al., 2014 | X |  | X | X |
| Forde et al., 2019 | X | X | X | X |
| Glover et al., 2014 |  | X | X |  |
| Heron et al., 2012 | X | X | X | X |
| Holford et al., 2018 | X | X | X | X |
| McGrath et al., 2013 | X | X | X |  |
| Plunkett et al., 2017 | X | X | X | X |
| Posmontier & Fisher, 2014 | X | X | X | X |
| Roberts et al., 2018 | X | X | X |  |
| Robertson & Lyons, 2003 | X | X | X |  |
| Stockley, 2018 | X | X | X |  |
| Wass et al., 2022 | X | X | X | X |
| Wyatt et al., 2015 | X | X | X | X |

## Appendix 1-F

### Thematic structure demonstrating relationship between themes



# Empirical Paper

UK midwives’ perspectives and perceptions in relation to psychotic-like experiences in the perinatal period: A qualitative study

Word count (excluding references, tables and appendices): 8000

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Declarations of interest: none

Prepared for submission to *Archives of Women’s Mental Health*

See Appendix 2-A for submission guidelines

## Abstract

**Purpose:** There appears to be barriers to midwives supporting the full range of mental health difficulties in new mothers.This study, therefore, aimed to explore UK midwives’ perspectives and perceptions relating to mothers’ psychotic-like experiences in the perinatal period.

**Methods:** This wasa qualitative study usingsemi-structured interviews with ten midwives recruited online. 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. Overall, midwives described their motivation to support women with these experiences but articulated many factors that made this difficult.

**Conclusions:** The results emphasise the importance of training and guidance for midwives to support them being able to offer support and information to women. Additionally, findings highlight the importance of systemic safety for midwives alongside support through supervision and reflective practice.

*Keywords:* midwives; 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) which affect up to one in five women[[3]](#footnote-3) (Bauer et al., 2014). Suicide is a leading cause of pregnancy-related death (Knight et al., 2021) and maternal postnatal distress can negatively impact babies (Hoffman et al., 2017) therefore, identifying and supporting these difficulties is crucial.

Postpartum, or puerperal, psychosis (PP) refers to a collection of experiences including mood changes, hearing, seeing or feeling things that others cannot (hallucinations) and unusual beliefs (delusions). PP is diagnosed in one to two in 1000 individuals during the perinatal period ([Vanderkruik et al., 2017](#_ENREF_7)) with genetic factors and hormonal imbalances implicated in PP occurrence (Boyce & Barriball, 2010). Some studies also report associations between PP and perinatal life stressors (Aas et al., 2020) and childhood adversities (Hazelgrove et al., 2021), however others find no association (Perry et al., 2016; Warselius et al., 2019).

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 often referred to as ‘psychotic-like experiences’ (PLEs) and include unusual experiences consistent with psychosis, e.g., hallucinations or delusions, that are below clinical threshold and may or may not cause distress (Van Os et al., 2009; Yung et al., 2009). Although the psychosis continuum remains a debated concept due to critiques of methodological approaches used to measure PLEs (David, 2010), research indicates increasing high-quality supporting evidence (Mcgrath et al., 2015; Stip & Letourneau, 2009).

In the general population, PLEs appear relatively common as Linscott & van Os, (2013) estimate the median population lifetime prevalence as 7.2%. Although PLEs are reportedly transient and do not transition to psychosis for most individuals, they are associated with increased risk of psychosis (Kaymaz et al., 2012) and other mental health difficulties (Dhossche et al., 2002; Holt et al., 2018). Additionally, experiences of psychosis in those who do or do not require mental health care appear to display some indistinguishable features. For example, Johns et al. (2014) found no significant differences in auditory verbal hallucinations between those who did or did not require mental health care in perceptual characteristics of voices, loudness, and voice personification.

Although PP is relatively rare, subclinical perinatal PLEs appear common with 37.2% -93.3% of women surveyed during the perinatal period endorsing at least one PLE (Holt et al., 2018; Lu et al., 2022; Mackinnon et al., 2017; Mannion & Slade, 2014). These experiences have been associated with post-traumatic stress symptoms (Holt et al., 2018), which supports wider findings that stressful or traumatic events increase risk for PLEs (Linscott et al., 2013). 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).

Women who experience PMH difficulties, such as experiences of psychosis, appear to experience difficulties with seeking professional perinatal mental health support (Schmied et al., 2016). This may be linked to multiple barriers for women including healthcare professionals’ perceived 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 this period. In the UK, typically pregnant women will regularly see midwives 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 postnatal mental health concerns such as experiences of psychosis. Midwives will continue to see women in the early postnatal period, with postnatal care being 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 mum and baby, and provide information (NHS, 2023). National Institute for Health and Care Excellence guidelines also stipulate that professionals should discuss mental health with women postnatally (NICE, 2014). Therefore, these contacts provide invaluable opportunities for midwives to discuss PMH concerns ([Alderdice et al., 2013](#_ENREF_1)), inform mothers about experiences such as PLEs or identify and support women with these experiences.

Midwives recognise their responsibility to have a role within PMH but express confusion regarding this role (Bayrampour et al., 2018). They 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). Midwives report more frequently assessing for depression and anxiety than psychosis (Carroll et al., 2018; Hauck et al., 2015), suggesting additional barriers related to discussing psychosis with women.

The small body of research exploring midwives’ views towards PP is quantitative and 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). Additionally, 7% of midwives within Ross-Davie et al. (2006) perceived mothers with PP as ‘often violent’ and, in another study, midwives perceived women with schizophrenia as lower in warmth than women with depression (Hauck et al., 2015).

It is important that midwives can discuss PLEs with women, as distinguishing the ‘expected’ 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. Additionally, women who have experienced PP report desiring professional information and reassurance around PP (Doucet et al., 2012) with some reporting they did not feel listened to by their midwife (Glover et al., 2014).

It is noteworthy that a midwife’s response to an acute onset of 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 to mum and baby (NHS, 2020). As such, it is treated urgently and often women are quickly admitted to Mother and Baby Units (MBU). Midwives’ roles in these situations 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 for these experiences is likely to involve midwives providing information to women about these experiences and offering reassurance and normalisation, as women who have experienced PP describe desiring this type of support (Doucet et al., 2012).

The above research indicates that many midwives do not feel confident in addressing women’s perinatal experiences of psychosis. Consequently, midwives may feel unable to initiate conversations and offer support for women experiencing PLEs. These experiences can be distressing for women but difficult to disclose, therefore midwifery support is important. To address this problem, an in-depth understanding of midwives’ perspectives is required to understand potential barriers and facilitators to their roles within perinatal PLEs. The current study will address this by exploring midwives’ perspectives and perceptions regarding perinatal PLEs.

## Method

**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). The vignette was utilised due to anticipations that midwives may not have directly experienced supporting new mothers experiencing PLEs therefore presenting a possible barrier for exploring their perspectives. This method, therefore, allowed for exploration of midwives’ perspectives without direct experience.

The data were analysed using Braun and Clarke’s (2021a) reflexive thematic analysis which allowed for a flexible yet detailed approach. This allowed an inductive analysis, incorporating coding at both a semantic (meaning explicitly expressed) and latent level (implicit meaning). Braun and Clarke (2006) propose that thematic analysis can be used with different epistemological positions. This study takes a critical realist position which is ontologically realist (i.e., assumes reality exists) and epistemologically relativist (i.e., assumes this reality is not objective as it is mediated by context). Consequently, critical realism posits that reality is shaped by language, culture and social context, meaning that research accesses participants’ interpreted reality (Willig, 2013).

**Sampling and 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 sought registered midwives currently working in the UK in a role which predominantly included direct contact with expectant or new mothers. Participants were required to interview in English due to the absence of funds for an interpreter.

Midwives who had a professional background working as a mental health practitioner (e.g., mental health nurse) 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. However, Specialist Perinatal Mental Health midwives were not excluded as it was deemed that they would still provide insight into the perspectives of midwives without substantial prior mental health training.

Ten midwives took part in this study, all of whom currently lived and worked within the UK and worked in the public sector. 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. Table 1 summarises the demographic information of participants.

(Insert table 1)

**Recruitment**

All ten participants were recruited online. The study advertisement was posted on the Royal College of Midwives (RCM) website, Twitter and midwifery Facebook groups. All participants emailed the researcher and were emailed an information sheet and consent form with a request to respond if they wanted to take part. On agreeing to participate, they were sent a demographic form and part one of the vignette to be discussed during the interview. This was to reduce any anxiety caused by being presented with unexpected vignettes during the interview that may result in feeling “tested”. As the vignettes were provided to prompt midwives’ thinking, and not to examine diagnostic knowledge, it was not felt that providing the vignettes in advance would compromise the interviews.

**Data Collection**

Interviews took place between February 2022 and October 2022 and all participants were interviewed via Microsoft Teams. Informed consent was confirmed at the start of the interview. Participants were interviewed using the semi-structured interview schedule which included a hypothetical vignette of ‘Nina’ experiencing PMH difficulties with a focus on PLEs (Appendix 2-B). The vignette was developed using previous research (Anglin et al., 2014; Lee et al., 2016), consultation with the field supervisor (Clinical Psychologist working in PMH), the DSM criteria for ‘brief psychotic disorders’ (American Psychiatric Association, 2013) and information from Action on Postpartum Psychosis (APP) charity’s ‘personal stories’ videos (APP, 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 2-C) 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) and consultation with the research team. 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. Midwives’ perspectives were explored in relation to the vignette therefore this provided rich, detailed data that could be analysed using thematic analysis. During data analysis, the data relating to the vignette and the semi-structured interview questions were coded and analysed together to develop the final themes as it was felt that both parts of the interview provided an insight into midwives’ views and perceptions of PLEs.

Two midwives reviewed the vignette and interview schedule. The vignette was adapted according to feedback recommending extending ‘Nina’s’ stay on the postnatal ward to make the scenario more realistic and relevant for midwives. After the second interview, the vignette was discussed with the research team and a change was made relating to flexible use of the vignette with participants depending on their experience within PMH. Interviews were recorded and transcribed and lasted between 44 and 70 minutes (average 58 minutes).

**Data Analysis**

Thematic analysis was used to analyse the interview transcripts (Braun & Clarke, 2021a), approached from a critical realist position. This position meant that participant accounts were considered within the individual and social context they reported, and these contexts were considered within coding and theme write-up. The analysis followed the following steps outlined by Braun and Clarke (2021a). The researcher read transcribed interviews to familiarise themselves with the data and noted initial thoughts. After familiarisation, initial codes were produced and identified alongside transcription (Appendix 2-D).

Initial codes were discussed with 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. 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 (2021a) description of coding as an iterative process. Codes were then reviewed, refined, and organised into possible themes. This initially involved grouping of codes that appeared to indicate similar understanding or concepts and moved to naming and defining these groups (Appendix 2-E).

Initial themes were generated independently by the researcher and reviewed with the 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.

Subthemes have not been used within the results, per Braun and Clarke’s (2021a) guidance that subthemes should be used judiciously as they can create a fragmented analysis lacking analytical depth (Trainor & Bundon, 2021). However, initial dimensions of themes were identified (Appendix 2-F) which were encompassed within the final narrative. Within the reporting of themes, some unnecessary details of participants’ extracts have been removed. This data editing was considered carefully to only remove superfluous information, and not information that contradicted or changed the meaning of the data extract.

**Credibility of analysis**

Yardley (2015) describes the complexity of validity within qualitative research, particularly if dominant ideas related to quantitative research are erroneously applied. However, validity was still important to consider. Braun and Clarke (2021a) describe that generalised quality-ensuring methods in qualitative research may be inappropriate for some thematic analyses, therefore this should consider the study’s context.

Therefore, quality-ensuring strategies considered the context and theoretical position of this study. Informed by Yardley’s (2015) principles and suggestions; ‘commitment and rigour’ was incorporated through collaboration with supervisors during coding and theme development and ‘coherence and transparency’ was adhered to through a paper trail demonstrating the development of codes and themes from raw data (Appendix 2-E).

**Ethical considerations**

Ethical approval was granted by Lancaster University’s Research Ethics Committee. Pseudonyms have been used within the reporting of participants’ accounts, and exact demographic details have not been reported to maintain participant anonymity. There were no safeguarding, distress or risk issues during this study and no participants chose to end the interview early or contact the researcher due to distress after the study.

**Reflexivity**

Braun and Clarke (2021a) emphasise the role of researcher reflexivity within thematic analysis. This is particularly important within a critical realist approach due to the acknowledged impact of the researcher’s perspective and assumptions on data analysis and interpretation. Therefore, assumptions and reflections were recorded in the researcher’s reflective diary to reduce their unconscious impact on the research. One example included identification of an assumption that midwives may feel unknowledgeable about PMH, which led to surprise when some midwives reported confidence within this. This was discussed within research supervision, and interview questions were monitored to ensure curiosity around this confidence, rather than questions motivated by doubt.

## Results

The analysis generated four themes: (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

**Theme 1: Identifying psychotic-like experiences would not be as easy as it sounds: making decisions on behalf of women**

Several midwives reported a willingness to discuss PLEs with women but described multiple complicating factors. The concept 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[[4]](#footnote-4)) and alternatives to direct questions utilised, ‘I think maybe common sense and like your kinda, your interpersonal skills’ (Hannah). Throughout this, there was a sense of midwives making decisions on behalf of women concerning appropriate questions or conversations.

Other participants acknowledged that vague questions could confuse women, therefore described prefacing direct questions to avoid perceived negative reactions:

[…] I'll frame the question and just say “I'm gonna ask you a very direct question now, just want you to be open and honest” […] I think it's because it can come across as a very blunt.(Lucy)

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 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)

Shameful narratives around psychosis appeared to impact potential conversations, which was represented through midwives’ perceptions of barriers for women talking about PLEs:

I think particularly with um psychosis, it’s definitely not something people would be open about […] It's very hard and very scary. So it wouldn't be talked about. (Olivia)

For some participants, the notion of asking women about unusual beliefs evoked perceptions that this would be offensive or indicate judgement, reflecting 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 for midwives 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. This also impacted the information that midwives felt comfortable giving to women around PLEs or PP, as information was viewed as potentially distressing:

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 perinatal mental health information provided to women. Midwives’ decisions on behalf of women about suitable conversations and appropriate information were located within concern for women’s welfare, however this could invoke a sense of a lack of women’s autonomy.

Some midwives’ experiences of uncertainty and complexity around the prospect of identifying PLEs resulted in the pursuit of certainty. Midwives regularly discussed the concepts of ‘normal’ and ‘abnormal’ regarding women’s experiences and commented that the context of the significant transition to motherhood meant that this dichotomy was not clear:

Some of the things she's saying can be normalized, you know, 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 more clarity for midwives to be able to distinguish and identify ‘abnormality’. This dilemma between the perceived ‘normal vs abnormal’ dichotomy was reflected through desires 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)

The uncertainty around this dichotomy impacted midwives’ perceived confidence in identifying PLEs, as they reflected worries that getting this wrong could cause harm. Midwives therefore discussed trying to make decisions for women to keep them safe:

We've had a couple of women who, when they've been psychotic, you, you've got a plan for them, but actually they're not gonna cooperate.(Lucy)

Overall, midwives described that although they were not opposed to having a role in PLEs, multiple factors made this more complicated. 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**

Alongside difficulties identifying PLEs, midwives also articulated a perception that PLEs and psychosis were overwhelming to support which presented barriers. Within this, PLEs appeared to be viewed and described in the same way as PP, highlighting that midwives did not appear to distinguish these experiences. Midwives described their perception of PLEs as emergency situations which were sometimes conceptualised as overwhelming and feared. This fear was highlighted through emphasis on protecting their own safety when supporting women with experiences of psychosis, alongside a fear of what might happen in these situations:

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 appeared to provoke differing responses in midwives, with some feeling cautious around women experiencing psychosis and others being driven to learn more about psychosis to reduce this fear, highlighting that this could be experienced as either a barrier or a driver. This fear was described as particularly salient with psychosis compared to other PMH difficulties which appeared exacerbated by conceptualisations of psychosis as an unrelatable and abnormal experience:

Because it's not normal for a mum to have thoughts that a baby's possessed.(Lucy)

This conceptualisation appeared to be exacerbated by the expectation that PLEs would present as obvious and shocking. This implicit perception was represented through midwives’ descriptions of previous experiences of psychosis:

You could name it, immediately because it was such a change in character, she looked, like she opened the door and she looked totally different immediately because I’d met her before […] it was like something had kind of taken over, it was totally different.(Sophie)

These previous experiences of psychosis shaped some midwives’ expectations and contributed to the narrative of PLEs as significantly distinct and 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)

Some participants described how their perceived lack of knowledge and confidence around psychosis contributed to fear as it maintained the ‘unknown’ and feelings of being under-skilled. Several participants talked about the rarity of psychosis, and therefore described a lack of experience of this:

I've never had to deal with somebody experiencing postpartum psychosis, sort of in the room at that time […] I think for the first time to be the person to, for lack of better words, discover it or you know that's, that would be quite scary. So I think I’d probably feel quite nervous.(Lisa)

This contributed to midwives’ narrative that this was the role of ‘experts’ or ‘specialists’ as they were not skilled enough to support women with these experiences.

Participant accounts highlighted how societal narratives had shaped their view of psychosis and contributed to worries around supporting this. This influence was named as a conscious impact 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 in the way they respond 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)

As part of this responsibility, midwives described the importance of creating relational safety for women. This appeared to be particularly important due to midwives’ understandings of PLEs as shameful and secretive (theme one). This creation of safety was related to the importance of the relationship between a midwife and woman, which was perceived to significantly impact on conversations about PLEs and psychosis. The development of this relationship was largely attributed to continuity of care, which was viewed as important for both women and midwives:

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 described the importance of creating a safe space for women, which included considering the environmental setting. This involved emphasis on midwives’ interpersonal skills, for example: ‘I would be asking her more questions about what, what she, why she thought that the baby was possessed […] Conversation, a safe conversation with her, really. (Lucy)’. However, for others these skills were perceived as too ‘basic’ to support women:

Erm, so I dunno basic verbal, sort of being able to listen and actively respond, reassure them, basic support and like that, nothing specialist. (Eleanor)

Alongside interpersonal skills, 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 birth and parenting. Sophie articulates this normalisation around unusual experiences:

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 still important to validate and believe their experiences. This related to the sense of ‘duty’ for some participants 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’ feelings of confidence and trust in their own initiative. They also 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.

In summary, midwives conveyed their sense of responsibility to women in various ways. This responsibility impacted midwives’ behaviour resulting in them doing what was perceived to be best for women. At times, ‘doing what’s best’ was difficult and involved doing things that midwives felt apprehensive about, therefore participants articulated their attempts at overcoming this dilemma.

**Theme 4: The system feels unsafe and insecure which makes the anticipated role in supporting psychotic-like experiences harder**

This theme illustrates midwives’ perceptions that the systems they work in are unsafe, for both them and women, and not secure enough to confidently support women 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 described 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 until half past from 9:00 o'clock in the morning till 5:30 […]…maternity services is in a state of collapse. (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 support for women. Consequently, midwives perceived that women would be unlikely to ask for support due to feeling that midwives were too stretched. This was articulated as frustrating for midwives and contributed to burnout:

[…] 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 own integrity and 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 and actively harming women by referring them to inadequate services.

Midwifery services were also described as indirectly causing harm through burnt out midwives struggling to support women with experiences like PLEs. Participants described the midwifery way of coping as ‘head down and get on with it’ (Hannah) which meant detaching from emotional responses:

It's almost like the more emotionally detached you are from your job, the better the midwife you become, which is a really damaging culture when we think about birth trauma […] 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 worrying and unsafe due to possible severe consequences. Midwives described their view 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)

This was impacted by the responsibility that midwives perceived (theme three), alongside their need to protect themselves from mistakes in a psychologically unsafe system. 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)

Midwives described that these systemic impacts could feel overwhelming and perceived needing more support from leaders for their role within PMH. This involved seeking support from, and communicating with, other professionals. The potential emotional impact of PLEs for midwives was also highlighted:

…it would be important to talk about it, from an emotional side of things as well, because it would be, um, it would be a frightening experience, I think, to be told those things um and have to maintain that sort of calm, in control demeanour…(Olivia)

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 (2019)’s findings concerning general PMH. This dilemma involved midwives perceiving many barriers to identifying and supporting women with PLEs, whilst also recognising the importance of their role in 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 anticipated difficulties with identifying PLEs, echoing previous findings reporting professionals’ fear of offending or upsetting women as a barrier to asking direct questions about PMH (Higgins et al., 2018). However, women report finding vague questions about PMH confusing (Yapp et al., 2019), which was acknowledged by some participants in the current study. The results presented extend these findings as they describe 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.

Birchwood et al. (2007) discuss stigmatised social views towards psychosis. They describe how social rank theory (Gilbert, 1992), suggesting an evolutionary need to be accepted within a social group, contributes to people’s attempts to conceal unusual experiences due to stigma. McGrath et al. (2013) report women’s perceptions of negative reactions to their unusual postpartum experiences, particularly considering negative media representations of psychosis. Therefore, if midwives feel unable to ask about these experiences, women may not report them due to self-stigma (Wicks et al., 2019), reinforcing the value of creating safe spaces for women. In the present study, midwives identified creating safe spaces as important, however the role of stigma may hinder their ability to create these and open conversations about PLEs.

The impact of stigma on midwives’ perspectives highlights requirement for societal changes concerning the perception of psychosis, as the results extend previous quantitative findings indicating midwives’ negative views towards psychosis (Hauck et al., 2015; Ross-Davie et al., 2006) by describing how they impact women’s care. Understanding of PLEs and psychosis at a societal and maternity service level may encourage women to talk about experiences, as women describe perceiving low PP knowledge in the public and health professionals (Roberts et al., 2018).

These barriers for midwives discussing PLEs and psychosis with women appear to contribute to women receiving less information about PP. Women who experience PP report receiving little prior information about this, which reportedly increased distress (Forde et al., 2020; Heron et al., 2012) highlighting the importance of understanding barriers behind midwives providing this information. These findings increase understanding of why midwives may make these decisions on behalf of women, which may help develop interventions to increase shared decision-making with women (NICE, 2021).

Alongside perceptions of PLEs being potentially difficult to support, midwives conveyed their commitment and responsibility to support women, supported by wider research (Bradfield et al., 2019). Within this commitment, some participants described how experience and training increased confidence and reduced fear around PP, positively supporting suggestions that training for midwives could support the provision of PMH care (NHS England, 2021). Women who have experienced psychotic symptoms report feeling that professionals were unaware of these symptoms (Roxburgh et al., 2022), further reinforcing training needs.

Despite this sense of duty and responsibility, midwives described how the current systemic context made their anticipated role in supporting PLEs more difficult. 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 thoughts and feelings without the threat of punishment (Edmondson, 1999). This is particularly important within healthcare, as it can minimise error and improve professional wellbeing (Grailey et al., 2021). This lack of safety appeared to be particularly impactful when considering PLEs and psychosis, as this could elicit an increased sense of risk, therefore increasing the need for systemic safety.

Alongside psychological safety, midwives explained how additional systemic issues complicated their role within PLEs, extending previous similar findings within general PMH (Bayrampour et al., 2018). Recent research supports participants’ reports of increased workload and time pressures within UK midwifery, particularly due to the COVID-19 pandemic, increasing pressure on midwives and burnout (Cordey et al., 2022). Additionally, the RCM (2021), reported that 67% of UK midwives felt unsatisfied with the current care they could deliver and many were considering leaving the profession. 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 mental health (Coates & Foureur, 2019), midwives experience systemic barriers to this.

Mellor (2016) support participants’ views that inadequate PMH referral pathways and service provision can lead to frustration and self-blame for midwives when women are not offered adequate support. West et al., (2020) describe ‘moral distress’, caused by being unable to fulfil your professional duty due to constraining factors which is associated with burnout (Whittaker et al., 2018). Participants in this study 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 suggesting the need 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 within asking these questions (Williams et al., 2016). Therefore, training midwives to use these tools could increase confidence and reduce fear around upsetting or offending women. Specialist PMH Midwives may be well placed to offer individualised support with this, under ongoing supervision from clinical psychologists (Maternal Mental Health Alliance, 2013).

Training for midwives about the psychotic continuum, the frequency of PLEs and midwives’ roles within this could support understanding and knowledge around PLEs. In a recent NHS survey, less than half of midwives reported ability to access appropriate learning opportunities when needed (NHS, 2022), therefore accessible training could increase midwives’ abilities to recognise potential PLEs. Forde et al., (2020) highlight delayed support-seeking for women experiencing unusual experiences, therefore early recognition may support women’s wellbeing. A current campaign is aiming to provide information about PP to women in antenatal classes (APP, 2022) however training for midwives could support them in disseminating information to women about PLEs and PP. In particular, this would allow women at increased risk for PLEs, e.g., those experiencing depression or post-traumatic stress symptoms (Holt et al., 2018) to be provided with information.

Research indicates that women from minoritized ethnic backgrounds experience maternity care inequalities (Knight et al., 2021) including additional barriers to accessing PMH services (Jankovic et al., 2020). Considering that people from minoritized ethnic backgrounds may be more likely to experience PLEs (Tortelli et al., 2018), training for midwives concerning PLEs should include information around perinatal health inequalities alongside cultural differences that are important to consider within assessment of PMH (Watson et al., 2019).

Consistent with the NHS Long Term Plan (NHS, 2019) highlighting PMH as an NHS priority, participants highlighted the importance of supporting PMH and described their responsibility within this. However, alongside providing training and tools to support midwives in their role, evidently systemic changes are required including increased psychological safety for midwives. Supervision may be beneficial for increasing midwives psychological safety (Carter, 2022) along with allowing exploration of internally held narratives and ideas about PLEs, as Rothwell et al. (2019) highlight the importance of discussing clinically relevant personal factors in supervision. 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 within multiple aspects of PLEs. This could include the dissemination of relevant information, the monitoring of these experiences and related risk and, where indicated, onward referral to PMH services.

**Limitations and future research**

Due to online recruitment, the advertisement was shared more within environments where midwives held an interest in PMH. Despite broadening this by posting within general online midwifery groups, midwives with a prior PMH interest may have been more likely to take part, therefore findings may not capture views of midwives with a disinterest in PMH. Further research would benefit from using methods to recruit a broader range of midwives, to explore possible differing views towards PLEs.

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.

**Conclusion**

This study indicates the complexity of midwives’ involvement in supporting PLEs, highlighting the impact of individual, systemic and societal factors. Midwives’ views towards PLEs appeared to differ from views towards other PMH difficulties, which appeared to increase their fear and concern. Duty and responsibility were emphasised by midwives, however this was difficult to fulfil without systemic safety which was lacking. Therefore, increased support through supervision, reflective practice and training appears important.

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## Table 1

### *Participant demographic information*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Participant** | **Gender** | **Age range[[5]](#footnote-5)** | **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 - 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 |

## Appendix 2-A

### Instructions for authors submitting to Archives of Women’s Mental Health

**Instructions for Authors**

Types of papers

**Original Contributions/Research Articles**

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

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

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

**Reviews/Meta-analyses:**

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

**Please note:**

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

**Manuscript Submission**

Submission of a manuscript implies: that the work described has not been published before; that it is not under consideration for publication anywhere else; that its publication has been approved by all co-authors, if any, as well as by the responsible authorities – tacitly or explicitly – at the institute where the work has been carried out. The publisher will not be held legally responsible should there be any claims for compensation.

**Permissions**

Authors wishing to include figures, tables, or text passages that have already been published elsewhere are required to obtain permission from the copyright owner(s) for both the print and online format and to include evidence that such permission has been granted when submitting their papers. Any material received without such evidence will be assumed to originate from the authors.

**Title Page**

Please make sure your title page contains the following information.

**Title**

The title should be concise and informative.

**Author information**

* The name(s) of the author(s)
* The affiliation(s) of the author(s), i.e. institution, (department), city, (state), country
* A clear indication and an active e-mail address of the corresponding author
* If available, the 16-digit [ORCID](https://orcid.org/) of the author(s)

If address information is provided with the affiliation(s) it will also be published.

For authors that are (temporarily) unaffiliated we will only capture their city and country of residence, not their e-mail address unless specifically requested.

**Abstract**

Please provide a structured abstract of 150 to 250 words which should be divided into the following sections:

* Purpose (stating the main purposes and research question)
* Methods
* Results
* Conclusion

*For life science journals only (when applicable)*

* Trial registration number and date of registration for prospectively registered trials
* Trial registration number and date of registration followed by “retrospectively registered”, for retrospectively registered trials

**Keywords**

Please provide 4 to 6 keywords which can be used for indexing purposes.

**Statements and Declarations**

The following statements should be included under the heading "Statements and Declarations" for inclusion in the published paper. Please note that submissions that do not include relevant declarations will be returned as incomplete.

* **Competing Interests:** Authors are required to disclose financial or non-financial interests that are directly or indirectly related to the work submitted for publication. Please refer to “Competing Interests and Funding” below for more information on how to complete this section.

Please see the relevant sections in the submission guidelines for further information as well as various examples of wording. Please revise/customize the sample statements according to your own needs.

**Important note:**

Please ensure your authorship is correct, check spelling of authors' names, line up, etc.

**No changes can be made** once copyright has been transferred to us.

Text

**Text Formatting**

Manuscripts should be submitted in Word.

* Use a normal, plain font (e.g., 10-point Times Roman) for text.
* Use italics for emphasis.
* Use the automatic page numbering function to number the pages.
* Do not use field functions.
* Use tab stops or other commands for indents, not the space bar.
* Use the table function, not spreadsheets, to make tables.
* Use the equation editor or MathType for equations.
* Save your file in docx format (Word 2007 or higher) or doc format (older Word versions).

**Headings**

Please use no more than three levels of displayed headings.

**Abbreviations**

Abbreviations should be defined at first mention and used consistently thereafter.

**Footnotes**

Footnotes can be used to give additional information, which may include the citation of a reference included in the reference list. They should not consist solely of a reference citation, and they should never include the bibliographic details of a reference. They should also not contain any figures or tables.

Footnotes to the text are numbered consecutively; those to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data). Footnotes to the title or the authors of the article are not given reference symbols.

Always use footnotes instead of endnotes.

**Acknowledgments**

Acknowledgments of people, grants, funds, etc. should be placed in a separate section on the title page. The names of funding organizations should be written in full.

**Important note:**

Authors are requested to use **automatic continuous line numbering** throughout the manuscript and in double space.

References

**Citation**

Cite references in the text by name and year in parentheses. Some examples:

* Negotiation research spans many disciplines (Thompson 1990).
* This result was later contradicted by Becker and Seligman (1996).
* This effect has been widely studied (Abbott 1991; Barakat et al. 1995a, b; Kelso and Smith 1998; Medvec et al. 1999, 2000).

**Reference list**

The list of references should only include works that are cited in the text and that have been published or accepted for publication. Personal communications and unpublished works should only be mentioned in the text.

Reference list entries should be alphabetized by the last names of the first author of each work. Please alphabetize according to the following rules: 1) For one author, by name of author, then chronologically; 2) For two authors, by name of author, then name of coauthor, then chronologically; 3) For more than two authors, by name of first author, then chronologically.

If available, please always include DOIs as full DOI links in your reference list (e.g. “https://doi.org/abc”).

Tables

* All tables are to be numbered using Arabic numerals.
* Tables should always be cited in text in consecutive numerical order.
* For each table, please supply a table caption (title) explaining the components of the table.
* Identify any previously published material by giving the original source in the form of a reference at the end of the table caption.
* Footnotes to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data) and included beneath the table body.

**Figure Numbering**

* All figures are to be numbered using Arabic numerals.
* Figures should always be cited in text in consecutive numerical order.
* Figure parts should be denoted by lowercase letters (a, b, c, etc.).
* If an appendix appears in your article and it contains one or more figures, continue the consecutive numbering of the main text. Do not number the appendix figures,"A1, A2, A3, etc." Figures in online appendices [Supplementary Information (SI)] should, however, be numbered separately.

**Figure Captions**

* Each figure should have a concise caption describing accurately what the figure depicts. Include the captions in the text file of the manuscript, not in the figure file.
* Figure captions begin with the term Fig. in bold type, followed by the figure number, also in bold type.
* No punctuation is to be included after the number, nor is any punctuation to be placed at the end of the caption.
* Identify all elements found in the figure in the figure caption; and use boxes, circles, etc., as coordinate points in graphs.
* Identify previously published material by giving the original source in the form of a reference citation at the end of the figure caption.

## Appendix 2-B

### Vignette

**Part 1:**

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. During these 7 days, Nina told a midwife on the ward that she was not managing to sleep at all and was feeling much more emotional than usual. Nina talked about finding it very difficult to concentrate during conversations and was feeling exhausted after small tasks like getting dressed.

**Part 2:**

On the day that Nina was discharged from hospital, she reported that she was worried that she was not looking after her baby properly and was feeling anxious that her baby was going to die. She told the midwife that her thoughts were racing a lot of the time which was making it hard for her to focus on anything, and a lot of these thoughts were related to her being a bad Mum. These thoughts were upsetting Nina, and she said that she was feeling overwhelmed and low in mood some of the time. Nina described feeling that she was experiencing “mood swings” and said that her partner had commented that her mood was changing a lot.

**Part 3:**

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.

## Appendix 2-C

### Interview schedule

This interview schedule gives a general guide for the process of the interview however the interview will be guided by each individual being interviewed, and additional follow up questions may be asked depending on their responses. Participants will be reminded at the start of the interview that there are no correct or incorrect answers to these questions and I am interested in their own perspectives. This interview schedule involves a vignette which is separated into different parts, and has accompanying example questions after each section.

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

The initial part of the interview will focus on the participants’ perspectives and experiences of perinatal mental health in general, which is intended to get a broader sense of their perspectives and perceptions but is also intended to slowly introduce the topic of psychotic-like experiences and build rapport with the participant without them feeling ‘tested’ by the vignette.

[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?
* What types of difficulties have you had experience assessing and supporting women with?
* How confident do you feel within this role of assessing and supporting women with their mental health?
* 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?
* How have you felt about the amount of support you have been able to offer to women?

1. **Vignette**

The next part of the interview will ask questions in relation to the vignette presented to participants. The questions will focus on how the participants think they would act, think and feel in the situation.

**Part 1:**

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. During these 7 days, Nina told a midwife on the ward that she was not managing to sleep at all and was feeling much more emotional than usual. Nina talked about finding it very difficult to concentrate during conversations and was feeling exhausted after small tasks like getting dressed.

**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?
* What do you think you might think about what this woman was experiencing?
* What do you think would happen next in this situation?

**Part 2:**

The day before Nina was discharged from hospital, she reported that she was very worried that she was not looking after her baby properly and was feeling very anxious that her baby was going to die. She told the midwife that her thoughts were racing a lot of the time which was making it hard for her to focus on anything, and a lot of these thoughts were related to her being a bad Mum. These thoughts were upsetting Nina, and she said that she was feeling overwhelmed and low in mood some of the time. Nina described feeling that she was experiencing “mood swings” and said that her partner had commented that her mood was changing a lot.

**Predicted responses:**

[Example prompt questions]

* What would your thoughts be at this point?
* Is there any other information you think you would like from the woman after hearing this?
* Do you think that there is cause for concern at this point? Can you say more about this?
* Do you think that you would need to provide this woman any additional support?
* If no, why no? If yes, what support do you think you could offer her?
* Do you think this additional information would change what you would think about what the woman was experiencing? If yes, how would it change?
* How do you think you would view or understand the woman’s experiences?
* What do you think would happen next in this situation?

**Part 3:**

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 strongly 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 a few times and wondered if this might explain why she was a bad mum.

**Predicted responses:**

[Example prompt questions]

* Do you think this additional information would change you would think about what the woman was experiencing? If yes, how would it change?
* Do you think that there is cause for concern in the story at this point? Can you say more about this?
* What do you think you would do at this point?
* Do you think that you would need to provide this woman any additional support?
* If no, why no? If yes, what support do you think you could offer her?
* 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 view or understand the woman’s experiences?
* How do you think you would feel if you were faced with this situation?
* How confident would you feel with supporting the woman in this situation?
* Do you feel that you would know what to do to support the woman in this situation?
* Is there any support that you would need to feel more able to support the woman in this situation?

1. **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?
* What do you think about the current approach to assessing psychosis in women during the perinatal period?
* 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? How confident would you feel?
* How likely would you think it would be that women would report these difficulties to you spontaneously? How would you feel about your ability to respond to any disclosures of this nature? What would the barriers to this be?
* How able do you think that women would feel to discuss these experiences with their midwives?
* Could you tell me about how you would feel if women disclosed these experiences?
* 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?

1. **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?

1. **Anything else**

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

## Appendix 2-D

### Excerpt of coded transcripts

Excerpt from Eleanor’s interview (non-specialist midwife):

|  |  |
| --- | --- |
| I: OK. Yeah. OK. And how would you feel about yourself providing Nina with support in this situation as well as the referral? |  |
| P: Erm I wouldn't want to say the wrong thing, so obviously I don't think the babies possessed, but it would be difficult, I don't think [pause]. Yeah, I don't know whether- I think you'd have to be in that situation to know whether to sort of go along with it, but not go along with it as in encourage her and be like, yeah, it's possessed. But just kind of, um brush it off slash, ignore it when she says it or just, you know, kind of go- but it's important for her to feel listened to as well 'cause, otherwise she might not be compliant with getting assessed you know you don't want to be sectioned or something, so you want to make her feel listened to so, listen and believe 'cause to her this is very real, so obviously you have to show that you believe her when she's telling you that the people are staring at her and that she doesn’t like it and that the baby is possessed. You have to listen to her and make her make it feel, you know validate that, but I don't think you can really go along and say and agree that the baby’s possessed, really. | * Not knowing what to say or how to interact * Balancing your own truth with validating woman * Important for woman to feel listened to and believed * Women lack choice in care |
| I: OK, yeah. And how would you feel about asking her more questions about these feelings or these experiences kind of on your own? |  |
| P: Yeah, 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, so you'd have to when you’re in someone’s house anyway, you do have to think about your safety. Yeah, 'cause sometimes like obviously you have to ask do they have any thoughts about harming themselves or others? She might then become angry either because she doesn't have any thoughts about that and then she'll become angry that you think, well, she thinks you think you do or that she does and then she she's even more worried about people taking the baby away then. So then, you know, it's displayed as anger. Potentially anyways, obviously not everyone, but yeah. | * Perception of psychosis as unpredictable and angry * Concern about midwives own safety with psychosis * Questions may imply judgment * Stigma with PMH |
| I: OK. Yeah. And would that impact how you felt about asking those questions, those kind of worries about how she might respond? |  |
| P: 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. So yeah, you just have to obviously be sensitive, read her body language and you know the way she's acting. | * Importance to ask difficult questions * MH is part of my duty |
| I: OK. |  |
| P: Read the situation basically to know how to word it exactly |  |
| I: Yeah. OK, and again how would you feel yourself in this situation? Would it feel different from being in the situation before for you? |  |
| P: Yeah, it would be, I think there might be a bit of an adrenaline maybe or yeah, I think you'd know you might be there quite long time and you'd be thinking, oh no, I'm gonna like, what about all the other people I've got to see. Obviously, you gotta let the coordinator know somehow that you're gonna be there a long time. But yeah obviously, this is more important than just rushing round seeing everyone else, but yeah, so you probably would be yeah bit of adrenaline, kind of a bit. Yeah 'cause you don't see this every day, so. | * Emotional impact for midwife * Time pressures with PMH * Role in PMH important * Rare situation |

Excerpt from Linda’s interview (Specialist Perinatal Mental Health midwife):

|  |  |
| --- | --- |
| I: And so experiences like that, so things like feeling paranoid or things like hearing voices or seeing things. Are they things you would have asked about specifically or would now? |  |
| P: Umm, I would now if the line of conversation was taking me down that that route um, I don't know whether I would if somebody was engaging and speaking to me in a very you know expected way, I don't think I would ask, openly say ‘do you hear voices or you know, do you see anything?’ If their-- the conversation was if they were saying they felt unwell umm, you know, you would ask that then, the same as with suicide and self harm. You know, you don't ask everybody. Do you want-- have you thought about killing yourself? It's if they come to you and that conversation leads that way. Then you're gonna want to explore those thoughts a little bit more. | * Impact of own perceptions on asking questions about PP * Perception of external indictors of PLEs * Unusual to ask everyone about PLEs * Reliance on women indicating concerns |
| I: Mm-hmm. Yeah. Yeah, that makes sense. And as a community midwife would you have had any worries or thoughts or kind of reservations about how women would respond to those kind of questions? |  |
| P: Yeah, I think everybody, the stigma around mental health is everywhere umm, I think midwives are nervous to ask. I think they're nervous to open that conversation. And likewise, I think women are scared to volunteer that information you know, for fear of sounding mad. They don't wanna sound like they're going crazy. And that stops you being able to tease things apart and say well actually, that's a normal way to feel at the minute. So it's a lost opportunity, it's a lost opportunity really. I think the lack of continuity doesn't help, I think staffing levels is really damaging. Because you need, I said, I was fortunate to work and manage my caseload. Women nowadays they're meeting different midwives at every antenatal appointment, so the midwife skill is decreasing because they haven't got the confidence to have those conversations when they know families and the women's confidence in the profession is waning. You know so yeah, it's it's we need to pull it back really, and recognize that the foundations of the services we need to put in place to make these things happen. That's the prevention is better than cure, isn't it? Otherwise we're going to see our hospitals overrun with things we've gotta cure. | * Impact of stigma on midwives * Self-stigma for women talking about psychosis * Impact of societal portrayal of psychosis * Stigma prevents normalization * Lack of continuity affects midwives confidence to have MH conversations |
| I: Umm yeah. Do you think that that lack of continuity affects having conversations like this with women as well for midwives? |  |
| P: Absolutely. Yeah, absolutely. Yeah. They don't know, they don't know the women. You know, midwifery’s a profession and you know you don't do it for the money. Yeah, you do it like I would do on calls and I would do an extra on call if one of my women went into labour, but that was only because I was invested in that family because I knew them, I've been on that journey with them. So if the phone rang at 2:00 o'clock in the morning and it was one of my women and I wasn't on call, you know, if my family allowed it and I could, I would go out the house and I would look after her in Labour. You know, you don't do that in any other job, do you? If you're in Asda and they say that shelf needs a little bit of sorting, you're not gonna go in off your own time. So I think that it's a reciprocal relationship with continuity, women get the most out of it and midwives invest the most in it, which allows conversations to mean something, isn't it? That's what it's about, it needs to mean something. | * Knowing women is important for MH conversations * Midwives and women both benefit from continuity |
| I: Yeah, yeah, that makes sense. Yeah. And when you were talking about kind of asking these questions, I'm guess I'm talking about specifically psychosis, but you might be thinking of other things as well about asking these questions maybe when it's indicated more than for everybody. Could you tell me a bit about what would-- I think you mentioned a few things, but what else would make you think, OK, maybe I'll ask that question or maybe there's something else going on here. |  |
| P: Yeah, I think that that two way conversation, sometimes women, if they're hearing auditory hallucinations or if they're seeing something, it could be really difficult for them to focus on the conversation. So I might become a bit more questioning and not because I necessarily want the answer, but what I want is to see they're thinking around as they're trying to come up with the answer, you know, are they just, are they distracted, are they fidgeting and moving around, you know, some women will get up and move around the house and not actually sit and make eye contact with you. So, you know all of those behaviours would make me want to question it more. | * Perception of external indictors of PLEs |
| I:OK. |  |
| P: Umm. And question it so that I've got more information to hand over to the right professional who’s gonna come in and make that assessment, you know. | * Communication with other professionals important |
| I: Yeah, yeah, absolutely. OK. And I know you said that this isn't something you do or did because of that waiting kind of for things that might make you ask questions. But what do you think it would be like to ask every woman about things like this, experiences of hearing things or seeing things? How would you feel about doing that? |  |
| P: I think it's difficult to ask every single woman. I think the first step we've gotta get is to have everyone with being asked about how they feel that day or what their emotional well being is like on that day. I think that that is the paramount bit at the moment because that's not being done. And I think that alone is that stigma, isn't it? I think if you added a layer to that to ask about voices and seeing things, we might retract a little bit in being able to bring that stigma out. I think education, so the antenatal education is, um, they’re a massive opportunity and they're the first thing that got pulled in COVID and you know, and nobody's very fast thinking about bringing it back in. So I think when we're talking about breathing exercises and giving birth and, you know, all the stuff we talk about in antenatal education sessions. There needs to be a massive mental health element and then I think it's a safe place to say that to a group of women, say some women become mentally ill. Some women may hear voices and see things, and it's really important that we recognize this really quickly to start couples and families having conversation. ‘Jesus, do you know that happens? Oh my God’ You know, because the one thing women will always say is no one ever told me, no one ever told me this could have happened to me. Umm, so it's how we get it right and I don't think a blanket approach is the right way to get it right because there's no quality of conversation. I think upskilling and training is one arm of it. Identifying is another arm of it and the education of families really in society on the whole that this is a part of childbirth. | * Barriers to asking about PLEs * Impact of stigma of psychosis on midwives * Perception that it’s helpful for women to have information about PLEs * Blanket approach to asking about PLEs unhelpful * Societal expectations of parenting |
| I: Umm, yeah, absolutely. You said that actually it's not even happening that women are asked how-- every women's asked, how they feel. What do you think the barriers to that are at the moment? |  |
| P: Again, lack of continuity and lack of time. | * Lack of continuity prevents MH questions * Lack of time prevents MH questions |

## Appendix 2-E

### Example of theme development

Please note not all codes for each theme are represented below

|  |  |  |
| --- | --- | --- |
| Theme | Codes grouped in the theme | Illustrative participant quotes |
| Identifying psychotic-like experiences would not be as easy as it sounds: making decisions on behalf of women | Stigma of psychosis  Asking about PLEs would scare women  Asking about PLEs inappropriate  Asking about PLEs is too intrusive  Using indirect questions to assess MH instead of direct  Information about PLEs could be stress inducing  Lack of autonomy for women | “People are just nervous to say that these things are happening because they feel it's a local authority or a social services thing and you know, and I'm still untangling that thought process with midwives even now in my role, you know, somebody has mental health very often a referral will go off to social services just because they've got mental health.” (Linda)  “You know, I think there is a lot of stigma still around the kind of expression of intrusive thoughts or seeing that your baby, some kind, somehow possessed.” (Joanne)  “You know, I think it's gotta be a tentative way to ask that question because I think there's a lot of stigma around those specific questions. I think you’ve gotta be delicate in wording for that sort of thing because I don't, I don't think ‘have you been hearing voices Nina’ sends the message that you are an advocate at that point in time.” (Sophie)  “Erm, you know, some women, if you talk about that kind of thing, they might start to focus overly focus on it, if that makes sense.” (Sarah)  “Erm I think it might scare women. (Sarah)  “So if you said, Nina, are you hearing voices, she might say, why would you say that to me? Or she might feel kind of unpleasantly seen, attacked, and I don't think that generating that kind of behaviour is gonna encourage her to access that support with you.” (Sophie)  "I think they would, they would, they would wonder why I was asking that question.” (Lucy)  “Yeah. I mean, I think you might get a suggestion of of that if she started saying I was told to do this and you might then question who would told her and you know, but I mean, it wouldn't be an ordinary thing to say to a women are you hearing voices?” (Olivia)  “I think they would probably feel it's quite intrusive [laughs]. If if there had maybe been no other factors like that would suggest that that was like an appropriate question.” (Hannah)  “Do you see what I mean? Nina, are you thinking of hurting your baby? It's not gonna necessarily be appropriate to go that direct.” (Sophie)  “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)  “quite possibly Nina wouldn’t notice that there was anything abnormal about her behaviour so potentially she might be resistant” (Eleanor) |
| Psychotic-like experiences can feel overwhelming | Needing support of colleagues  Emotional impact of psychosis for midwives  Fear around psychosis  Association of PLEs with severity | “I’m not quite sure what I'd do. I'd definitely escalate to a senior midwife [laughing] to find out what the the process would be erm because it's not an acute situation where you'd need to send a team out or get her back in immediately, but definitely I'd be worried that it could escalate very quickly to something serious. Um just that she might erm experience psychosis basically and and do something silly” (Olivia)  “I've looked after people who have had it [postpartum psychosis], but I think for the first time to be the person to, for lack of better words, discover it or you know that's that would be quite scary. So I think I’d probably feel quite nervous, but I also think you think. Come on you know the questions that have to be asked, you know the basic thing and I think I've always just had it as a bit of a chance in the back of my head. And if you don't know what to do, just get more information to try and get as much as you can to hand it over to the people because you don't want to say this is Nina, she's telling me that she thinks someone's gonna steal her baby, good luck. You know, that's not very helpful. So I feel like I’d know the basics of what to do, but I’d definitely be wanting that support. I probably wouldn't feel vastly confident.” (Lisa)  “I've heard it before, you know and I've looked after ladies with postpartum psychosis as well and my first few experiences of it was kind of like really nervous, really like that kind of probably losing sleep at night myself, worrying you know, what were you going to find in the morning and you know, kind of wanting to go into work but not wanting to go into work just to find out what was going on. Uhm, and almost you know, sort of carrying that.” (Joanne)  “As a brand new, just qualified midwife, who are quite often coming out straight into community I probably wouldn't have a clue and would be quite anxious myself erm. And yeah yeah, I suppose it just depends on your own experience as a midwife, but I think there's potential to be very worried, worried and anxious, upset.” (Hannah)  “But I guess just because I'd learned about it at uni and never seen I'd learn about how, and heard from my mentor as well, where she had some women who tried to physically attack her. So I knew what, how unpredictable, how quickly it could uh, escalate kind of things. So I was a bit kind of wary, didn't want to say the wrong thing kind of thing.” (Eleanor)  “I think midwives would be petrified if they if they had to assess like subpsychotic symptoms. Because they've got no training” (Linda)  “it's fear of the unknown because you don't come across this very often.” (Lucy)  “I think the emotion emotionally it would be quite worried and and possibly a little bit fearful erm if I was trying to contact the person who I needed to contact and they weren't available I think that would increase and heighten those feelings, because then you've got to start try and start sort of start making decisions for yourself about what you need to do to keep this mum and baby safe.” (Lucy)  “Yeah because um those kind of um experiences that women have you immediately associate with something serious” (Olivia) |
| This is my responsibility: I’ll do what I can to support women even if it’s hard | Role in facilitating women to feel comfortable  Developing a relationship with woman is important  Minimising of experiences by professionals can result in mother locating problem in individual  Focus on meeting women’s needs  Knowing the woman’s ‘normal’ is important  This is my responsibility | “That, I find that really helpful and they'll just say it as is because sometimes women want to swear or do you know what I mean? And they just wanna be their natural selves. So I try and facilitate that.” (Lucy)  “I feel like, for me the the booking appointment is so important and it you know and I think that kind of sets the foundation that you are really interested in that woman and all aspects of her life and that you are there for her to to kind of open up you know if she like, I've asked all these questions and I I really kind of try and get across that these are the sort of things that I'm interested in and and if she doesn't want to speak about it that particular day she knows that she can come back” (Joanne)  “And especially the more we see them face to face and the longer we get to know them for the more they might feel able to open up.” (Lisa)  “And then everything she’s saying, ‘oh they don’t sleep, they’re really fussy’. It will all be minimized. It'll be minimized by professionals, it'll be minimized by family and then it will manifest as ‘I can't cope or I'm no good at this.’” (Sarah)  “So I, at that stage, you know two nights of no sleep, so often I'll be very specific around this is what you can expect at this stage, postnatally. But other times it's more subtle, it's more kind of just sitting there really and giving the woman space to to speak and kind of not leading so much, but just allowing the woman to come in and and talk to you first and prioritize what she wants to say rather than you working through your postnatal notes.” (Kate)  “And I think the biggest thing having been in these situations before is the continuity. That's that's the bottom line, if you don't know that person, you don't know the shift. Erm kind of in their behaviour. Then you've got, you know, you might be thinking gosh she’, she's a bit of a standoffish lady or, you know, and that's not representative of who they are. And what you know of them already, I think, I think a lot of the time when you're kind of noticing these things, you do need to know someone well enough. Because you can kind of say, would you just pop and see her? She seems really tired and I think that's totally sensible, but I need her to see someone familiar that she knows and has that rapport with because I think she might volunteer that information better to you.” (Sophie)  “I think you know, everyone felt reassured by her presentation that she was fine. Well, having met her before I I knew that that couldn't be the case so it's asking more questions I think.” (Lucy)  “it's very much about the continuity of care. And, and that relationship building and that puts me in a very privileged position where it is much easier for me to make- to intervene early early on and and to recognize deviations from the normal earlier on than if I was seeing that woman in a hospital setting for the first time ever for a postnatal check or whatever. Umm, you know so, yeah, that's my go too, I guess.” (Kate)  “I think as a midwife, that's what we've got to do. Yeah, whatever we find come what may we like, we will have to, we will have to care for because we're there to be an advocate for her at that point in time and first and foremost, her and her baby need to be safe.” (Sophie) |
| The system I work in feels unsafe and insecure which makes my role in supporting PLEs harder | Defensive practice  I can’t risk not referring  Better safe than sorry  We’re not doing enough for women  Support for women can be restricted by systemic barriers | “I think midwives will make a judgment about whether the baby safe or not. You know, I think that's the first judgment. I think there's an element of defensive practice that would go with that then ‘Oh my God, I've gotta do the right thing because if she did anything to her baby.’” (Linda)  “It's it's like if I did a blood pressure is really high I can't just think oh that’ll- she's just here 'cause, it’s high 'cause she's anxious it'll go down later. Like you still got to if it's, you know, if it's high enough, then you still got to refer into the hospital. Uhm, and monitor that, I don't think mental health’s different to physical health in that way so. Yeah, I think just in case, it does transition and obviously for the woman as well, that if she's aware, that would be really frightening as well. And for the partner and yeah.” (Eleanor)  “I think I've probably got quite a low threshold for um, you know, uh, escalating a problem just in case.” (Olivia)  “I'd feel absolutely no problem in um being being over cautious in this situation rather than I wouldn't play it down, I'd rather um put all the safeguards in place, incase and and feel silly that I'd gone over the top then, than not. So rather, you know, I would definitely escalate and and get it treated seriously.” (Olivia)  “No, I don't think so. I think any warning signs they need to, I think you should escalate any concerns. I don't think you can kind of think well that's that's okay or some people can be very composed and um try and control it kind of thing. I don't think, yeah, I think if they disclose anything or if you detect something, I don't think even if it's just something I think it should definitely be checked out, yeah.” (Eleanor)  “I think it's about asking enough questions to understand the context of what's happening. But if I have got somebody who is hearing voices or depending on what the thoughts are, I would still be concerned and I would still be making sure they had a specialist input.” (Lucy)  “Erm it feels like us as midwives aren't doing enough because I wish that we, you know, we can't prescribe we can’t, you know, carry out CBT or anything like that. So it just feels like we're letting women down, even though it's not our speciality it-- I wish we could do more. I wish the services existed for women 'cause sometimes you'll recommend they go see the GP and that and then the next time you see them they have done it but they feel let down from their GP. So then I feel bad that that I kind of caused that kind of thing that I don’t have anyone better to refer them to.” (Eleanor)  “And I also think I'm very lucky in that when I've had problems before, when I've had women that I said, you know what, she's only the first visit I've got of the day, but this is something serious, I've been able to phone my line manager and they've gone, you know what, give, forget the other visits, we’re gonna farm them out to someone else and you stay there and focus on what you've got to do. And I think that's a really, really good thing. But unfortunately, you know, that will vary from trust to trust in how able they are to provide that for you. You know, if there's only three staff members on that day, what are they gonna do? (Lisa)” |

## Appendix 2-F

### Dimensions of themes



## Appendix 2-G

### Thematic structure

## Appendix 2-H

### Participant accounts contributing to each theme

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Participant | Identifying psychotic-like experiences would not be as easy as it sounds: making decisions on behalf of women | Psychotic-like experiences can feel overwhelming | This is my responsibility: I’ll do what I can to support women even if it’s hard | The system feels unsafe and insecure which makes the anticipated role in supporting psychotic-like experiences harder |
| Olivia | X | X | X | X |
| Joanne (Specialist PMH midwife) |  | X | X | X |
| Eleanor | X | X | X | X |
| Hannah (Specialist PMH midwife) | X | X | X | X |
| Linda (Specialist PMH midwife) | X | X | X | X |
| Sarah | X | X | X | X |
| Sophie | X | X | X | X |
| Lucy (Specialist PMH midwife) | X | X | X | X |
| Lisa |  | X | X | X |
| Kate |  | X | X | X |

# Critical Appraisal

Word count (excluding references, tables and appendices): 3998

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Declarations of interest: none

## Introduction

This critical appraisal section will summarise the findings of the systemic literature review and empirical paper within this thesis, drawing together the implications of these. It will also consider the strengths and limitations of the research, with critical reflection on the decisions taken and the researcher’s position.

## Overview of results

The systematic literature review explores the role of the couple and parent-infant relationships within postpartum psychosis (PP), and the impact of PP on these relationships. For many couples, these relationships supported the journey through PP. However, couples had to undertake relational adjustment to inherent relationship changes, alongside trying to maintain these relationships through an uncontrollable situation. For some, navigating these relationship changes strengthened their relationships. However, for others, it caused relationship strain. The findings highlighted the important role of the couple and parent-infant relationships within PP, alongside the potentially significant impact on them.

The empirical paper provides insight into the perspectives and perceptions of midwives in relation to perinatal psychotic-like experiences (PLEs). The findings highlight midwives’ perceptions of difficulties within their potential role in identifying and supporting women experiencing PLEs. The impact of personal and societal perceptions of psychosis were highlighted within participant accounts. Despite these complicating factors, midwives conveyed a sense of responsibility and duty for women. However, the systemic context of midwives’ work presented further barriers for them fulfilling this responsiblity. The results highlighted that midwives appear to often consider their important role within perinatal mental health. It also highlighted the importance of systemic support for midwives, alongside training on PLEs and psychosis.

The review findings indicate the considerable impact of PP for the whole family including mother, partner, and infant. Relational difficulties can impact emotional wellbeing of both mothers and fathers (Parfitt & Ayers, 2014), as well as impacting mother-infant attachment (Bianciardi et al., 2023). Therefore, early intervention for PP is evidently crucial (Doucet et al., 2011). This indicates the relevance of the empirical paper results, as supporting midwives to identify and support mothers’ PLEs may allow early identification of women at increased risk for PP (Kaymaz et al., 2012). Additionally, the early identification of unusual postnatal experiences that could impact the couple and parent-infant relationship would allow for systemic family intervention.

## Strengths, limitations, and methodological considerations

**Systemic literature review**

The findings of the systematic literature review offer an important novel insight into how relationships are experienced during PP. Each final theme represented findings across the majority of studies, indicating that themes did not rely on studies appraised as lower in quality. Although other papers have briefly explored this topic (Arampatzi et al., 2022), this is the first systematic review of the literature utilising thematic synthesis to produce new insights. A previous review explored the perspectives of PP from women and family members which highlighted that a woman’s social context can impact, and be impacted, by PP (Forde et al., 2020). However, the current review extends these findings through providing an in-depth understanding of how relationships are experienced, navigated and impacted by PP from the perspective of both women and male partners, whilst also considering the parent-infant relationship. The dual perspective is a strength of this review, as research into paternal emotional wellbeing during the perinatal period remains a developing research area (Shorey & Chan, 2020) and therefore it is important to continue to represent fathers’ views. Additionally, I felt it was crucial to include data relating to the relationship with baby within this review, as this appeared to be an important aspect of the experience of PP, as evidenced through this reflexive diary quote:

As I am looking through the papers that could be included in the review, it seems that the relationship with baby can influence the couple relationship and the experience of PP. It feels like I would be missing something to exclude this data from the review.

Furthermore, ‘Keeping the baby in mind’ is important within perinatal mental health (Barlow & Svanberg, 2009), therefore the inclusion of baby within the review aligns with clinical practice and policy.

Although the views of women and male partners were represented within this review, the primary data was skewed to women’s perspectives. This indicates the need for further research with male partners of women who have experienced PP. Additionally, there were no papers available that explored the experience of PP from the perspective of LGBTQ+ parents. A limited amount of research explores the perinatal mental health of lesbian mothers (Alang & Fomotar, 2015; McKelvey, 2014; Ross, 2005) which indicates some differences in the experience of parenting compared to heterosexual couples. This includes the impact of societal narratives (Alang & Fomotar, 2015) and additional stressors including being treated as if not a ‘true parent’ (Ross, 2005, p. 121). However, there are still gaps in this area with an absence of research relating to perinatal mental health in transgender and non-binary people (Greenfield & Darwin, 2021).

Evidently, further research into the perinatal mental health experiences of LGBTQ+ parents is needed, echoed by Darwin and Greenfield (2019). In particular, future research would benefit from exploring the relational experience of PP from the perspectives of LGBTQ+ couples. This research would contribute to ensuring that services are able to offer appropriate, evidence-based support that is inclusive of the needs of all parents.

**Empirical paper**

The empirical paper provides an in-depth understanding of midwives’ perspectives towards PLEs. This extends the existing literature into midwives’ views and experiences within perinatal mental health (Coates & Foureur, 2019), contributing to the important provision of holistic maternity care (Renfrew et al., 2020). The combination of the vignette and semi-structured interview questions allowed the exploration of an area that midwives may not have directly experienced, therefore facilitating richer discussion (Murphy et al., 2021).

This was an exploratory study focusing on a novel area, and was limited in size. This sample, however, allowed for the in-depth exploration of midwives’ perspectives and perceptions. This sample size was continuously reviewed to ensure its adequacy to generate detailed findings that met the study aims (Patton, 2015). This involved beginning data analysis during ongoing recruitment to determine the level of relevant rich data that had been collected. 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 the search for ‘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.

During initial recruitment difficulties, I was contacted by a Specialist Perinatal Mental Health (SPMH) midwife wishing to participate in the study. Initially, I wondered whether SPMH midwives would be excluded under the criteria due to their potential further training in mental health. However, the SPMH midwife role is relatively new, developed due to government priorities of supporting perinatal mental health (Maternal Mental Health Alliance, 2013). Consequently, training for SPMH midwives remains an ongoing process, with current varied levels of knowledge and skills reported from these midwives (MMHA, 2013). Some SPMH midwives report no formal training and perceive that they have insufficient knowledge and experience to work effectively within this role (MMHA, 2013; Royal College of Midwives, 2014). Therefore, after consideration and consultation with the research team, these midwives were included as it was felt that they would be able to offer a valuable insight into the perspectives of midwives towards PLEs. Additionally, considering the absence of research in this area, it felt important that willing participants could contribute to this body of literature.

This research project was exploratory in nature, therefore the heterogenous nature of the participant sample was appropriate as it allowed for a range of views within the topic area. Thematic analysis (Braun & Clarke, 2021b) was therefore appropriate for analysis due to its flexible nature, unlike other qualitative research methods requiring a more homogenous sample, e.g., Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009). Additionally, IPA explores lived experiences of phenomena, whereas in the current study midwives were not required to have direct experience of supporting women with PLEs, therefore thematic analysis was more appropriate for use.

The potential limitations of this methodological decision to include SPMH midwives were considered, as it was acknowledged that they may bring more topic experience and knowledge than non-specialist midwives. To account for potential limitations, during analysis I colour-coded codes that exclusively related to SPMH interviews to ensure that themes encompassed the views of both specialist and non-specialist midwives. However, it became clear throughout analysis that there were more similarities than expected between specialists and non-specialists, including experiences of drawing on societal narratives and appraising PLEs as worrying and scary. Although there were some differences within the experience and confidence experienced by specialist and non-specialist midwives, all the final themes encompassed views of both.

The vignette was designed to provide an example scenario of perinatal PLEs. Within this vignette, other experiences that may be experienced alongside PLEs (e.g., depression) were included (Holt et al., 2018), alongside common emotional implications of new parenthood (Lee et al., 2007). This was to provide a realistic representation of the context in which PLEs might be experienced, as well as allowing the comparison of midwives’ views towards PLEs compared to these other difficulties, such as depression.

Due to limited research indicating how perinatal PLEs may present (Mannion & Slade, 2014; Holt et al., 2018), the vignette was also informed by research into experiences of PP (Glover et al., 2014; Robertson & Lyons, 2003; Stockley, 2018), alongside tools to assess PLEs (Launay & Slade, 1981; Peters et al., 2004). Other specific symptoms associated with PP were not included (e.g., loss of inhibitions, fast rate of speech, feeling “high” in mood, unusual behaviour, restlessness) (NHS, 2020) as the aim of the research was to explore midwives’ perspectives specifically in relation to PLEs rather than diagnosed PP. However, in order for the scenario to be significant enough for midwives to discuss and recognise as possible experiences of psychosis, the example experiences were on the more extreme end of PLEs. Subclinical PLEs can demonstrate a considerable cross over with experiences within diagnosed psychosis. For example, triggers to these experiences (Heriot-Maitland et al., 2012) and frequency, loudness and personification of auditory hallucinations (Daalman et al., 2011; Johns et al., 2014).

Due to these similarities, the challenge of dichotomously distinguishing features of PLEs from those of clinical psychosis is discussed within the literature (Hinterbuchinger & Mossaheb, 2021). Additionally, PLEs and clinical psychosis are widely thought to exist on a continuum, therefore the categorical distinction of clinical psychosis may be erroneous (DeRosse & Karlsgodt, 2015). PLEs may result in distress and help-seeking, similarly to psychosis (Van Os et al., 2009). Some research indicates differences between subclinical PLEs and experiences within clinical psychosis, including a higher perception of threat and negativity within experiences of clinical psychosis (Peters et al., 2017), alongside an increased belief that unusual experiences were ‘caused’ by others (Lovatt et al., 2010). Despite this, within these studies there remains cross over between both groups with, for example, participants in both groups appraising experiences of psychosis as dangerous and external to them.

This, therefore, may support Hinterbuchinger and Mossaheb’s (2021) suggestion that further research is needed to distinguish between subclinical and clinical psychotic experiences. Consequently, it is likely that the PLEs described in the vignette show many similarities to experiences within PP. Semi-structured interview questions were therefore used to supplement the vignette, including specific questions explaining the nature of PLEs and exploring whether perspectives to subclinical experiences would differ from PP (Appendix 2-C). As evidenced within theme four, the ‘better safe than sorry’ position of many participants meant that their feelings and response towards subclinical PLEs did not differ than those towards clinical PP.

Initially, the vignette was created with accompanying questions around participants’ views of the thoughts, feelings and anticipated actions of the midwife in the scenario. This was intended to reduce participant anxiety of feeling ‘tested’ on their competence, as vignettes can help reduce discomfort around sensitive topics (Murphy et al., 2021). However, discussion of this with the research team, alongside consultation with the literature, highlighted that this could create analytical difficulties as the data may not represent midwives’ own perspectives and may elicit idealised answers (Sampson & Johannessen, 2020). Therefore, the vignette was instead used to ask midwives about their own thoughts, feelings and anticipated actions. Although this allowed the rich exploration of midwives’ perspectives towards an area they may not have directly experienced, there remains limitations to this approach. Barter and Renold (2000) highlight that vignettes used in this way, with questions around anticipated responses, may not reflect real-life experiences and responses. However, alternative research suggests that anticipated decision-making in response to health-related vignettes appear to reflect intended real-life decision making (Van Liew et al., 2020).

To account for possible limitations with using vignettes, follow up questions within the interview schedule were used to explore midwives’ own thoughts, feelings and understandings, aside from the scenario in the vignette. The vignette was reviewed by two midwives to ensure it was suitable and appropriate for research with midwives, as recommended to ensure vignettes resemble realistic situations for participants (Evans et al., 2015). However, it would have been beneficial to pilot the vignette on a group of participants before data collection (Gray, Royall & Malson, 2017). Recruitment difficulties and time limits meant this was not feasible for this project, however this should be considered in future research.

Within this research, the vignette was useful for providing a context for the interview focus, as well as allowing a framework to discuss perspectives and perceptions. However, in the early stages of the research I noticed that for participants who were more comfortable talking about perinatal mental health, the vignette could potentially present a barrier to rich conversation:

I wondered if the vignette was more of a hindrance than a help in this interview, because at times it felt like it was interrupting richer conversations and bringing it back to more thin descriptions. (Reflexive diary excerpt)

Therefore, in subsequent interviews, after consultation with the research team, I decided to use the vignette flexibly. This meant that for participants who, during the initial stages of the interview, appeared more able to talk about perinatal mental health in-depth, I used the third part of the vignette to maintain exploration of the research question in relation to PLEs, but did not require the use of the first two parts to build up to this. This is consistent with the use of semi-structured interviews, where identical interview questions do not need to be maintained between individuals and instead can be adapted to correspond with participants’ responses (Adams, 2015). Many midwives had experienced supporting women with experiences of psychosis and could reflect on these experiences and their thoughts and feelings towards this. However, it may be that the use of vignettes impacted midwives’ responses, and therefore future research without the use of vignettes may be beneficial.

Participants were offered face-to-face or remote interviews and all chose to conduct the interview remotely. Remote interviews can be more convenient and accessible for participants (Gray et al., 2020) and provide access to data from participants from varying geographical areas (Keen et al., 2022). This benefitted the current study, as participants from England, Wales and Scotland participated. Some research indicates that video interviews can reduce the ‘richness’ of collected data (Johnson et al., 2019), suggesting that in-person interviews achieve a more in-depth discussion (Krouwel et al., 2019). However, guidance for remote interviews (Engward et al., 2022) was considered within the current study, with time taken to build rapport at the start of the interview and non-verbal communication used throughout to convey interest and understanding to participants. Rapport building was considered within the interview schedule through ‘warm up’ questions around perinatal mental health to build rapport with the participant before talking about PLEs. The average length of interview was 58 minutes, suggesting that participants felt comfortable discussing their perspectives. All participants were familiar with the remote video software used, possibly due to adapting to this in their professional context during COVID-19 (McGrory et al., 2022), which may have benefitted the quality of interviews.

## Epistemological position

Upon initial reading of epistemological and ontological positions, I felt confused by language used to describe these concepts that felt inaccessible to me. Braun and Clarke’s (2021b) overview of these positions supported my understanding into this area of research, which informed the epistemological positioning of the current study. Upon reading about realism (Wiltshire & Ronkainen, 2021), which represents an objective ‘truth’ in the world and describes the researcher’s position of objectively conveying the meaning within data, I felt this was inconsistent with my way of understanding the world. This led to my exploration of critical realism, which suggests that within thematic analysis, the researcher accesses ‘participants’ perception of (their) reality, shaped by and embedded within their cultural context, language and so on’ (Braun & Clarke, 2021b, p. 171). This reflected my own ideas around ‘truth’ and ‘reality’ being impacted by individual communications and interpretations, and therefore was the epistemological position taken. Within this position, it is important to recognise that the interview and analysis was conducted through the lens of my own social context, cultural position and beliefs which will have influenced the represented reality.

In line with my epistemological position, the themes generated consider and discuss the social and systemic world that participants’ realities were grounded in. For example, theme four discusses the influence of working within NHS systems in the current political climate, as this was an important aspect of participants’ realities. I also felt it was important that participant narratives were not separated from the western societal context around psychosis, therefore participant accounts have been situated within relevant societal narratives.

## Personal reflections

Personal reflexivity was an important aspect of this thesis due to the epistemological position alongside the principles of reflexive thematic analysis (Braun & Clarke, 2019). Coming into the research, I had a heightened awareness of aspects of my identity including belonging to a different professional group from the participants I would be recruiting. The NHS is described as a hierarchical organisation (Fernandopulle, 2021) and I was conscious of my position as a professional typically viewed as more ‘senior’ than midwives, due to the positioning of Clinical Psychologists as leaders (Skinner et al., 2010). Going into interviews as an ‘outsider’ to the participant group (Dwyer & Buckle, 2009), I was apprehensive that participants would perceive me as holding a ‘superior’ role to them which would impact the interview dynamics:

(Before first interview) I think I’m very conscious of ensuring I don’t come across as patronising towards participants and I’m not sitting in an ‘expert’ position that might stop them from feeling safe to share their honest thoughts. (Reflexive diary excerpt)

To address this, before starting the interviews I reiterated to participants that they were the expert within this interview as I was purely interested in their perspective. I acknowledged that I may ask questions which were perceived to have a ‘right or wrong’ answer, but that this was not the case, and I encouraged them to be as honest as possible. After the first interview, I reflected on these concerns:

I felt like she may have perceived me as ‘testing her’ throughout the interview and I felt conscious that she did not feel I was doubting her ability, even though I’d done the caveat at the start.

In response to these reflections, in future interviews I was conscious of how I worded questions so they did not evoke a sense of being tested, e.g., language around perspectives and views was used rather than around knowledge. It is possible this prevented deeper exploration around midwives’ knowledge of PP and PLEs, however I felt that this was acceptable to support rapport and safety within interviews, considering the research question was focused on perspectives rather than knowledge.

The difference in my professional identity compared to participants also prompted reflections of influences on my lens of viewing participant accounts:

Today I’ve been reflecting on my own role within the research. I’ve been thinking about how I am more privileged in the NHS than the midwives I’m interviewing – paid more, more hierarchical power, more protected (supervision). So, I’m viewing their experiences through a lens of having more time, space and permission to emotionally process what it’s like to work with people in distress. It’s made me consider what it’s like to work with women and babies without this space, and how this may impact the high levels of fear around experiences of psychosis that I’ve heard in interviews so far that were initially quite surprising to me. 26/07/22 (Reflexive diary excerpt)

During my third year, I started a placement on a Mother and Baby Unit which helped me further reflect on the emotional experience of this role:

I’ve found the first few weeks of placement quite emotionally demanding. I think there’s something overwhelming about feeling that you hold a responsibility for babies, considering the possible long-term impact of maternal mental health for them. This has made me think about my thesis, in terms of the responsibility that midwives hold. I’ve been reflecting on the fact that they are expected to do a lot without much support, so it’s understandable that adding a perinatal mental health role into this may feel overwhelming. (Reflexive diary excerpt)

Writing about these thoughts and reflections throughout the research helped me to maintain a conscious awareness of my position and the potential impact on data analysis. Initially, I viewed the responses to experiences of psychosis as reflecting a disproportionate level of fear and panic, however these reflections helped me to ground these perspectives within participants’ professional contexts and alter my perceptions around this.

In the beginning stages of the research, I noticed I initially held assumptions and predictions of what midwives’ perspectives may be, informed by the literature I had read reporting that midwives felt unconfident and unknowledgeable within mental health (Bayrampour et al., 2018):

I am predicting that midwives won’t be asking women about these experiences often, that they will hold negatives views or have very little knowledge about it. 24/05/21. (Reflexive diary excerpt)

Therefore, I noticed that when some midwives reported confidence in their role, my initial response to this was to feel doubtful and surprised. Being consciously aware of this helped me to ensure that I explored these experiences of confidence with the same level of detail as I explored those of feeling unconfident, and ensure that they were captured within coding. This experience of confidence was not shared across participants, however it felt important that this was reflected within the themes, so themes did not rest entirely on narratives of those who felt unconfident. Therefore, this was reflected within theme three of the results.

## Conclusion

Within this section, I have identified the strengths and limitations of my research, critically reflected on methodological decisions, and discussed my personal reflections. Future work would benefit from addressing the limitations acknowledged above through further exploration of midwives’ perspectives towards PLEs with homogenous, larger samples. Nonetheless, the systematic literature review and empirical research offer valuable, novel insights that could contribute to the continued development of support for women and families affected by PP or PLEs.

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# Ethics application and approval

Ethical application and proposal for the empirical research study

Word count (excluding references, tables and appendices): 4819

Molly Turgoose

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

## Application for ethical approval

**Faculty of Health and Medicine Research Ethics Committee (FHMREC)**

**Lancaster University**

**Application for Ethical Approval for Research**

***for additional advice on completing this form, hover cursor over ‘guidance’.***

**Guidance on completing this form is also available as a word document**

**Title of Project**: Midwives’ perspectives and perceptions in relation to psychotic-like experiences in the perinatal period

**Name of applicant/researcher**: Molly Turgoose

**ACP ID number (if applicable)\*:**       **Funding source (if applicable)**

**Grant code (if applicable):**

**\*If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [**[link](http://www.lancaster.ac.uk/fhm/research/research-ethics/#documentation)**].**

**Type of study**

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

**SECTION ONE**

**1. Appointment/position held by applicant and Division within FHM**  Trainee Clinical Psychologist – Doctorate in Clinical Psychology

**2. Contact information for applicant**:

**E-mail**: **Contact details removed for submission** **Telephone**: **Contact details removed for submission** (please give a number on which you can be contacted at short notice)

**Address**: **Contact details removed for submission**

3. **Names and appointments of all members of the research team (including degree where applicable)**

Molly Turgoose, Trainee Clinical Psychologist

Professor Bill Sellwood – Programme director

Dr Craig Murray – Senior Lecturer

Dr Elizabeth Chamberlain – Clinical Psychologist

**3. If this is a student project, please indicate what type of project** by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the [FHMREC website](http://www.lancs.ac.uk/shm/research/ethics)  
  
PG Diploma  Masters by research  PhD Thesis  PhD Pall. Care

PhD Pub. Health  PhD Org. Health & Well Being  PhD Mental Health  MD

DClinPsy SRP  [if SRP Service Evaluation, please also indicate here: ] DClinPsy Thesis

**4. Project supervisor(s), if different from applicant**:

Professor Bill Sellwood

Dr Craig Murray

Dr Elizabeth Chamberlain

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:

Professor Bill Sellwood – Programme director (Doctorate in Clinical Psychology – Lancaster University)

Dr Craig Murray – Senior Lecturer (Doctorate in Clinical Psychology – Lancaster University)

Dr Elizabeth Chamberlain – Clinical Psychologist (Merseycare NHS)

**SECTION TWO**

**Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants**

1. Anticipated project dates (month and year)

Start date: End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person’s language):

**Data Management**

*For additional guidance on data management, please go to*[Research Data Management](http://www.lancaster.ac.uk/library/rdm/) *webpage, or email the RDM support email:* [rdm@lancaster.ac.uk](mailto:rdm@lancaster.ac.uk)

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line ‘chat-rooms’

4c. If yes, where relevant has permission / agreement been secured from the website moderator?

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users?

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain?

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

**8. Confidentiality and Anonymity**

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

**SECTION THREE**

**Complete this section if your project** **includes *direct* involvement by human subjects**

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

Some new mothers report ‘psychotic like symptoms’. This means, having unusual beliefs that other people don’t have, or hearing or seeing things that other people cannot. This can be frightening and may be connected to other mental health problems related to giving birth.

During their pregnancy, women will often see midwives. This means that midwives are in a good position to support women with unusual thoughts or beliefs. We don’t have a good idea about midwives’ views and thoughts about these experiences. However, we know that midwives have difficulties when supporting mums with their mental health.

This study aims to find out more about midwives’ views on new mothers’ psychotic like experiences. The study will give midwives examples of these thoughts and beliefs and ask them to talk about them. The results will show different areas that seem important and relevant for midwives. The results can then be used to support and train midwives. This support and training will be important to help women with these thoughts and beliefs.

2. **Anticipated project dates (month and year only**)

Start date: December 2021 End date March 2023

**Data Collection and Management**

*For additional guidance on data management, please go to*[Research Data Management](http://www.lancaster.ac.uk/library/rdm/) *webpage, or email the RDM support email:* [rdm@lancaster.ac.uk](mailto:rdm@lancaster.ac.uk)

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

This qualitative study will aim to recruit 10-20 participants as this allows for intensive analysis of participant accounts, whilst still aiming to provide a range of perspectives.

The inclusion criteria for participants is:

- Midwives registered with the relevant UK professional body, which is the Nursing and Midwifery Council (NMC)

- Midwives who are currently in an environment where most of their role includes direct contact with expectant and/or new mothers

- Ability to take part in the interview in English due to a lack of funds for interpreters

Exclusion criteria:

- ~~Midwives who have a professional background working as a mental health practitioner. This is because these midwives are likely to have a particular interest and increased knowledge of perinatal mental health. They are, therefore, less likely to provide an insight into the perspectives of the majority of midwives without professional mental health training.~~

- Midwives who have a professional background working as a mental health practitioner (e.g. mental health nurse). This is because these midwives will have had extensive training and experience in different areas of mental health and therefore may differ considerably from the perspective of a midwife without this training. This exclusion does not include Specialist Mental Health Midwives, who can still be included in the study as they can still provide insight into the perspectives of midwives without prior mental health training.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Participants will be recruited for this study through the Maternity and Midwifery Forum website and the Royal College of Midwives. Both organisations will advertise the research project to their respective members through their websites and social media platforms, e.g. Twitter and Facebook, subject to ethical approval. An advertisement for the study (Appendix B) will be sent to both organisations which will include a brief summary of the project and contact details for the researcher. The poster will ask individuals who are interested in participating in the research to contact the researcher via their academic email or research telephone number. Once adequate participant numbers are reached, the organisations will be informed and any further volunteers will informed that the study has reached maximum participant numbers.

If sufficient participant numbers are not achieved through this method then social media sites will be utilised. An information poster (Appendix C) will be posted on social media websites to increase recruitment numbers. The researcher’s contact details will be provided on this information poster and individuals will be asked to contact the researcher.

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

Participants will be interviewed either face-to-face, via Microsoft Teams or telephone. Face-to-face interviews will only be possible for participants who are in the Northwest area. For face-to-face interviews, participants will be given the consent form to read and sign. For remote interview, the consent form will be read out to participants, and they will be asked for their verbal consent for each question. Participants will be reminded that they do not have to take part and are able to withdraw from the interview at any point during the interview and up to 14 days after the interview. Interviews will be recorded for the purposes of transcription and data analysis.

After participants have given consent to take part, they will be asked to complete the demographic information questionnaire. Participants taking part remotely will be asked to complete this questionnaire verbally. This data will be stored on Lancaster University’s password protected secure drive and kept separately from the interview data.

Participants will then be engaged in the interview. This includes hypothetical vignettes of women experiencing mental health difficulties, particularly focusing on PLEs. Participants will be asked questions in relation to this vignette that will allow for exploration and focus on their perspectives, sense-making and predicted responses. This will be done using a semi-structured interview schedule to allow for a more in-depth qualitative understanding of participants’ perspectives. The flexible interview schedule will include questions around their perceptions and understanding of new mothers with experiences as described in the vignette, as well as experiences they may have had working with mothers with similar experiences to the vignette. This method is effective for exploring perspectives and understandings without requiring participants to have had direct experiences of the topic (Gray, Royall & Malson, 2017).

Thematic analysis will be used to analyse the interview transcripts. The analysis will be approached from a critical realist theoretical position which will aim to understand participants’ reality, meaning and interpretations. This approach acknowledges that whilst the intention is to develop an understanding of reality, the data may not always reflect ‘true’ reality due to the researcher’s interpretations being shaped by their own experiences and knowledge (Willig, 2012).

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

Face-to-face and telephone interviews will be recorded with an audio recorder. These recordings will be transferred to Lancaster University’s secure password protected drive using their virtual private network (VPN) or secure University OneDrive. Data will be transferred as soon as possible. Once the recordings have been securely transferred, they will be deleted from the audio recorder. Participant audio recordings will be deleted from the university’s drive once the researcher has passed their viva voce examination. Microsoft Teams interviews will be recorded using the internal recording feature and uploaded to a secure folder on the University’s OneDrive immediately after the interview. The recordings will then be immediately deleted from Microsoft streams and the meeting chat.

The audio recordings will be transcribed and participant transcripts will be labelled with pseudonyms to identify them. A key will be made to link participants to their pseudonym in case they wish to withdraw their data before the project has been completed. This key will be password protected and stored in Lancaster University’s password protected drive. Any further identifiable data will be removed from interview transcripts.

Participant’s consent forms, audio consent form files and demographic questionnaires will be password protected and stored electronically on Lancaster University’s secure encrypted drive. They will be labelled with a pseudonym to connect them to the respective participant interview, but will be stored in a separate file to the interview transcripts.

Any personal contact details from the participants will be encrypted and stored on the University’s secure password protected drive. These details will be deleted as soon as the interview collection is complete, unless participants wish to receive the findings of the study in which case the details will be deleted after findings have been sent out.

Interview transcripts and encrypted data will be shared with the Doctorate of Clinical Psychology programme’s Researcher Co-ordinator and stored electronically by Lancaster University in a secure location for 10 years. This data will be transferred through the University’s encrypted secure OneDrive software. The storage of this data will ultimately be the responsibility of the project’s main supervisors.

7. Will audio or video recording take place?  no  audio  video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

Audio recording of interviews will take place on a portable audio recorder which cannot be encrypted. Therefore, the audio recordings will be transferred from the portable recorder to Lancaster University’s secure password protected drive. The audio recordings will be deleted off the portable audio recorder as soon as they have been transferred.

b What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

The audio recordings from the interviews will be written up into a transcript format and all audio recordings will be deleted once the researcher has passed their viva voce examination. Audio recordings of verbal consent will be encrypted and stored on Lancaster University’s secure drive. Audio recordings will be labelled with a pseudonym to link them to interview transcripts. Audio recordings of verbal consent will be stored for 10 years. The storage of these recordings will ultimately be the responsibility of the research director.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

The raw interview data will not be shared as the sample size of the study is small and sharing the transcripts of full interviews may compromise participant’s anonymity. Participants’ interview narratives will be unique and sharing these in their entirety may risk participants being identifiable. Raw data will be transferred to the Doctorate of Clinical Psychology’s Research Coordinator after submission where it will be stored for 10 years before being deleted.

8b. Are there any restrictions on sharing your data ?

Full raw data will not be shared as this may compromise participant anonymity.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law?

b. Detail the procedure you will use for obtaining consent?

Once individuals contact the researcher, they will be sent the individual the participant information sheet and consent form to review. Participants can raise questions via email or research telephone. The consent form will highlight situations in which confidentiality may need to be broken and what will happen in this scenario. Additionally, at this point the participant will be sent a copy of the vignettes that they will be asked questions in relation to in the interview. This is to reduce any anxiety that may arise because of being presented with unexpected vignettes during the interview that may result in midwives feeling “tested”. As the vignettes are being provided to prompt midwives thinking around these issues, and not to examine their diagnostic knowledge or competence, it is felt that providing the vignettes in advance will not compromise the results.

If the individual would still like to participate after reading the materials, the researcher will contact the potential participants to arrange an interview time. At the start of the interviews, the researcher will obtain consent from the participants using this consent form. Participants will be given another opportunity to raise any questions about the consent form or research. Participants will be reminded that they do not have to take part in the study and are able to withdraw from the interview at any point up to two weeks after their interview.

For face-to-face interviews, participants will be given a paper consent form to read and sign. The same consent form will be read out to participants taking part remotely, and they will be asked for their verbal consent for each question on the consent form. Verbal consent will be recorded as a separate audio file to the interview audio recording. This verbal consent will be stored separately from the participant’s interview.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

It is not anticipated that the questions asked during the interview will cause distress for the participants as the topic of the interview will be regarding the participant’s perspectives towards imagined situations and responses in a professional capacity. However, there is still a possibility that difficult feelings may arise for participants. This risk of distress will be highlighted on the participant information sheet and a list of support services will provided.

Participants will be reminded at the beginning of the interview that they can take breaks throughout the interview wherever necessary or stop the interview and reschedule if they wish. They will also be informed that they can decline to answer any question at any point during the interview. The researcher will hold participant wellbeing as a priority throughout the interviews and be mindful of any indications of distress. If participants appear distressed, they will be reminded that they are able to take a break or stop the interview. Participants will also be directed to support resources; namely the Royal College of Midwives health and wellbeing support services on their website: <https://www.rcm.org.uk/health-and-wellbeing-support/>, Mind: 0300 123 3393, <http://www.mind.org.uk/> or their GP.

Participants will be informed that they are able to withdraw from the study at any time during the interview and can withdraw their data from the study up to two weeks after the date of the interview. After this two week period, interview data will begin to be analysed and collated therefore it may not be possible to extract individual participant data.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

For remote interviews, there are no physical risks anticipated. Participants will be asked to contact the researcher via their university email, and a non-personal research phone will be used for participants to contact the researcher by phone. The researcher will use non-personal accounts and IDs for interviews that are conducted via videoconferencing software.

For face-to-face interviews, the researcher will follow Lancaster University’s guidance for lone working as well as the Division of Health Research’s ‘Lone researching policy’. The researcher will have a safety partner who will be given details of the location of the interview in an enclosed envelope or password protected document. The researcher will contact their safety partner by telephone on arrival at the interview location, and after the interview is completed. The safety partner will be informed of the time that the researcher will contact them after the interview to confirm their safety. The safety partner will be informed that if the researcher does not contact them, they should try to contact them and if they cannot, they should open the envelope to determine the location of the interview and contact the police.

If the researcher experiences any distress as a result of the study, they will contact their research supervisors who will offer support in relation to this.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There are no direct benefits to taking part in this study. However, it is hoped that the results will help us to support midwives with their role of supporting perinatal mental health which participants will hopefully find a positive and meaningful contribution to their profession.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

If participants wish to take part in the interviews face-to-face, travel costs for participant travel will be reimbursed by the DClinPsy programme at Lancaster University up to the maximum of £20 per participant. This reimbursement can only be made for travel within the North West, therefore face-to-face interviews will not be able to take place outside of this region.

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Transcripts will be anonymised in order to protect participant anonymity and identifiable data will be removed. Interview data will be transcribed by the interviewer and the researcher will be mindful to ensure that any direct quotes used from the interviews protect the participant’s anonymity.

For interviews that take place over videoconferencing software, the researcher will use their professional work account, or set up a new account for the purposes of the research. Participants will be reminded at the start of remote interviews that the researcher cannot completely guarantee the security of online videoconferencing platforms and reminded that they can withdraw their data from the study up until 2 weeks after their interview.

In the participant information sheet and at the start of the interview, participants will be informed about the limits of confidentiality and informed that if they discuss information that indicates a risk to themselves or other people, this information will be passed on to the researcher’s supervisors in the first instance to determine a course of action. Due to the nature of the project focusing on professionals’ views and perspectives on mothers’ experiences, it is not anticipated that this is likely to arise during interviews. Participants will also be informed that if their interviews reveal malpractice or professional misconduct, this information will be passed on to the researcher’s supervisors and their professional body, if necessary. If malpractice or a breach of confidentiality is identified, the researcher will contact their research supervisors in the first instance to determine whether this information needs to be passed on. If it is deemed by the researcher’s team that this information needed to be taken further then the professional body for midwives, the Nursing and Midwifery Council (NMC), would be informed.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

Qualified midwives, sourced through the field supervisor for this project, have reviewed the study materials and provided feedback. A midwife sourced through social media provided feedback on the vignette.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The findings from this research will be written into a research paper which will form part of the researcher’s thesis for the Doctorate of Clinical Psychology. A lay summary of the findings will be written and shared with the participants of the study if they wish to receive it. The findings will also be shared with the organisations that assisted in recruitment and study design. The researcher will write the findings into a publishable format and aim to publish this in appropriate research journals. If the opportunity arises, the findings may also be presented at a relevant conference.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

None.

**SECTION FOUR: signature**

**Applicant electronic signature**: Molly Turgoose Date 08/11/2021

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review

**Project Supervisor name** (if applicable): Craig Murray, Bill Sellwood, Elizabeth Chamberlain

Date application discussed 20/10/2021

**Submission Guidance**

1. **Submit your FHMREC application by email to Becky Case (**[fhmresearchsupport@lancaster.ac.uk](mailto:fhmresearchsupport@lancaster.ac.uk)) as two separate documents:
   1. **FHMREC application form.**Before submitting, ensure all guidance comments are hidden by going into ‘Review’ in the menu above then choosing *show markup>balloons>show all revisions in line.*
   2. **Supporting materials.**Collate the **following materials for your study, if relevant, into a single word document:**
      1. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
      2. Advertising materials (posters, e-mails)
      3. Letters/emails of invitation to participate
      4. Participant information sheets
      5. Consent forms
      6. Questionnaires, surveys, demographic sheets
      7. Interview schedules, interview question guides, focus group scripts
      8. Debriefing sheets, resource lists

**Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.**

1. Submission deadlines:
   1. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to [Becky Case](mailto:fhmresearchsupport@lancaster.ac.uk) **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the [FHMREC website](http://www.lancs.ac.uk/shm/research/ethics). Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.
   2. The following projects will normally be dealt with via chair’s action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:
      1. existing documents/data only;
      2. the evaluation of an existing project with no direct contact with human participants;
      3. service evaluations.
2. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

**Ethical application approval**



Applicant: Molly Turgoose  
Supervisor: "Professor Bill Sellwood, Dr Craig Murray, Dr Elizabeth Chamberlain" Department: DHR  
FHMREC Reference: FHMREC21040

03 December 2021

**Re: FHMREC21040  
Midwives’ perspectives and perceptions in relation to psychotic-like experiences in the perinatal period**

Dear Molly,

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

-  ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;

-  reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);

-  submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information. Email: fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

Tom Morley,  
Research Ethics Officer, Secretary to FHMREC.

**Ethical application amendment**



Graphical user interface, application

Description automatically generated

Graphical user interface, application, email

Description automatically generated

Graphical user interface, text, application, email

Description automatically generated

Graphical user interface, application

Description automatically generated

Graphical user interface, text, application, email

Description automatically generated

Text

Description automatically generated with medium confidence

**Ethics amendment approval**

FHM-2022-0701-AmendPaper-1 Midwives’ perspectives and perceptions in relation to psychotic-like experiences in the perinatal period

Dear Molly Turgoose,

Thank you for submitting your ethics amendment application in REAMS, Lancaster University's online ethics review system for research. The amendments have been approved by the FHM REC.

Yours sincerely,

Faculty Research Ethics Officer on behalf of FHM

## Appendix 4-A

### Research Protocol

Title of Project: **Midwives’ perspectives and perceptions in relation to psychotic-like experiences in the perinatal period**

Researcher: Molly Turgoose, Trainee Clinical Psychologist, Lancaster University

Research Supervisor(s): Dr Craig Murray, Senior Lecturer, Lancaster University

Prof. Bill Sellwood, DClinPsy Programme Director, Lancaster University

Field Supervisor: Dr Elizabeth Chamberlain, Mersey Care NHS Foundation Trust

**Introduction**

Around one in 1000 women are diagnosed with postpartum psychosis during the perinatal period ([Vanderkruik et al., 2017](#_ENREF_7)). However, ‘psychotic-like experiences’ (PLEs) are considerably more common for women during this period ([Mannion & Slade, 2014](#_ENREF_5)). PLEs are similar to experiences of psychosis, e.g. hallucinations and delusions, but are subclinical, i.e. below clinical threshold (Yung et al., 2009).

PLEs appear common during the perinatal period, with 56%-93.3% of women endorsing at least one PLE (Holt et al., 2018; Mackinnon et al., 2017; Mannion & Slade, 2014). There is a limited understanding of the mechanisms underlying these experiences in this period, however some research suggests this is linked to post-traumatic stress symptoms (Holt et al., 2018).

PLEs are transient experiences for many women, and are often unaccompanied by mental health difficulties (Yung et al., 2006). However, PLEs can be worrying experiences and women may be concerned about disclosing them due to worries about stigma and anticipated consequences, such as having their baby removed (Goodman, 2009; Jones, 2019). Some new mothers report that PLEs are very distressing (Holt et al., 2018; Mackinnon et al., 2017) and they may indicate early signs of increased risk for postpartum psychosis (Van Os et al., 2009).

Although new mothers often do not seek support from mental health services ([Schmied et al., 2016](#_ENREF_6)), most mothers will regularly see midwives during the perinatal period. NICE guidelines recommend that conversations about mental health should be had with pregnant women during the first primary care contact and early postnatal phase (NICE, 2014). This provides opportunities for midwives to give reassurance to mothers who are worried about experiences like PLEs ([Alderdice et al., 2013](#_ENREF_1)) and provide support for women at increased risk for postpartum psychosis.

Midwives appear to appreciate the importance of their responsibility regarding perinatal mental health (PMH) but indicate confusion regarding the extent of their role (Bayrampour et al., 2018; Carroll et al., 2018). Multiple barriers are identified by midwives that cause difficulties when approaching mental health concerns, including low confidence, low perceived knowledge and skills, and worries about offending women (Bayrampour et al., 2018; Carroll et al., 2018). Midwives report that they will assess more frequently for depression and anxiety compared to psychosis (Carroll et al., 2018; Hauck et al., 2015), suggesting the presence of specific barriers preventing midwives from discussing psychosis with women. If midwives do not ask women about experiences of psychosis, they are likely to miss the presence of PLEs, which are common in the perinatal period (Holt et al., 2018; Mackinnon et al., 2017; Mannion & Slade, 2014).

It is fundamental that midwives are able to discuss PLEs with women, as women report uncertainty around the difference between the ‘typical’ emotional impact of having a baby, and mental health difficulties (Delaney et al., 2015). Women may experience shame when discussing experiences of unusual thoughts or hallucinations (Glover, Jomeen, Urquhart, & Martin, 2014), therefore it is vital that midwives can provide a non-judgmental space to allow women to feel comfortable discussing these experiences. Additionally, women who have experienced psychosis report wanting information and reassurance from healthcare professionals (Doucet et al., 2012) and some did not feel listened to by their midwife (Glover et al., 2014), therefore it is important that midwives feel able to provide this support.

PLEs may sound concerning to professionals, however, evidence indicates that PLEs are likely to be fleeting experiences for most women that cause minimal distress (McGrath et al., 2015) and women are likely to benefit substantially from information and support from midwives.

This study will focus on exploring midwives’ perspectives and perceptions of PLEs in the perinatal period. The aims of the study will be to achieve a greater understanding of midwives’ perspectives and the barriers that may prevent midwives opening conversations and/or supporting women with PLEs. Current research demonstrates that there is a considerable lack of knowledge of midwives’ perspectives and perceptions around perinatal PLEs. Increasing our understanding of midwives’ perspectives would inform interventions and training to support midwives to feel more confident in this role, and consequently improve care that new mothers receive. A qualitative methodology will be used with thematic analysis as this will allow in-depth and rich information regarding the perspectives of midwives to be obtained. This qualitative method will allow for the exploration of the multiple factors that may contribute to midwives’ perspectives on these topics, and interviews will allow for a deeper understanding of these to be gained.

**Method**

**Participants**

This qualitative study will aim to recruit 10-20 participants as this allows for intensive analysis of participant accounts, whilst still aiming to provide a range of perspectives.

The inclusion criteria for participants will be as follows:

* Midwives who are registered with the relevant UK professional body, which is the Nursing and Midwifery Council (NMC)
* Midwives who are currently working in an environment where the majority of their role includes direct contact with expectant and/or new mothers
* Ability to take part in the interview in English due to a lack of funds for interpreters

Exclusion criteria:

* Midwives who have a professional background working as a mental health practitioner (e.g. mental health nurse). This is because these midwives will have had extensive training and experience in different areas of mental health and therefore may differ considerably from the perspective of a midwife without this training. This exclusion does not include Specialist Mental Health Midwives, who can still be included in the study as they can still provide insight into the perspectives of midwives without prior mental health training.

**Design**

This study will combine the use of vignettes and semi-structured interviews to explore participants’ perspectives, understanding and perceptions of PLEs. Previous studies have demonstrated that combining the use of vignettes and open-ended questions in this way can produce rich data (Dixon, Murray & Daiches, 2013). Midwives may have experienced new mothers with PLEs, but they are unlikely to label these experiences this way, therefore it would be difficult to ask midwives about direct experiences of this. This method, therefore, allows for exploration of midwives’ personal perspectives and perceptions without requiring them to have direct experiences of PLEs.

This is a qualitative research project that will use thematic analysis. This will be used to allow for a flexible yet rich and detailed approach towards the analysis. Braun and Clarke (2006) state that thematic analysis can be used with different theoretical frameworks, therefore this study will use a realist thematic analysis method which focuses on participants’ understandings, meanings, and interpretations.

**Recruitment**

Participants will be recruited for this study through the Maternity and Midwifery Forum website and the Royal College of Midwives. Both organisations will advertise the research project to their respective members through their websites and social media platforms, subject to ethical approval. An advertisement for the study (Appendix B) will be sent to both organisations which will include a brief summary of the project and contact details for the researcher. The poster will ask individuals who are interested in participating in the research to contact the researcher via their academic email or research telephone number.

If sufficient participant numbers are not achieved through this method then social media sites, e.g. Twitter and Facebook, will be utilised. An information poster (Appendix C) will be posted on social media websites to increase recruitment numbers. The researcher’s contact details will be provided on this information poster and individuals will be asked to contact the researcher.

Once individuals show interest in participating by contacting the researcher, the researcher will send the individual the participant information sheet (Appendix D) and consent form to review (Appendix E). If the individual would still like to participate after reading this, the researcher will contact the potential participants by telephone to arrange an interview time. Additionally, at this point the participant will be sent a copy of the vignettes that they will be asked questions in relation to in the interview. This is to reduce any anxiety that may arise from being presented with unexpected vignettes during the interview that may result in midwives feeling “tested”. As the vignettes are being provided in order to prompt midwives thinking around these issues, and not to examine their diagnostic knowledge or competence, it is not felt that providing the vignettes in advance will compromise the results.

**Data Collection**

Participants will be interviewed either face-to-face, via Microsoft Teams or telephone. The researcher will conduct the remote interviews in private, confidential locations to protect the privacy of the participants. Participants will be informed before the interview that due to the nature of remote interviews, confidentiality cannot be completely ensured, but will be informed of the steps that will be taken to protect their information, e.g. storing and transferring the interview recordings securely, deleting recordings off initial software and not storing interview recordings on personal or unsecure devices.

Participants will also be reminded about the limits of confidentiality, namely if it is felt that they, or someone else, may be at risk. Participants will be reminded that they can withdraw their participation at any point during the interview and up to 14 days after the interview. Face-to-face interviews will be conducted either in the participant’s home, or a neutral confidential space. For face-to-face interviews, participants will be required to be currently living in the Northwest area due to the location of the researcher and limits on funding for travel reimbursement.

For face-to-face interviews, participants will be given the consent form (Appendix E) to read and sign. The consent form will be read out to participants taking part remotely, and they will be asked for their verbal consent for each question on the consent. Participants will be reminded that they do not have to take part in the study and are able to withdraw from the interview at any point during the interview. Interviews will be recorded for the purposes of transcription and data analysis. All interviews will be recorded using a digital audio recorder. Participants’ verbal consent to take part will be recorded as a separate audio recording.

During the initial phone contact with potential participants, the researcher will clarify that individuals are fully qualified midwives who are currently registered with the Nursing and Midwifery Council (NMC) and that the majority of their role involves direct work with mothers. Individuals will be asked to confirm that they do not have a professional background in which they have trained and/or worked as a mental health professional. Potential participants can ask the researcher any initial questions about the project at this stage.

After participants have given consent to take part, they will be asked to complete the demographic information questionnaire (Appendix A). Participants taking part remotely will be asked to complete this questionnaire verbally.

Participants will then be engaged in the interview (Appendix F). This includes hypothetical vignettes of women experiencing mental health symptoms, particularly focusing on PLEs. This vignette has been developed using previous research (Anglin et al., 2014; Lee et al., 2016), the DSM criteria for ‘brief psychotic disorders’ (American Psychiatric Association, 2013) and has been adapted using information presented in the Action on Postpartum Psychosis charity’s ‘personal stories’ videos, which are from the perspective of women with lived experiences. The vignette will allow discussion of this topic, even if the participants do not have in-depth knowledge of psychosis and PLE’s (Hughes & Huby, 2002). Participants will be asked questions in relation to this vignette that will allow for exploration and focus on their perspectives, sense-making and predicted responses. This will be done using a semi-structured interview schedule (Appendix F) to allow for a more in-depth qualitative understanding of participants’ perspectives. This schedule has been developed based on a narrative literature review that the applicant wrote which summarised findings and methodologies from previous research in similar areas (Carroll et al., 2018; Downes et al., 2017; Hauck et al., 2015; Higgins et al., 2018; Noonan et al., 2018). A midwife contacted through social media has reviewed the vignette, and the vignette was adapted in response to her suggestion to extend the length of time that ‘Nina’ stayed on the postnatal ward to make the scenario more realistic and relevant for midwives. The flexible interview schedule will include questions around their perceptions and understanding of new mothers with experiences as described in the vignette, as well as experiences they may have had in their career where they have worked with mothers with similar experiences to the vignette. The interviewing process is expected to take around an hour per participant.

**Proposed Analysis**

Thematic analysis will be used to analyse the interview transcripts (Braun & Clarke, 2006). The analysis will be approached from a critical realist theoretical position which will aim to understand participants’ understandings, meaning and interpretations. This assumes there is a relationship between what people say, how they think and how they behave, however the data will require interpretation to understand the unobservable structures beneath this. This approach will be informed by phenomenology which aims to understand the lived experience and reality of participants. In this approach, language is acknowledged as the means in which participants communicate their ideas and understandings and make meanings, which is understood to reflect their lived experiences. This approach also acknowledges that whilst the intention is to develop an understanding of reality, the data may not always reflect ‘true’ reality due to the researcher’s interpretations and meaning making being shaped by their own experiences and knowledge (Willig, 2012), which emphasises the importance of the researcher’s reflexivity in this approach.

The audio data from the interviews will be transcribed by the researcher. Braun and Clarke (2006)’s guidance on thematic analysis will be followed for analysis. The researcher will familiarise themselves with the data through transcription and reading through participant accounts. Initial codes will then be produced from the data which will be identified alongside the relevant line of transcription. Analysis will involve moving from one transcript to the other whilst refining codes and noting their reoccurrence. These codes will be documented within the research paper to demonstrate how they were identified. They will also be shared with the researcher’s supervisors for accuracy and suitability. The codes will identify salient features from the data and then the codes will be sorted into possible themes that encompass multiple codes. The themes will be shared with the researcher’s supervisors and refined to ensure they fit with the initial codes and the data set as a whole. Finally, the themes will be named and defined to explain the content and meaning of the themes. The final results will aim to be checked with the participants to confirm that they reflect the perspectives of the participants and feedback will be sought from them.

The process of analysis, and the rationale for decisions made during this process, will be documented to provide justification for decisions. The researcher will keep a reflective diary to document their thinking around decisions made.

**Practical issues**

**Storage**

Data from the interviews will be accessible by the researcher’s research supervisors, and participants will be informed of this on the consent form. The interviews will be recorded on an audio recorder and transferred to Lancaster University’s secure password protected drive using their virtual private network (VPN). Data will be transferred as soon as possible. Once the recordings have been securely transferred, they will be deleted from the audio recorder. Participant audio recordings will be deleted from the university’s drive once the researcher has passed their viva voce examination.

The audio recordings will be transcribed and participant transcripts will be labelled with pseudonyms to identify them whilst protecting their identity. A key will be made to link participants to their pseudonym in case they wish to withdraw their data up to and including the 14 days following their interview. This key will be password protected and stored in Lancaster University’s encrypted, password protected drive. Any further identifiable data will be removed from interview transcripts.

Participants’ consent forms and demographic questionnaires will be password protected and stored electronically on Lancaster University’s secure encrypted drive. They will be labelled with a pseudonym to connect them to the respective participant, however these forms will be stored in a separate file to the interview transcripts.

Interview transcripts and encrypted data will be shared with the Doctorate of Clinical Psychology programme’s Researcher Co-ordinator and stored electronically by Lancaster University in a secure location for 10 years. These data will be transferred through the University’s encrypted secure OneDrive software. The storage of this data will ultimately be the responsibility of the project’s main supervisors.

**Costs**

If participants wish to take part in the interviews face-to-face, travel costs will be reimbursed by Lancaster DClinPsy programme up to £20 per participant.

**Lone working**

For face-to-face interviews, the researcher will follow Lancaster University’s guidance for lone working as well as the Division of Health Research’s ‘Lone researching policy’. The researcher will have a safety partner who will be given details of the location of the interview in an enclosed envelope or password protected document. The researcher will contact their safety partner by telephone on arrival at the interview location, and after the interview is completed. The safety partner will be informed of the time that the researcher will contact them after the interview to confirm their safety. The safety partner will be informed that if the researcher does not contact them, they should try to contact them and if they cannot, they should open the envelope to determine the location of the interview and contact the police.

**Ethical concerns**

**Confidentiality**

Transcripts will be anonymised to protect participant anonymity and identifiable data will be removed. Participants will be informed about the limits of confidentiality and informed that if they discuss information that indicates a risk to themselves or other people, this information will be passed on to the researcher’s supervisors in the first instance to determine a course of action. Due to the nature of the project focusing on professionals’ views and perspectives on mothers’ experiences, it is not anticipated that this is likely to arise during interviews. There is a small risk that professionals may reveal malpractice during the interviews, or breach confidentiality of one of their service users. Participants will be reminded before the interview to protect the confidentiality of their service users by not sharing identifiable information. If malpractice or a breach of confidentiality is identified, the researcher will contact their research supervisors in the first instance to determine whether this information needs to be passed on. If it is deemed by the researcher’s team that this information needed to be taken further then the professional body for midwives, the Nursing and Midwifery Council (NMC), would be contacted and informed. Any information shared by the participants that breaches the confidentiality of the participant’s service users will be removed from the interview transcript.

**Dissemination**

The findings from this research will be written into a research paper which will form part of the researcher’s thesis for the Doctorate in Clinical Psychology. A lay summary of the findings will be written and shared with the participants of the study if they wish to receive it. The findings will also be shared with the organisations that assisted in recruitment and study design. The researcher will also write the findings into a publishable format and aim to publish this in appropriate research journals. If the opportunity arises, the findings may also be presented at a relevant conference.

**Service user involvement**

Qualified midwives, sourced through the project field supervisor, have reviewed the study materials and provided feedback to add questions about midwives’ history of mental health training. An experienced midwife sourced through social media gave feedback on the vignette which was incorporated.

**Timescale**

* December 2021 – Amend ethics application
* January – February 2022 – Advertise study and contact potential participants
* April 2022 – Data collection
* June 2022 – Submit first draft of literature review
* July 2022 – Submit second draft of literature review
* August 2022 – Data analysis
* October 2022 – Submit first draft of research paper
* November 2022 – Submit second draft of research paper
* January 2023 – Submit first draft of critical review
* February 2023 – Submit second draft of critical review
* March 2023 – Submit thesis

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## Appendix 4-B

### DClinPsy logo - white backgroundDemographic information questionnaire

Participant ID:

Please could you answer the following questions. This information will be used to describe the sample of participants who took part in this study.

1. Gender:

Male

Female

Other – please specify:

Prefer not to say

1. Age:
2. What is your ethnic group? (Choose the option that best describes your ethnic group or background)

*(Categories taken from the Office of National Statistics Census of England and Wales, 2021)*

1. Asian or Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background, please state

1. Black, African, Caribbean or Black British

Caribbean

African, please specify

Any other Black, African or Caribbean background, please state

1. Mixed or Multiple ethnic groups

White and Black Caribbean

White and Black African

White and Asian

Any other Mixed or Multiple background, please state

1. White

English / Welsh / Scottish / Northern Irish / British

Irish

Gypsy or Irish Traveller

Roma

Any other White background, please state

1. Other ethnic group

Arab

Any other ethnic group, please state

1. How long have you been qualified as a midwife for? (in years)

      years

1. What area of midwifery do you currently work in?

1. What sector are you currently employed as a midwife in?

Public sector

Private sector

1. Have you ever undertaken professional education or qualifications in mental health (e.g. mental health nursing training)?

Yes, please specify

No

1. Have you ever undertaken any training events or courses in mental health?

Yes, please specify

No

1. Do you feel that you have been given, or offered, adequate training in mental health?

Yes

No

## Text, letter Description automatically generatedAppendix 4-C

### Advertisement for study

## Appendix 4-D

### Information poster for social media

## DClinPsy logo - white backgroundAppendix 4-E

### Participant information sheet

**Midwives’ perspectives and perceptions in relation to psychotic-like experiences in the perinatal period**

My name is Molly Turgoose and I am completing this research as part of my Doctorate in Clinical Psychology at Lancaster University.

**What is the study about?**

This study aims to explore midwives’ views, thoughts and experiences in relation to mental health difficulties in new mothers during the perinatal. The study will ask about a specific aspect of perinatal mental health called ‘psychotic-like experiences’. You do not need to have experience with women who have experienced psychotic-like experiences, or any knowledge of these experiences, to take part.

**Do I have to take part?**

No, you do not have to take part. Participation is voluntary.

**What will I be asked to do if I decide to take part?**

If you decide you would like to take part, we will arrange a time for an interview which is anticipated to last approximately an hour. This interview can be held face-to-face if you are based in the North West and an appropriate venue is available. The interview can also be held via telephone or Microsoft Teams whichever method is preferable for you. At the start of the interview, you will be asked to sign the consent form if you are happy with the information on it. You will then be asked to complete a short questionnaire which will ask for some information about you (e.g. gender, ethnicity, time qualified as a midwife etc). If the interview is conducted remotely, these forms will be completed verbally, by me reading the contents of the forms aloud to you. If the interview is remote, I will also audio record your consent to take part.

The interview will last around an hour and you will be asked to talk about your views and experiences of aspects of perinatal mental health difficulties in mothers. During the interview, I will provide you with hypothetical scenarios that will describe experiences that some women have during the perinatal period. We are really interested in your views towards these kinds of experiences therefore you will be asked questions about these in the interview. This interview will be audio recorded. Your interview data will be anonymised, and any identifiable information will be removed.

**Are there are risks or disadvantages anticipated from taking part in this study?**

We do not anticipate any risks that will arise from taking part in this study. However, if you experience any distress during the interview you are encouraged to inform the researcher and use the resources listed at the end of this sheet.

**Are there any benefits to taking part?**

There are no direct benefits to taking part in this study, and your participation would be on a voluntary basis. However, it is hoped that the results will help us to support midwives with their role of supporting perinatal mental health. If you would like to conduct the interview face-to-face and you have to travel to the interview, you will be reimbursed for travel within the North West up to the value of £20.

**Will my data be identifiable?**

Interview data from this study will be anonymised and stored securely. Personal information collected during the study will be encrypted and stored separately from the interview data to protect your anonymity.

Please be aware that although all reasonable steps will be taken to protect the anonymity of your data as much as possible, the researcher cannot completely guarantee the security of online videoconferencing software such as Microsoft Teams.

Your data will be protected in the following ways:

* Audio data will be deleted after the study has been submitted and examined
* Your data will be encrypted and stored electronically on the secure password-protected University private system.
* Your interview data will be typed up by the researcher and stored in written form. This data will be anonymised, and any identifiable information will be removed. Direct quotes from your interview may be used in the report of this study, however this data will be anonymous. This written data and any additional data from the study, for example consent forms and demographic questionnaires, will be stored for 10 years on the Lancaster University secure network and deleted after this period of time.
* Your personal details (email address, telephone number etc) will be deleted at the end of the study, unless you would like to be sent the results of the study in which case they will be deleted after this is sent to you.

Although every effort will be made to keep your data confidential, there are some occasions in which confidentiality would have to be broken. If anything said during the interview suggests that you, or somebody else, is at risk of harm, I will have to break confidentiality and pass this information to my supervisors. Additionally, if anything said during the interviews reveals any professional malpractice or misconduct, I will have to pass this information on to my supervisors and may have to contact the relevant professional body if necessary.

**What if I change my mind about taking part?**

You can change your mind about taking part and withdraw your data from the study up until 2 weeks after your interview.

**What will happen to the results?**

The results will be written up as part of a report that will be submitted to meet requirements of my Doctorate in Clinical Psychology. Direct quotes from your interview may be used in the report of this study, however this data will be anonymous. A summary report will be available for participants if you wish to receive this. You will have the opportunity to comment on a draft analysis of all participant data if you would like to. Data from this project may also be submitted for publication or presented at relevant conferences.

**Who has reviewed the study?**

This study has been approved by the Faculty of Health and Medicine Ethics Committee at Lancaster University.

**Where can I get further information or volunteer to take part?**

If you would like any further information or would like to take part in the study, please contact me on [m.turgoose@lancaster.ac.uk](mailto:m.turgoose@lancaster.ac.uk). Additionally, you can contact my research supervisors using the contact information below:

**Professor Bill Sellwood**.

Email: [b.sellwood@lancaster.ac.uk](mailto:b.sellwood@lancaster.ac.uk)

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4YW

**Dr Craig Murray**.

Email: [c.murray@lancaster.ac.uk](mailto:c.murray@lancaster.ac.uk)

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4YW

**What if I want to make a complaint?**

You can contact Dr Ian Smith to make a complaint using the contact details below.

**Dr Ian Smith**.

Email: [i.smith@lancaster.ac.uk](mailto:i.smith@lancaster.ac.uk)

Health Innovation One

Sir John Fisher Drive

Lancaster University

Lancaster

LA1 4YW

Alternatively, if you would like to speak to someone outside of the Doctorate of Clinical Psychology programme you can contact Dr Laura Machin:

**Dr Laura Machin**

Email: l.machin@lancaster.ac.uk Tel: 01524 593746

Chair of Faculty of Health and Medicine Research Ethics Committee

Faculty of Health and Medicine

Lancaster University

Lancaster

LA1 4YG

**What if I want to talk to someone after the study?**

For some people, participating in research and discussing their perspectives and experiences can bring up thoughts, reflections and questions after the research interview. If anything comes up for you that you wish to discuss after the interview has taken place, please feel free to contact me using the details at the end of this information sheet.

**Support resources**

It is not anticipated that taking part in this study will result in any distress for you, however if you do feel distressed as a result of the study, the following resources may be helpful:

* The Royal College of Midwives have a list of support services on their website that may be helpful for midwives experiencing distress. Website address: <https://www.rcm.org.uk/health-and-wellbeing-support/>
* Mind. Phone number: 0300 123 3393 Website address: <http://www.mind.org.uk/>
* GP. You may also wish to contact your GP to discuss how you are feeling as they can direct you to a local support service.

**Thank you for considering participating in this study.**

**Molly Turgoose**

Trainee Clinical Psychologist

Email: [m.turgoose@lancaster.ac.uk](mailto:m.turgoose@lancaster.ac.uk)

Telephone: 07508 375 653

Health Innovation One

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## Appendix 4-F

### Consent form

**Midwives’ perspectives and perceptions in relation to psychotic-like experiences in the perinatal period**

We are asking if you would like to take part in a research project which will look at midwives’ views and thoughts about perinatal mental health.

Before you consent to taking part in this study, please read the Participant Information Sheet and the information below. If you have any questions about any of the following information before you sign the form, please speak to the researcher (Molly Turgoose). If you are taking part in the study face-to-face, please put a tick in each box below. If you are taking part remotely, I will ask for verbal consent for each of the following points:

Please tick each statement

1. I confirm that I have read the participant information sheet and understand

what I will be asked to do during the study

1. I confirm that I have had the opportunity to ask any questions and have had

them answered

1. I understand that my interview will be audio recorded and then typed into a

written transcript

1. I understand that the audio recordings will be kept until the study has been

assessed

1. I understand that my participation is voluntary and I can withdraw my data

up until 2 weeks after my interview without any negative consequences

1. I understand that my interview data will be combined with other participants

interview data, will be anonymised and may be published

1. I consent to information from my interview being used in reports,

conferences and training events

1. I understand that the researcher will share interview data with their

supervisors and discuss this as needed

1. I understand that the information I give will be kept confidential and

anonymous, unless the researcher believes there may be a risk to myself or

another person or if the researcher believes my information has revealed

professional misconduct or malpractice. I understand that in this case information will be shared with the researcher’s supervisors.

1. I consent to Lancaster University keeping written interview transcriptions,

coded data, demographic data and consent forms for 10 years after the study

has finished

1. I consent to take part in the above study

Name of participant:       Signature:       Date:

Name of researcher:       Signature:       Date:

## Appendix 4-G

### Vignette and interview schedule

This interview schedule gives a general guide for the process of the interview however the interview will be guided by each individual being interviewed, and additional follow up questions may be asked depending on their responses. Participants will be reminded at the start of the interview that there are no correct or incorrect answers to these questions and I am interested in their own perspectives. This interview schedule involves a vignette which is separated into different parts, and has accompanying example questions after each section.

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

The initial part of the interview will focus on the participants’ perspectives and experiences of perinatal mental health in general, which is intended to get a broader sense of their perspectives and perceptions but is also intended to slowly introduce the topic of psychotic-like experiences and build rapport with the participant without them feeling ‘tested’ by the vignette.

[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?
* What types of difficulties have you had experience assessing and supporting women with?
* How confident do you feel within this role of assessing and supporting women with their mental health?
* 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?
* How have you felt about the amount of support you have been able to offer to women?

1. **Vignette**

The next part of the interview will ask questions in relation to the vignette presented to participants. The questions will focus on how the participants think they would act, think and feel in the situation.

**Part 1:**

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. During these 7 days, Nina told a midwife on the ward that she was not managing to sleep at all and was feeling much more emotional than usual. Nina talked about finding it very difficult to concentrate during conversations and was feeling exhausted after small tasks like getting dressed.

**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?
* What do you think you might think about what this woman was experiencing?
* What do you think would happen next in this situation?

**Part 2:**

The day before Nina was discharged from hospital, she reported that she was very worried that she was not looking after her baby properly and was feeling very anxious that her baby was going to die. She told the midwife that her thoughts were racing a lot of the time which was making it hard for her to focus on anything, and a lot of these thoughts were related to her being a bad Mum. These thoughts were upsetting Nina, and she said that she was feeling overwhelmed and low in mood some of the time. Nina described feeling that she was experiencing “mood swings” and said that her partner had commented that her mood was changing a lot.

**Predicted responses:**

[Example prompt questions]

* What would your thoughts be at this point?
* Is there any other information you think you would like from the woman after hearing this?
* Do you think that there is cause for concern at this point? Can you say more about this?
* Do you think that you would need to provide this woman any additional support?
* If no, why no? If yes, what support do you think you could offer her?
* Do you think this additional information would change what you would think about what the woman was experiencing? If yes, how would it change?
* How do you think you would view or understand the woman’s experiences?
* What do you think would happen next in this situation?

**Part 3:**

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 strongly 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 a few times and wondered if this might explain why she was a bad mum.

**Predicted responses:**

[Example prompt questions]

* Do you think this additional information would change you would think about what the woman was experiencing? If yes, how would it change?
* Do you think that there is cause for concern in the story at this point? Can you say more about this?
* What do you think you would do at this point?
* Do you think that you would need to provide this woman any additional support?
* If no, why no? If yes, what support do you think you could offer her?
* 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 view or understand the woman’s experiences?
* How do you think you would feel if you were faced with this situation?
* How confident would you feel with supporting the woman in this situation?
* Do you feel that you would know what to do to support the woman in this situation?
* Is there any support that you would need to feel more able to support the woman in this situation?

1. **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?
* What do you think about the current approach to assessing psychosis in women during the perinatal period?
* 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)?
* What would you think the implications of asking these questions would be? How do you think women would respond to this?
* How do you think women would feel and think if you asked more about these experiences?
* How would you feel about asking these questions? How confident would you feel?
* How likely would you think it would be that women would report these difficulties to you spontaneously? How would you feel about your ability to respond to any disclosures of this nature? What would the barriers to this be?
* How able do you think that women would feel to discuss these experiences with their midwives?
* Could you tell me about how you would feel if women disclosed these experiences?
* 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?

1. **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?
* Have you heard of colleagues experiencing similar situations to that described in the story? What happened?

1. **Anything else**

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

## DClinPsy logo - white backgroundAppendix 4-H

### Participant Debrief Sheet

Thank you for participating in this study.

For some people, participating in research and discussing their perspectives and experiences can bring up thoughts, reflections and questions after the research interview. If anything comes up for you that you wish to discuss after the interview has taken place, please feel free to contact me by emailing [m.turgoose@lancaster.ac.uk](mailto:m.turgoose@lancaster.ac.uk) or calling 07508 375 653. If you would like emotional support after the interview, please refer to the list of support services given on the participant information sheet.

If you decide that you would like to withdraw your data from this study, you can request for your interview data to be removed and deleted up to and including the 14 days following your interview. Please contact me via email on [m.turgoose@lancaster.ac.uk](mailto:m.turgoose@lancaster.ac.uk)

or telephone 07508 375 653 if you would like to do this. You will not be required to give a reason for your withdrawal.

A summary report detailing the results of this study can be sent out to participants who wish to receive it. Please let me know if you would like to receive this and are happy for me to store your contact details securely until this report has been completed and sent to you.

If you have any questions or concerns regarding any aspect of this study please feel free to

contact the researcher, Molly Turgoose, on the details provided above.

Please keep a copy of this debrief sheet in case you need to refer to it in the future.

Thank you again for giving your time to participate in this study.

**Molly Turgoose**

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1. The terms “woman” and “mother” are used, however, these terms include individuals who are pregnant or have given birth but do not identify as women. [↑](#footnote-ref-1)
2. Searchable years [↑](#footnote-ref-2)
3. The terms “woman” and “mother” are used, however, these terms include individuals who are pregnant or have given birth but do not identify as women. [↑](#footnote-ref-3)
4. All names used are pseudonyms [↑](#footnote-ref-4)
5. Age and year range has been used to protect participant anonymity [↑](#footnote-ref-5)