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Perinatal Mental Health: Experiences of Seeking and Receiving Healthcare Intervention

Thesis presented by

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Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism.

Signed: 

Date: 29/04/2025

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Abbreviations and Terminology

Term	Abbreviation & Definition
Biopsychosocial Model	BPSM: The interplay between biological, psychological and social factors in health.
Health Care Professional	HCP: A professional with recognised education and training, who works as part of a healthcare team, across a variety of hospital and community services.
Interpretative Phenomenological Analysis	IPA: A qualitative research approach which aims to provide detailed examinations of personal experience.
Perinatal Mental Health Difficulties	PMHD: Encapsulates the continuum of perinatal mental health difficulties women experience
Perinatal period	From pregnancy to 1 year after giving birth.
Public Patient Involvement	PPI: Working in collaboration or partnership with patients, carers, service users or the public in planning, designing, managing, conducting, dissemination and translation of research.

Chapter One

Background Literature

Transition to the Perinatal Period

The perinatal period is commonly defined as the period from pregnancy to one year post birth, and is a period of tremendous change for women, both physically and psychologically (Garcia & Yim, 2017). Within this perinatal period, there are no universal stages of adjustment but rather several. From recognition and acceptance of the pregnancy, to developing internal representations and attachment feelings to the foetus in later stages (Wenzel, 2016). The adjustment continues to the postpartum period, where a woman is tasked with adjusting to the arrival of her newborn, and to motherhood. Transition to motherhood, often referred to as *matrescence*, is a developmental passage where a woman journeys through pre-conception to beyond the postnatal period, applicable to the variety of gestational relationships e.g. birth-giving/ non-birth-giving (Orchard et al., 2023; Raphael-Leff, 1993). Psychodynamic theorists assert that matrescence as a developmental process consists of inevitable maturational challenges which require tolerance of instability and uncertainty, and development of cognitive flexibility and development of coping strategies (Baraitser, 2008; Hall, 2016; Orchard et al., 2023). Matrescence, as an epic, emotionally conflictual, and physically demanding transition is perhaps most vividly described by the work of psychoanalyst Raphael-Leff (Raphael-Leff, 2018c, 2018a, 2018b). A key sentiment within Raphael-Leff's work is the individuality of the perinatal adjustment, based on expectation and inner life, which can be lost within theoretical views on "women" (Balsam, 2017).

Psychological and social changes involve changing to an unknown reality, new maternal identity and negotiation of social roles, balancing demands and experience of losses e.g., control, sleep and freedom (Emmanuel & St John, 2010). The maternal brain also

undergoes significant structural and functional neuroplasticity, and cognitive adaptations which last throughout the lifespan (Orchard et al., 2023). Despite the gravity of these changes, many women will transition relatively easily through the psychological tasks of pregnancy and adapt to the biological, psychological and social changes they experience (Wenzel, 2016). This adjustment and transition will undoubtedly involve apprehension, uncertainty, an abundance of emotional experiences and demands, however these are considered normative rather than pathological (Miller, 2016). Nevertheless, multifaceted wellbeing interventions are recommended to support parents in this transition (Middleton et al., 2025).

Difficulties Within the Perinatal Period

As the perinatal period is characterised by significant biopsychosocial changes, it can render women vulnerable to psychological distress, and at increased risk of developing, or experiencing the reoccurrence of, mental health problems (Bright et al., 2022). Anxiety and depression are the most commonly reported perinatal mental health disorders, internationally and within an Irish context (Huschke et al., 2020). Anxiety disorders, which are among the most common globally (estimated 25% prevalence), are twice as likely to present in women than men, 20% of these presentations within the postpartum period (Furtado et al., 2018). These mental health difficulties may stem from individual vulnerabilities, inadequate support systems, or complex interplays of biological, psychological, and social factors (Ussher et al., 2019; Wenzel, 2016).

There are well-researched psychosocial, environmental, biological and obstetric risk factors in the development of perinatal mental health difficulties (PMHD), with particular risk factors associated with anxiety and depression (Biaggi et al., 2016; Furtado et al., 2019; Quatraro & Grussu, 2020). A recent systematic review has highlighted similar risk factors in

the development of concurrent perinatal mood disorders in parental dyads (Smythe et al., 2022).

For some women with PMHD, suicidal ideation and suicide are co-occurring experiences (Bright et al., 2022; Knight et al., 2020; Ussher et al., 2019). Suicide remains the leading direct cause of maternal death within one year postpartum in both Ireland and the United Kingdom (UK), echoing global trends (Felker et al., 2024; Guillard & Gressier, 2017; Humphrey, 2016; Knight et al., 2020). According to the MBRRACE-UK & Ireland report on maternal deaths, a stark 34% of maternal deaths occurring between six weeks and one year postpartum were attributed to substance misuse and psychiatric causes (Felker et al., 2024).

Varied and complex biopsychosocial risk factors contribute to perinatal suicidal ideation including sleep deprivation, pregnancy complications, mood disorders, intimate partner violence and low socioeconomic status (Bright et al., 2022). PMHD present on a spectrum, from transient fluctuations in emotions and mood, to mild, moderate or severe presentations that significantly impact functioning (World Health Organisation [WHO] 2022). Globally, approximately 20% of women are impacted by PMHD annually (as measured by a range of data collection methods), with depression and anxiety the two most common mood disorders associated with birth (Schmied et al., 2013; Ussher et al., 2019).

More recent research highlights the prevalence of antenatal anxiety and depression, with approximately 33% of pregnancies affected by these conditions, and approximately 40% of postnatal depression (PND) episodes beginning in the antenatal period (Bright et al., 2022). The early onset of these difficulties within the antenatal period highlights the fluidity of perinatal depression, and the need to research what has historically received less attention in comparison to PND (Martin et al., 2021). Rates of perinatal depression are disproportionately greater in low-and middle-income countries. Within high-income countries, migrant women, including asylum-seeking women and refugee women, experience

higher rates of PND than non-migrant women (Brown-Bowers et al., 2015). Similar trends have been observed in countries such as Canada and other international host nations (Dennis et al., 2017; Heer et al., 2024).

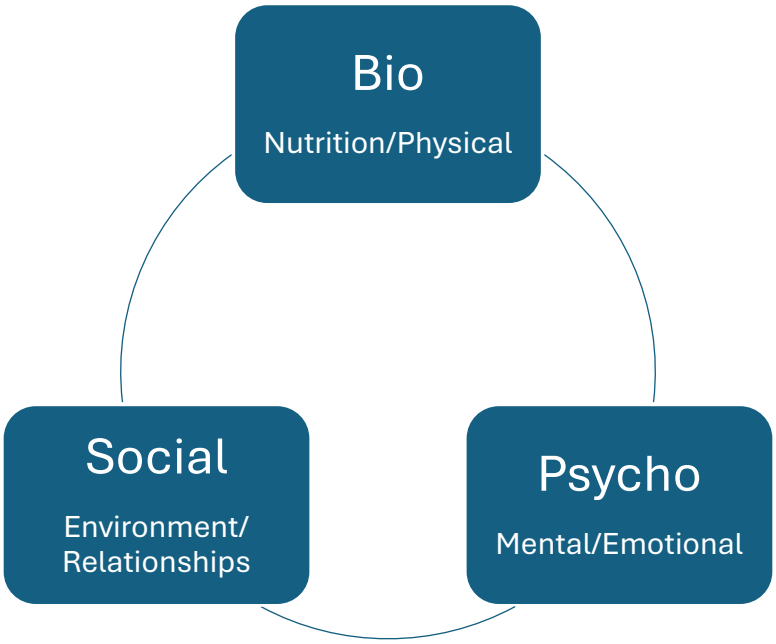
While it is important to acknowledge these prevalence rates, critical health perspectives caution the pathologizing of migrant women's distress through the application of psychiatric labels. These diagnostic systems fail to consider the broader migrant and cultural contextual factors in which this distress occurs (Brown-Bowers et al., 2015). More recently, developments in maternal and reproductive healthcare, along with greater awareness of psychological and social dynamics, have fostered a more holistic understanding of perinatal mental health risks (Ussher et al., 2019).

Biopsychosocial Model: Interconnectedness

The biopsychosocial model (BPSM) recognizes that maternal mental health is influenced by a complex web of biological, psychological, and social factors (Engel, 1977) . This model has become a dominant framework within healthcare, and adaptable to the perinatal context given the significant psychological, behavioural and cognitive changes (Miller, 2016). Common biological factors (e.g. hormonal changes, genetics, and physical health) interact with psychological factors (e.g. cognitive changes, previous mental health history, coping style, self-esteem), and social factors (e.g. poverty and social support). Notably biopsychosocial factors are comparable across high and low income countries, however risk factors are more prevalent with reduced access to protective factors in low income countries (Ussher et al., 2019). These differences highlight the dynamic and context dependent nature of the framework, rather than a purely diagnostic lens. The biopsychosocial framework (see Figure 1) illustrates the dynamic and bidirectional interplay between biological, psychological, and social factors (Schaffir, 2016).

Figure 1

Biopsychosocial Perinatal Model



Note. Adapted from "Biopsychosocial Factors During the Perinatal Period: Risks, Preventative Factors, and Implications for Healthcare Professionals," by A. B. Blount, 2021, *International Journal of Environmental Research and Public Health, 18*(15), Article 8206 (https://doi.org/10.3390/ijerph18158206). Copyright 2021 by the authors.

Traditionally, emphasis has been placed on the biological factors of perinatal health, at the expense of psychological and social determinants, which are frequently associated with maternal and neonatal outcomes (Blount et al., 2021). Indeed, these psychological and social determinants, are often important, modifiable, predictors of positive outcomes, as emphasised by WHO, "health is a state of complete physical, mental, and social well-being and not merely in the absence of disease or infirmity" (WHO, 2025).

Viewing a woman's perinatal health holistically, allows greater understanding of the perinatal period and the factors that can influence perinatal mental health difficulties. Furthermore, adopting this biopsychosocial lens supports screening and assessment of perinatal risk factors, informing appropriate intervention (Biaggi et al., 2016; Blount et al., 2021; Furtado et al., 2019; Quatraro & Grussu, 2020). Blount et al. (2021, p. 2) provide a comprehensive overview table (see Appendix A), *BPSM of wellness*, detailing biopsychosocial risk factors throughout the perinatal period, which are discussed in detail below. Establishing an integrative BPSM of PMHD requires ongoing refinement to integrate factors and implement evidence-based interventions that target psychological and physiological outcomes (Bergunde et al., 2022).

Biological Risks

The physical taxation of pregnancy, delivery and caring for a newborn are significant biological risk factors within the perinatal experience alone (Miller, 2016; Wenzel,). Biological factors may impact the development of perinatal mental health difficulties, with hormones, sleep, neurotransmitter, endocrine and immune systems all proposed as underlying vulnerability and risk factors for mental health difficulties (Vigod & Steiner, 2015).

While sleep disruption is a common perinatal experience, acute childbirth related sleep loss is associated with postpartum psychosis within women with bipolar disorder (BD), implicating risk prediction (Perry et al., 2024). Chronic sleep disruption can also lead to cognitive changes, such as increased amygdala response to perceived fear and threat (Cárdenas et al., 2023). Developmental psychology highlights the exceptional neuroplasticity exhibited by women during this life phase which may account for this increased vulnerability for psychopathology (Glynn et al., 2018). Neurobiological research on postnatal anxiety and depression suggests that distinct neurobiological patterns in the maternal brain contribute to PND and susceptibility to postpartum anxiety, although less studies are available for the later

(Pawluski et al., 2017). Given the central role of the amygdala in parenting behaviours, the dysregulation of this system in maternal anxiety has been linked to lower sensitivity to infant cues (Yatziv et al., 2021).

A substantial body of biological research has focused on hormonal changes in estrogen and progesterone as biological mechanisms for psychopathology in the perinatal period (O'Hara & McCabe, 2013; Stewart & Vigod, 2019; Vigod & Steiner, 2015). Hormonal fluctuations can lead to a dysregulated stress response system which can heighten a woman's vulnerability to perinatal mental health challenges (Cárdenas et al., 2023). Two hormonal hypotheses, the hormonal withdrawal and hormonal sensitivity hypothesis, propose that conditions such as PPD and postpartum anxiety are a result of withdrawal and fluctuations in hormones (Welander et al., 2021). While demonstrating preliminary evidence, some of the studies used self-report measures to determine mood symptoms, and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) to establish a diagnosis of depression (American Psychiatric Association, 2013; Vigod & Steiner, 2015). The absence of perinatal specific diagnosis within the DSM-IV, and all previous editions, has received criticism for its limited definition and consideration of perinatal depression, and other mental health conditions (Wenzel,). This lack of recognition of perinatal mental health conditions presents limitations for research utilizing the DSM-IV as a diagnostic outcome measure, and as such caution is necessary when interpreting findings (Fonseca et al., 2020) Reflective of the psychiatric establishment's dismissal of female health and mental health conditions, such as menopause, advocating for inclusion of perinatal mental health conditions as a distinct diagnosis continues (Radoš et al., 2024; Wenzel, .

It is suggested that some women are genetically and biologically predisposed to perinatal mental health difficulties. Genetic and heritability factors have demonstrated some evidence of risk for PND, particularly in familial aggregation studies, with preliminary

evidence of genetic variability contributing to the susceptibility and onset of post-partum mood symptoms (Vigod & Steiner, 2015) . Recent studies have demonstrated that the risk of genetic factors may be associated with other social risk factors, such as stress and adverse life events, highlighting the bidirectional and multifaceted pathways at play in activating this underlying vulnerability (Haris et al., 2025; Mughal et al., 2019; Payne & Maguire, 2019).

In addition to hormonal and neurological factors, recent studies have explored the role of inflammation and immune system dysregulation. These propose systemic inflammation, the body's broad immune response, as a risk for perinatal depression, given the changes in inflammatory markers, stress system and gut microbiome in the perinatal period, replicating previous research linking both conditions (Christian et al., 2009; Van Den Bergh et al., 2020; Welander et al., 2021) . Migraine which is a highly comorbid condition of depression in non-perinatal populations, has been identified as a risk factor for anxiety in mid-pregnancy, and mixed depression and anxiety in late pregnancy when experienced prior to pregnancy (Welander et al., 2021). These findings may further support inflammatory and hormonal hypotheses with proposed biological mechanisms for migraine.

Biological research on PMHD has identified key risk factors, including general health, nutritional status, comorbid infectious or chronic illness, substance use, and adverse obstetric events (Ning et al., 2024; Ussher et al., 2019; Zhang et al., 2025). Conditions frequently observed in perinatal women such as preeclampsia, hyperemesis gravidarum (HG), or gestational diabetes may predispose mothers to emotional stress and depressive symptoms (Grinberg & Yisaschar-Mekuzas, 2024; Mitchell-Jones et al., 2020; Roberts et al., 2022; Srajer et al., 2022). Within an Irish context, one major longitudinal study has demonstrated significant links between physical and mental health in the perinatal period, with a higher number of physical health conditions linked to comorbid anxiety and depression (Hannon et al., 2023).

However, the results of these quantitative studies lack insight into the subjective experience. This is particularly evident in how obstetric events are interpreted, where a medical classification of an 'adverse event' may differ significantly from a woman's lived experience of the birth (Huschke et al., 2020). One recent qualitative study has demonstrated the biopsychosocial challenges of HG, beyond the traditional pharmacological management (Elder et al., 2025). These findings highlight the importance of integrating biological, subjective, and contextual factors when assessing risk for PMHD. While biological processes such as hormonal shifts, sleep disruption, and systemic inflammation contribute significantly to vulnerability, they interact dynamically with psychological factors that shape a woman's emotional experience during the perinatal period. The following section will explore psychological risk factors, including personality traits, cognitive style, and attachment patterns, that further influence the development and course PMHD.

Psychological Risks

Psychological risk factors for perinatal common mental conditions consist of cognitive capability and learning style, personality (including emotional regulation and adaptation capacity), interpersonal skills (including trust and forming relationships), past experience of abuse and past mental health problems (Ussher et al., 2019; Wenzel, 2016,).

Psychological, personality, and psychiatric factors like personal mental health history, childhood maltreatment, adverse life events, and high stress are most significant risk factors in pregnancy and postpartum (Quatraro & Grussu, 2020). Other individual risk factors such as maternal childhood experiences of being parented and caregiver attachment relationship are correlated with perinatal anxiety and depression, albeit less 'significant' risk factors (Quatraro & Grussu, 2020; Wenzel, 2016). For multiparous women, having a previous difficult birth is also a risk factor for mental health difficulties (WHO, 2022).

Psychological risk factors in perinatal depression include personality style and personal history of depression (Wenzel, 2016). Neuroticism, perfectionism, and low self-esteem are consistently associated with perinatal depression and anxiety, highlighting the relevance of cognitive-emotional vulnerability across multiple studies (Schmied et al., 2018; Severo et al., 2024; Wenzel, 2016). Personality traits and cognitive style appear to influence vulnerability to perinatal depression, where neuroticism and interpersonal sensitivity are vulnerability factors for PND (Severo et al., 2024; Terrone et al., 2023) Within perinatal women accessing psychiatric support, traits such as conscientiousness and neuroticism were identified as significant predictors, with high conscientiousness correlating with lower depression rates, while neuroticism was linked to higher levels of PND (Terrone et al., 2023).

Some research has focused on the role of temperament in modulating PND and Generalised Anxiety Disorder (GAD) within the perinatal period. One study identifies that cyclothymic, depressive, and anxious temperaments are frequently associated with both PND and GAD (Mazza et al., 2024). Previous research has shown that women experiencing depression during pregnancy often exhibit higher levels of neuroticism, perfectionism, and dysfunctional beliefs, along with lower self-esteem and extraversion. These traits, including interpersonal sensitivity and a strong need for control, may contribute to a heightened risk of both the onset and recurrence of PND (Wenzel, 2016).

In addition to trait-based vulnerabilities, attachment theory which refers to the unique relationship between infant and caregiver, and acts as a secure base for exploration and development, offers a complementary lens to conceptualize risk of PMHD (Ainsworth et al., 2015; Bowlby, 2012). Psychodynamic theories of attachment and interpersonal functioning aid our understanding of the perinatal period and have provided evidence-based intervention (Wenzel et al., 2015). Attachment theory can aid our understanding of the maternal-fetal attachment, and the woman's adjustment to the perinatal period (Raphael-Leff, 1993;

Wenzel, 2016). Psychodynamic theories highlight the unconscious conflicts activated during motherhood, including unresolved issues from a woman's own childhood or ambivalent feelings about dependency and attachment (Stern, 1995). Recent research has highlighted insecure attachment styles, particularly anxious attachment, are significantly associated with higher levels of depressive symptoms both antepartum and postpartum. Avoidant attachment, while also linked to depressive symptoms, shows a more complex relationship, particularly in the postpartum phase (Altamura et al., 2023) Given less adaptive coping styles are associated with insecure attachment style, this research found that coping strategies play a significant role in mediating the effect of anxious and avoidant attachment styles on depressive symptomatology (Altamura et al., 2023). Such findings support a deeper understanding of how attachment style may contribute to psychological risk in the perinatal period. For example, insecure attachment may manifest as maladaptive coping strategies used to manage the stress of perinatal adjustment.

Perhaps reflective of the strength of psychodynamic theories within perinatal mental health, interpersonal psychotherapy (IPT) with perinatal depression has a strong evidence base (Nillni et al., 2018; Pettman et al., 2023; Sockol, 2015). While psychodynamic theorists broadened the understanding of individual characteristics of vulnerability to perinatal mental health difficulties, consideration of the social, cultural and contextual factors were neglected until later encapsulated by the BPSM (Ussher et al., 2019). This holistic understanding has addressed traditionally held ideas that PMHD are attributable to psychological vulnerabilities within the individual, understanding the risk of PMHD are multifactorial and interactional, inclusive of social, cultural and contextual risk and protective factors (Ussher et al., 2019). Social, cultural, and contextual influences further interact with individual vulnerabilities, underscoring the need to consider the broader environment in which perinatal experiences unfold. The following section will explore the social risk factors that contribute to PMHD.

Social Risks

Social risk factors encompass the relational, economic, and cultural conditions that shape a woman's experience during the perinatal period, often amplifying or mitigating the impact of biological and individual psychological vulnerabilities. These factors have been found to significantly influence the onset and course of perinatal anxiety and depression. For instance, poor-quality relationships and low social support, particularly from partners, family members, and the wider community are consistently identified as high-risk factors (Lancaster et al., 2010; Longoria et al., 2024). These findings extend to vulnerable populations, including adolescents (Beckie & Oruche, 2024). Low social support has also been associated with increased risk for antenatal and PND, anxiety, and self-harm, with lack of partner support demonstrating the strongest association. It is proposed that this may result as a lack of opportunity to connect with others and seek support in pregnancy, which may lead to stress, and later depression (Bedaso et al., 2021; Lancaster et al., 2010).

Other socio-demographic vulnerabilities such as a history of abuse, young maternal age, low educational attainment, unemployment, and poverty have been consistently demonstrated in multiple reviews to elevate the risk of perinatal mental health conditions, mainly anxiety and depression (Beckie & Oruche, 2024; Biaggi et al., 2016; British Psychological Society, 2022; Quatraro & Grussu, 2020; Sufredini et al., 2022). Broader social risk factors include low socioeconomic status, income insecurity, interpersonal violence and lack of access to family planning services to support reproductive autonomy (Hutchens & Kearney, 2020; Ussher et al., 2019; Yang et al., 2022). Risk of domestic violence often begins or escalates in the perinatal period, with higher rates of domestic violence against individuals with mental health difficulties (Peacock et al., 2024).

Further illustrating these themes within an antenatal specific population, a systematic review by Biaggi et al. (2016) identified six distinct categories of social risk for antenatal

anxiety and depression: lack of social or partner support; current or past abuse; personal mental health history; unplanned or unwanted pregnancy; adverse life events and high perceived stress; and pregnancy complications or loss. Notably, lack of support and current or past abuse were the most significant predictors of poor perinatal mental health outcomes.

It is increasingly evident that social inequalities and mental health conditions are intertwined, with research demonstrating a significant increase of PND among refugee and asylum seeking women (Brown-Bowers et al., 2015; Heer et al., 2024). The unique issues faced such as migration, familial separation, in addition to well established risks of domestic abuse, prior mental health illness, create a significant vulnerability to PND. These may be exasperated due to absence of protective factors and barriers to appropriate healthcare (Heer et al., 2024). Understanding the protective factors for vulnerable populations requires further exploration (Giacco, 2020). In Europe, Gypsy, Roma and Traveller communities face similar social inequality and poor perinatal outcomes (Ekezie et al., 2024; Reid & Taylor, 2007). Access to a psychiatric diagnosis, which can be necessary to access services, can be a barrier in itself for some marginalised groups (Huschke et al., 2020; Reid & Taylor, 2007).

Recent conceptual shifts emphasize these factors as social determinants of health, where risk is shaped by the environments in which individuals are born, grow, and live (Pardo et al., 2024). While individual behaviours may be modifiable, they are constrained and/or supported by the social context. These determinants are particularly relevant in explaining racial and ethnic disparities in maternal mental health care. Despite similar prevalence rates of mental health conditions across racial and ethnic groups, systemic inequalities mean that minoritized populations often have reduced access to timely and high-quality care (Pardo et al., 2024). These social determinants are key drivers of racial/ethnic maternal health disparities such as access to healthcare, compounding mental health vulnerability among minoritized and marginalized groups (Pardo et al., 2024).

Impact of PMHD

Mental illnesses are the most common health complications of childbirth within the UK (Maternal Mental Health Alliance, 2023). Maternal death due to mental health problems, and increasing suicide remain the leading cause in maternal deaths one year post childbirth (Felker et al., 2024; Maternal Mental Health Alliance, 2023).

Infant and early childhood mental health is inextricably linked with maternal mental health (Goodman, 2019; Zeanah, 2019). A mother's mental health throughout the perinatal period is of distinct importance to the cognitive, social, and emotional development of her child. The impact of perinatal stress and psychopathology has been associated with long term changes in the offspring's immune system and hypothalamic-pituitary-adrenal axis (HPA) functioning (associated with stress response), highlighting the epigenetic pathways that can occur (Heim et al., 2019). While the sole presence of PMHD does not directly lead to negative child outcomes, a multitude of risk factors including these biological changes can impact the child's trajectory.

Perinatal depression has been associated with increased risk of child emotional problems, however recent research has highlighted the onset and timing of perinatal depression, and maternal bonding as mediating factors (Fransson et al., 2020; Goodman, 2019) . Similar analysis has been conducted with prenatal anxiety, which found no impact on pregnancy or maternal role, however prenatal anxiety impaired perceived emotional proximity to the foetus (Göbel et al., 2018). These mixed findings highlight the variability within timeframe of the perinatal period and the psychological tasks, while also highlighting the importance of maternal bonding within perinatal mental health care. Failing to effectively treat perinatal mental health issues carries a far greater cost than providing appropriate care. The long-term impact, particularly on children, has been estimated at £8.1 billion, affecting

areas such as health, education, social services, and the criminal justice system (Bauer et al., 2022). When the perinatal woman is supported, so too is the infant and child.

Supporting a holistic approach, research increasingly highlights the role and mental health of partners, particularly fathers, in perinatal mental health literature (Antoniou et al., 2021; Smythe et al., 2022). When assessed within parent dyads, concurrent perinatal depression was identified in 3.18% of couples (N = 29,286). Other recent studies estimate that approximately one in ten fathers experience perinatal depression. (Smythe et al., 2022; Walsh & Garfield, 2024) As presence of partner support has been identified as a protective or risk factor in perinatal mental health (Antoniou et al., 2021), inclusion of and strengthening the partners role is recommended. This is important when partners have demonstrated a key role in the identification of perinatal distress and supporting the perinatal woman in seeking professional support (Antoniou et al., 2021; Leach et al., 2016; Walsh & Garfield, 2024). Contemporary research proposes further research and application of gender-based assessment of perinatal distress in both mothers and fathers (Baldoni & Giannotti, 2020; Zindani et al., 2025).

Experience of Perinatal Services

For many women, there are psychosocial risk factors and social determinants of health which not only impact on their perinatal mental health but also their access to perinatal mental health care. Trauma, deprivation and discrimination are distinct barriers to accessing perinatal mental health care (Felker et al., 2024; Maternal Mental Health Alliance, 2023). The quality of care received during the perinatal period significantly impacts maternal mental health. Supportive, empathetic care can be a buffer against stress, while negative or dismissive experiences within maternity services such as birth trauma, lack of continuity in care, or poor communication can increase the risk of psychological distress (Sandall et al., 2016). Despite our understanding of these biopsychosocial risk factors, screening and

identification of these in the context of PMHD relies on Health Care Professionals (HCPs), and research demonstrates that despite risk factors, women often do not receive appropriate care (McNicholas et al., 2023).

Biopsychosocial factors (sociodemographic, psychological and social & family context) are robust predictors of perinatal care utilization (Duberstein et al., 2021). Within this prospective, longitudinal study, postnatal visit completion was significantly associated with smaller household membership, elevated pregnancy-related anxiety, elevated general anxiety/worry, increased social support, being employed, and medical-aid status. Prenatal care utilization also predicted postpartum visit completion, as did social support and employment status. Interestingly, anxiety predicted healthcare utilization, which replicates other studies, and may reflect desire for assurance and assistance observed in the presentation of perinatal anxiety (Hutti et al., 2011; Smith et al., 2022; Smith et al., 2025) and PND (Adler & Azuri, 2021; Pollack et al., 2022). These findings, related to perinatal anxiety and healthcare utilization, also reflect findings within non-perinatal populations (Horenstein & Heimberg, 2020). Regarding trauma as a predictor of healthcare utilization, pregnant women with this risk factor also demonstrated higher healthcare usage and received more intensive prenatal care (Duberstein et al., 2021). This intensive care was not associated with better infant outcomes such as birth weight, however this raises consideration of outcomes beyond medical outcomes. Additionally, intensive care is defined in this study by guidelines regarding intensity of visits, which may reflect increased healthcare monitoring, in the absence of trauma-informed perinatal healthcare (Law et al., 2021; Ward, 2020). Nevertheless, these findings highlight the biopsychosocial factors that require sensitive models of care to ensure healthcare utilization is enhanced (Duberstein et al., 2021; Onoye et al., 2014).

While focused specifically on Covid-19, a recent systematic review reflected existing risk factors for negative perinatal mental health, with additional variables such as resilience, educational attainment, trimester and ethnicity as potential influences on mental health during perinatal periods experienced during lockdown (Wall & Dempsey, 2023). These additional variables provoke thought given self-reliance and risk of depression was found to be moderated by race, with greater self-reliance predicting lower levels of depression for white, but not black, women. Women with the lowest incomes also demonstrated the most resiliency, followed by highest income earners. These findings highlight the intersectionality of PMHD, with potential disparities in mental health care among black women, where cultural and systemic contexts may have contributed to the experience of self-reliance. The findings also highlight the psychological factors which may become buffers for socioeconomic risk factors such as low income. Overall the findings highlight the need for universal screening and assessment that is sensitive to interdependent and individualised factors.

Need for Careful Assessment and Intervention

Timely, accurate assessment is critical in identifying at-risk mothers. Early interventions can mitigate long-term impacts for both mother and child (National Institute for Health and Care Excellence [NICE], 2014). Within Ireland and the UK, perinatal health care is structured upon HCP screening and assessing perinatal mental health. Typically, this screening occurs within community health care by HCPs working in general services, and often without specific mental health training (Health Service Executive, 2017; NICE, 2021). Traditionally, screening and assessment in the perinatal period has focused on measures of mental health such as the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987), Generalised Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006), or the Whooley Questionnaire (Whooley et al., 1997). These measures are typically administered by

midwives and public health nurses at the antenatal and postnatal appointments, with guidelines in Ireland, the UK and USA varying in their recommended administration (Ayers et al., 2024; Department of Health, 2016; Ford et al., 2019; Health Service Executive, 2017; Huschke et al., 2020; NICE, 2020) . It should be noted, these measures used to screen and assess for mental health difficulties, and indeed predict risk, are often measures which focus on general symptoms of anxiety and depression, with many of the diagnostic symptoms attributable to the experience of being pregnant rather than due to mood or worries (Matthey & Ross-Hamid, 2011), despite guidelines cautioning that these measures have not been validated in perinatal populations. A recent longitudinal study of the diagnostic accuracy of five commonly used measures of perinatal anxiety, found the Clinical Outcomes in Routine Evaluation-10 (CORE-10; Evans et al., 2002) and Stirling Antenatal Anxiety Scale (SAAS; Sinesi et al., 2022) demonstrated the best diagnostic accuracy for anxiety and depression, with the Whooley questions also demonstrating accuracy for depression (Ayers et al., 2024).

Reflective of the increased understanding of psychosocial vulnerabilities in the perinatal period, recommended screening and assessment has evolved to incorporate these factors, to support early intervention (Gram et al., 2024). Although antenatal psychosocial assessment tools which use a conversational approach were high in acceptability for women, evidence regarding their effectiveness is limited (Gram et al., 2024). One standardised psychosocial measure is the Antenatal Risk Questionnaire (ANRQ; Austin et al., 2013), which addresses key domains of psychosocial health associated with increased risk of perinatal mental health morbidity (e.g., depression or anxiety) and less optimal mother-infant attachment (Austin et al., 2013). While comprehensive measures are necessary, administering these in a structured fashion yields mixed results (Gram et al., 2024).

Although universal screening is recommended in Ireland (Health Service Executive, 2017), the role of HCPs extends beyond the mechanical application of screening measures; it

involves creating a supportive environment where women feel comfortable discussing mental health concerns, and are supported in overcoming stigma of help seeking (Dennis & Chung-Lee, 2006; Perera et al., 2023). Previous research has highlighted screening as a sensitive and confronting experience, particularly for women who have experienced the risk factors being assessed (Rollans et al., 2013b). While perinatal women accept and engage in screening, the approach of the HCP is influential to their experience and disclosure (Rollans et al., 2013a). Considering screening involves discussion of sensitive topics such as mental health, trauma and loss, both the perinatal woman and HCP must navigate the aetiology of these presentations and associated risk factors such as capacity to trust and nonverbal indicators of distress (Benton et al., 2024; Ussher et al., 2019).

The relational aspect of care becomes integral to the effectiveness of screening and subsequent intervention, as the level of trust and quality of the HCP relationship influences uptake of support in the perinatal period (Rollans et al., 2013a). The call to humanize maternity care, and move towards relationship-based models has highlighted the importance of positive HCP experiences and continuity of care (Kennedy et al., 2018; , 2018).

The Role of the HCP

HCPs play a key role in identification, referral, and support. Healthcare utilisation is affected by user and provider characteristics which can act as barriers or facilitators to support. HCPs who are empathetic, respectful, interested, and kind can facilitate healthcare utilisation, in comparison with HCPs who are task orientated and minimise women's concerns which reduces healthcare utilisation (Grand-Guillaume-Perrenoud et al., 2022).

Within an Irish context, perinatal maternal health care provided by the public sector, generally ceases at 6-week postpartum, at which point women must identify their own mental health needs and seek treatment (Hannon et al., 2022). The largest longitudinal study on maternal mental health in an Irish context has concluded the current model of 6-week

postpartum care in Ireland is insufficient to detect and provide support for women's mental health needs (Hannon et al., 2022; Huschke et al., 2020). Perinatal policy makes a compelling case for the extension of postpartum care to at least three months to reflect the onset of PMHD (National Women's Council, 2024).

In Ireland there have been recent strategic developments regarding maternity care policies, most significantly the development of the first National Maternal Strategy in 2016 (Health Service Executive, 2017). This national strategy, similar to UK perinatal guidelines, includes the introduction of specialist multidisciplinary perinatal mental health teams in all large maternity hospitals and an integration of maternity services and mental health services in the community (Health Service Executive, 2017).

A key aspect of the model of care is the provision of training to all HCPs involved in perinatal health care, ensuring women with mental health difficulties are identified, with necessary onward referral appropriate community or specialist services. Specialist perinatal mental health services (SPMHS) support perinatal women with moderate to severe perinatal mental health difficulties. SPMHS are rapidly expanding services, mainly integrated within maternity services, in acknowledgment of maternal mortality rates (Moran et al., 2023).

A recent qualitative evidence synthesis of women's experiences of these specialist services, concluded that women require flexible and accessible specialist services with non-judgemental clinicians, sensitive to their individual psychosocial needs and preferences (Moran et al., 2023). The review additionally highlighted the need to examine discharge practices and continuity of care to ensure optimal outcomes.

As per perinatal guidelines, routine screening and identification of PMHD by HCPs is essential for assessment and treatment (Coates & Foureur, 2019). However, existing research identifies persistent challenges among HCPs in completing this screening and assessment (Noonan et al., 2017;Noonan et al., 2018a; Noonan et al., 2018b; Pope et al., 2023)These

barriers are related to the identification and management of perinatal mental health problems, as well as challenges in care provision (Noonan et al., 2018b). Specifically, they involve the conceptualization and detection of PMHD, as well as barriers and facilitators to management, such as the use of formal screening tools versus clinical intuition, and issues like inadequate referral pathways and time constraints (Noonan et al., 2017) Further service and systemic barriers exist, such as HCPs limited capacity, clinical culture and hierarchy, insufficient organisational investment and social inequalities impacting support access (Pope et al., 2023).

Interestingly, midwives surveyed in one study indicated high levels of knowledge in identifying PMHD, however they reported less confidence in caring for these women due to lack of cultural competence and HCPs own mental health related stigma (Noonan, et al., 2018c). These findings highlight the interpersonal barriers for HCPs that require support beyond knowledge improvement, particularly as HCPs mental health related stigma has been identified as a barrier for help seeking (Dolman et al., 2013; Megnin-Viggars et al., 2015).

Providing care to women who have mental health difficulties is a complex task for HCPs, impacted by individual and systemic factors (Pope et al., 2023). A recent integrative review highlights that HCPs caring for women with psychological birth trauma or post-traumatic stress disorder (PTSD) often report a lack of education and training, limited use of standardized screening tools, and poor coordination in accessing evidence-based therapies (O'Donoghue et al., 2025). Similar findings are identified within research of maternity HCPs' attitudes towards screening and assessment of suicide. The study found HCPs felt uncomfortable with assessment, and avoided the word 'suicide' with perinatal women. Given PMH services are situated within maternity settings to aid identification and support, the need to support this specific group of HCP is crucial (Moran et al., 2023; O'Donoghue et al., 2025). Reflective of the interpersonal nature of these interactions between HCPs and

perinatal women, similar barriers exist within research of perinatal women's experiences of disclosing suicidality within maternity care settings (Dudeney et al., 2024).

While education and training are repeatedly cited as barriers to effective screening and assessment of PMHD by HCPs, evaluation of an interdisciplinary perinatal mental health module has highlighted the need for ongoing implementation, and importantly the systemic obstacles such as time, resources and compartmentalised care pathways as impediments to the enactment of module learning (Byrne, 2024).

It is apparent from research and clinical reports that barriers exist for HCPs in effectively supporting perinatal mental health needs. How these barriers are experienced by perinatal women warrants further exploration.

While isolated risk factors are often highlighted, the interaction of these at an individual and social level presents significant risk, emphasising the need for person-centred assessment and intervention (Quatraro & Grussu, 2020; Wilson et al., 2024). We can also prevent modifiable factors and promote protective factors against poor mental health, both individually and systemically, such as strong social support, positive relationships, communication, childbirth experiences, and quality mental health services (Pilkington et al., 2015; Wilson et al., 2024; WHO, 2022).

Understanding Perinatal Women's Experiences

Qualitative research allows for a deeper understanding of maternal mental health through women's experiences. Feminist theories emphasize the need for woman-centered care, where women's voices and realities are listened to, unlike in patriarchal systems that often medicalize or minimize their distress (Ussher, 2006). In a comprehensive scoping review of perinatal mental health within an Irish context, authors convey the dominance of quantitative approaches and medicalisation of perinatal mental health within the research

field (Huschke et al., 2020). This feminist approach calls for woman-centred models of care, which prioritise women's holistic needs beyond medicalisation.

While a recent thematic synthesis of women's experiences of specialist PMH services has added qualitative research to the evidence base (Moran et al., 2023). Additional woman-centred research is required to complement existing quantitative studies (Huschke et al., 2020; Moran et al., 2023). Existing studies, while helpful, tend to recruit from within the health service, or recruit participants who have accessed the SPMH service. In light of our understanding of systemic barriers, accessing these traditional healthcare systems and a psychiatric diagnosis can be a barrier for some groups which impacts on the women who participate in research (Huschke et al., 2020; Reid & Taylor, 2007). Women's voices are largely absent from research, particularly women from migrant or ethnic minority backgrounds, including Irish Travellers, which exacerbates existing barriers faced by these perinatal women (Reid & Taylor, 2007).

Indeed, women with lived experience have been advocating for woman-centred maternity care that is less focused on medical needs, and as such, is more holistic (Brady et al., 2024; Huschke et al., 2020). The concept of woman-centred care is conceptualised as an approach that prioritises the needs of the woman and neonate, regardless of the model of care in place (Brady et al., 2024). This emphasis is particularly important in light of current models that continue to prioritise medical needs, while the integration of psychosocial support remains limited and underdeveloped (WHO, 2022).

The prioritization of evidence based research to understand quality care, that is individualised, considers benefits and harms, person-centered, spans the continuum of perinatal health care, and prioritises equity has been called to action for women and children (Kennedy et al., 2018). To achieve this, qualitative research with perinatal women is key to understanding their experience of perinatal mental health care, in a field that is traditionally

dominated by quantitative research (Huschke et al., 2020). While distress often requires most clinical attention, exploring the span of experience is essential to understand the complexity and nuance of PMHD (Ussher et al., 2019). This is particularly important within the relational model of perinatal healthcare, where understanding both intra and interpersonal factors is crucial for developing effective interventions (Wall & Dempsey, 2023).

It is evident that barriers to perinatal mental healthcare exist, and yet we lack qualitative understanding of women's experiences of navigating these and seeking perinatal mental health support (Huschke et al., 2020). Gaining this understanding is a welcome addition to a biopsychosocial feminist understanding of perinatal women's experience of seeking and receiving healthcare intervention (Lokugamage et al., 2022; Ussher et al., 2019). Indeed it was through feminist psychology that robust alternatives to a medicalized view of the perinatal period created models such as the psychosocial model of perinatal adjustment (McKenzie-Mohr & Lafrance, 2014; Oakley, 2016; Saxbe, 2017; Ussher & Kimball, 2007). By adopting this model, this research aims to understand the diversity of perinatal women's PMHD experiences and how they interact with the health system when seeking and receiving support.

Relevance to Clinical Psychology

Clinical psychologists are uniquely positioned to address perinatal mental health through assessment, formulation, and intervention (British Psychological Society, 2016) . Perinatal women have indicated a clear preference for psychological support for mental health problems, which highlights the critical role of clinical psychologists in delivering high quality evidence based therapy (British Psychological Society, 2016; Buist et al., 2015; O'Brien et al., 2023) Given their extensive training, clinical psychologists can offer nuanced understanding of complex, intersecting influences on maternal well-being and the use of evidence-based psychological therapies (Branquinho et al., 2023; British Psychological

Society, 2016, 2023). Previous feminist scholars have articulated how therapists such as psychologists can recognize PMHD, such as disenfranchised grief after perinatal loss, and provide a safe therapeutic space that overcomes social barriers and stigma, providing psychological care beyond medical needs (Cosgrove, 2004). In consideration of the impact of PMHD on child outcomes, clinical perinatal psychologists are also qualified to support mothers and babies during this critical period, using sensitive attachment informed intervention (Centre of Perinatal Excellence (COPE), 2017; Quatraro & Grussu, 2020; Zeanah, 2019). Notably, a growing method of intervention in the perinatal period, particularly for perinatal mental health, are psychosocial interventions, which are non-pharmacological interventions aimed at improving the biopsychosocial functioning of patients (and their wider family) (Clarke et al., 2013; O'Brien et al., 2023; Quatraro & Grussu, 2020; Shaohua & Shorey, 2021; Wenzel, 2016). To uphold an ethical model of perinatal care, the outcomes of psychosocial assessments in perinatal services must be met with the provision of appropriate interventions which address the identified psychosocial vulnerabilities of mothers, the mother-infant dyad and partners (O'Brien et al., 2023).

Finally, understanding service users' experience of support pathways, is essential for clinical practice, especially for clinical psychologists, who may not always work directly in perinatal mental health services but still interact with them in various capacities (British Psychological Society, 2023). Clinical psychologists may be involved in consultation, training, and support of HCPs in maternity hospitals, and therefore increased understanding of this subject can potentially improve psychological assessment, intervention and development of clinical pathways (British Psychological Society, 2023; Clinkscales et al., 2023).

The Current Study

This study seeks to contribute to the gap in qualitative research by exploring perinatal women's experiences of seeking and receiving healthcare intervention, with a focus on psychosocial support. These two qualitative studies will explore (1) perinatal women and their families' experiences of psychosocial interventions for perinatal mental health, and (2) the experiences of perinatal women seeking mental health support from Health Care Professionals.

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Chapter Two

Systematic Review

Title: How do Women and their Families Experience Psychosocial Interventions for Perinatal Mental Health: A Systematic Review and Thematic Synthesis of Qualitative Studies

Prepared in accordance with submission guidelines of Women's Health (see Appendix B)

Word count: 7,938 (excluding abstract, tables, figures and references)[1]

[1] Although all figures and tables are usually included as separate files for the journal, they are included in the text for ease of examination.

How do Women and their Families Experience Psychosocial Interventions for Perinatal Mental Health: A Systematic Review and Thematic Synthesis of Qualitative Studies

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How do Women and their Families Experience Psychosocial Interventions for Perinatal Mental Health: A Systematic Review and Thematic Synthesis of Qualitative Studies

Abstract

Background**:** The perinatal period is a time of profound biopsychosocial change, during which many women experience mental health challenges driven in part by psychosocial risk factors. Although psychosocial interventions targeting perinatal mental health needs exist, evaluations have been predominantly quantitative, resulting in an absence of studies exploring women's experiences.

Objectives: To review and synthesise primary qualitative evidence on perinatal women's (and their families') experiences of psychosocial interventions for PMHD, synthesise findings, and derive implications.

Design: Systematic review and thematic synthesis of qualitative studies

Methods: In November 2024, a systematic search was conducted in Medline, PsycINFO, PubMed, CINAHL, Web of Science, and Google Advanced (for grey literature). English-language, peer-reviewed studies reporting qualitative data from recipients of psychosocial interventions were eligible for inclusion. Reviewers screened titles, abstracts, and full texts, and assessed study quality using the Joanna Briggs Institute checklist and the Authority, Accuracy, Coverage, Objectivity, Date, Significance tool for grey literature.

Results: Thirty-one studies met inclusion criteria. Thematic synthesis identified six core themes: Navigating matrescence, A tapestry of relationships, The influence of a

therapeutic facilitator, Invisible walls faced by participants, What works for perinatal women? and “Left hanging”. These encompassed 21 subthemes.

Conclusion: Perinatal women reported positive experiences with various psychosocial interventions, including psychological therapies and alternative approaches (e.g. singing, yoga, play, and home visits). Inclusion of family systems, clear engagement facilitators and barriers, and the central role of the therapeutic relationship emerged as key considerations for refining practice and directing future perinatal research.

Keywords: perinatal mental health; psychosocial interventions; systematic review; thematic synthesis; healthcare

Registration: PROSPERO CRD42024580079

Introduction

Adjustment in the perinatal period can impact on the mental health of perinatal women, and internationally, rates indicate 10-13% of women experience PMHD. For 21.2 % of women, psychological distress arises during the prenatal period, and 26.7 % in the postnatal period (O'Brien et al., 2023). The spectrum of perinatal mental health difficulties can range from temporary changes, to mild symptoms, to moderate-severe presentations which significantly impact functioning (WHO, 2022). Perinatal mental health conditions such as schizophrenia, postpartum psychosis and BD, have lower prevalence rates, however these are considered high risk and require complex perinatal care to manage adverse obstetrical outcomes and associated psychosocial risk factors (Wenzel, 2016).

While prevalence rates can be useful, there is significant debate about what level of anxiety, depression, and stress are normal during matrescence (i.e. the transition to motherhood) rather than being precursors to clinical presentations. Research, psychometric measures, and service provision have been argued to pathologize maternal experiences (Athan, 2024; Quatraro & Grussu, 2020; Rallis et al., 2014; Reid & Taylor, 2007; Wenzel, 2016).

Mental health difficulties in the perinatal period can result from a combination of biological, psychological, and social factors, and research shows bidirectional pathways between these changes (Schaffir, 2016). The MBRRACE UK & Ireland report on maternal deaths highlights the stark impact of perinatal mental health difficulties, with substance misuse and psychiatric causes accounting for 34% of maternal deaths between 6 weeks - 12 months postpartum (Felker et al., 2024). A key message from the MBRRACE-UK report is the inequalities in maternal mortality due to race and social deprivation. Women with multiple disadvantages (mainly mental health diagnosis, substance misuse and domestic abuse) continue to be over-represented amongst maternal deaths (Felker et al., 2024). Given

the complex interplay between biopsychosocial factors, particularly for vulnerable women with complex biopsychosocial presentations, targeted systemic intervention is imperative to improve care (Felker et al., 2024).

Perinatal Mental Health Risk Factors

While research has traditionally focused on biological risks within the perinatal period, the biopsychosocial paradigm of risk factors are integral to understanding PMHD (Blount et al., 2021). There are a number of established biological risk factors for PMHD, such as physical and nutritional health, neurobiological issues, genetics, and adverse childhood events (ACEs) (Blount et al., 2021).

In addition to the psychological nature of pregnancy itself, women can experience complex mood changes, anxiety, stress, depression, fatigue and excitement during the perinatal period (Bjelica & Kapor-Stanulović, 2004). These psychological changes can leave women vulnerable to PMHD, or interact with existing vulnerabilities such as cognitive capability, substance abuse, stress, personality factors, previous mental health problems, and past experience of abuse (Blount et al., 2021; Quatraro & Grussu, 2020; Ussher et al., 2019; Wenzel, 2016,). The healthcare experience for women during the peri-partum and post-partum period can also impact on psychological wellbeing, for example healthcare pressure to make certain medical decisions or lack of communication with HCPs (Bjelica & Kapor-Stanulović, 2004; Blount et al., 2021; Jou et al., 2015). Social risk factors may include low socioeconomic status, discrimination/race-based issues, poor partner and wider support systems, and overall access to quality healthcare services (Biaggi et al., 2016; Blount et al., 2021; Lancaster et al., 2010; Longoria et al., 2024). Evidence suggests that perinatal depression is associated with lower levels of education, poor family economic status, and experiences of domestic violence (Yang et al., 2022).

These findings regarding domestic violence as a significant risk factor reflect previous research not only related to perinatal depression, but anxiety and PTSD (Howard et al., 2013).

Risk factors for common PMHD have been demonstrated across cultures and geographical locations, highlighting the intersectionality of risk factors (Kalra et al., 2021). However the social determinants of perinatal mental health, exacerbate vulnerability among certain perinatal populations, often marginalised women, and negatively impact access to support and intervention (Endres et al., 2023; Holcomb et al., 2025; Howard & Khalifeh, 2020; Pardo et al., 2024). These intersecting biological, psychological, and social risks highlight the need for holistic care. As such, psychosocial interventions are key to addressing the modifiable factors contributing to PMHD.

Psychosocial Interventions

A psychosocial intervention is a non-pharmacological intervention that aims to improve the biological functioning, psychological and emotional well-being of patients (and their family/carer) with change in one's behaviour, emotional state or thinking (Clarke et al., 2013; Shaohua & Shorey, 2021). Effective psychosocial interventions have common nonspecific elements (e.g., the therapeutic alliance), and specific elements linked to a particular model or psychosocial approach. Psychosocial interventions are not limited to a specific professional discipline; rather, effective delivery requires that the intervention include structured actions, a targeted psychosocial mediator, and be directed toward a defined outcome (England et al., 2015). Previous systematic reviews have cited psychosocial intervention examples of psychoeducation, home visits, peer support groups, counselling support, and internet/mobile application support (Dennis & Dowswell, 2013; Prina et al., 2023).

Psychosocial interventions are less specific than psychological interventions, which are typically based on a theory of psychological functioning and a specific psychological method (Dennis & Dowswell, 2013). Approaches that focus exclusively on the mother through structured psychological interventions risk neglecting the broader psychosocial context of perinatal mental health. This is particularly critical in cases of moderate to severe mental illness, where the inclusion of family and significant others is essential (Austin et al., 2017). However, the distinction between psychosocial and psychological interventions can be unclear as they can frequently include common elements evidenced in deep analysis of protocols (Lin et al., 2023). In consideration of this, and the novel nature of this review, a broad definition of psychosocial interventions was applied.

Psychosocial interventions are crucial in the perinatal period due to the psychological and social needs of the pregnant woman, infant, and family. In the context of mental health, perinatal women often prefer psychological intervention over psychotropic drugs (Buist et al., 2015; Stevenson et al., 2016). Psychosocial factors significantly contribute to mental health difficulties, and guidance exists on reducing their impact (British Psychological Society, 2022). Addressing mental health inequalities requires action on wider social inequalities and psychosocial interventions at the micro and meso-system levels, rather than solely focusing on the macrosystem. Systemically targeted interventions are recommended to improve maternal mental health and childhood development (Shaohua & Shorey, 2021; WHO, 2020).

The effectiveness of psychosocial interventions has previously been examined in studies focusing either on their delivery by non-mental health specialists or on specific mental health presentations such as perinatal loss, prenatal anxiety, and postnatal anxiety (Atif et al., 2023; Clarke et al., 2013; McCarthy et al., 2021; Shaohua & Shorey, 2021). These reviews concluded that psychosocial interventions can be effective in treating mental health needs, and in particular sociodemographic contexts such as low-middle income

countries. For example, psychosocial interventions consisting of adapted manualised CBT-based psychosocial programme (Atif et al., 2023), attachment orientated home visits, interpersonal psychotherapy orientated education programme, and emotional self-management programme (Clarke et al., 2013).

It has been noted that psychologists play a key role in design and delivery of psychosocial approaches to perinatal mental health difficulties along with multi-disciplinary colleagues (O'Brien et al., 2023a; Prina et al., 2023; Purgato et al., 2020). In a recent systematic review of clinical psychological guidance for perinatal mental health, psychosocial approaches were broadly included in guidelines, for mothers, the mother-infant dyad, and partners (O'Brien et al., 2023b). The focus of these psychosocial recommendations on social connections and support network is reflective of the developing role of psychologists, moving beyond one-to-one therapy to systemic working. They concluded that evidence is required to underpin these recommendations for psychological/and or psychosocial interventions (O'Brien et al., 2023b).

Rationale for the Current Review

To date, no systematic review that has explored psychosocial interventions from a qualitative perspective, focusing on the experience of women and their familial systems as evidence to underpin psychosocial interventions was identifiable. While existing reviews are available, they are diagnosis-specific and have not explored the experience of psychosocial interventions with the breadth of perinatal mental health presentations. While a mental health diagnosis can be helpful to contextualise research participants, for many perinatal women who experience psychosocial risks, accessing a diagnosis can be a barrier (Reid & Taylor, 2007). Women from minority backgrounds and cultures such as Traveller women[2] often face

[2] In the Republic of Ireland, Travellers form a small indigenous ethnic minority group with distinctive cultural values, language and nomadic tradition (Reid & Taylor, 2007)

marginalisation by services that lack community integration, and as a result, often view these groups as high risk due to their culture, rather than understanding of their difficulties in accessing ethnocentric maternity services (Reid & Taylor, 2007). As a result, the predominantly quantitative approach of mental health prevalence and treatment outcome, often lacks the qualitative experience of perinatal women. This can neglect diversity and cultural sensitivity by omission of women who typically engage less in these formal clinical research settings. It is an important rationale of this review therefore, to include both women with an identified mental health difficulty, but also women identified 'at risk' of developing same, where a diagnosis is not the determinant to accessing psychosocial support.

The importance of conducting a qualitative review of psychosocial interventions reflects several key issues highlighted to this point, such as the limitations of quantitative measures of perinatal mental health, the social and cultural risk factors for perinatal women which are not captured by quantitative data, and the call for woman-centred care. The absence of qualitative evidence is a major shortcoming in the research base and documented as an outstanding need (Huschke et al., 2020). Additionally, by synthesising the evidence underpinning psychosocial interventions, this systematic review can support practitioners to use and implement recommendations in clinical practice.

This qualitative systematic review intends to address this need by reviewing primary qualitative and mixed-methods research publications about perinatal women's experience, and/or their families' experience, of psychosocial interventions for perinatal mental health. We will specifically focus on the experience of perinatal women and their families having received a psychosocial intervention, and their perception of the intervention.

The aims of this systematic review are:

1. To systematically review and collate empirical qualitative literature on psychosocial interventions for perinatal mental health needs.

2. To provide a comprehensive evaluation of qualitative studies investigating psychosocial interventions for perinatal mental health needs by understanding how these interventions are experienced by participants.

Method

This systematic review was conducted using Rayann software and applying the PRISMA-P (Preferred Reporting Items for Systematic reviews and Meta-Analyses Protocols) and PRISMA-S (Preferred Reporting Items for Systematic reviews and Meta-Analyses Search extension) recommendations. The systematic review protocol was registered on PROSPERO on 15/08/2024, registration number: CRD42024580079.

Research Question

The SPIDER framework (Sample, Phenomenon of interest , Design, Evaluation, Type of Research) was used to formulate the research question and develop the search strategy (see Table 1). Several initial scoping searches were conducted to refine the search terms and inform the finalised systematic search.

The perinatal period was defined as being from pregnancy to one year post birth. We defined psychosocial interventions as; any interpersonal activity that aims to improve the biological functioning, psychological and emotional well-being of patients, family and carer with change in one's behaviour, emotional state or thinking (Shaohua & Shorey, 2021). The specific focus for psychosocial interventions are: (a) structured or planned, with an explicit intended goal or objective to address perinatal mental health difficulties, and/or identified risk factors for perinatal mental health difficulties; (b) targeted for use with perinatal women experiencing perinatal mental health difficulties and (c) in a community or specialist perinatal service in low, middle, and high income countries. We excluded solely pharmacological interventions or interventions that are predominately pharmacological in nature.

Search Strategy

Initial scoping searches were conducted across five databases; Medline, PsycINFO, PubMed, CINAHL, and Web of Science, between August and November 2024, culminating in a finalised search in November 2024. To finalise appropriate search terms, the lead researcher consulted with supervisors and an academic librarian. The first 10 pages of results from Google advanced search were screened. The sources of grey literature were limited to the following: theses/dissertations, conference proceedings e.g., oral or written contributions, guidelines and policies published by organisations (government and non-governmental organisations) concerned with perinatal mental health (e.g. WHO, Cope Centre of Perinatal Excellence and Maternal Mental Health Alliance). Search terms were adapted where necessary by consulting with database thesauruses with search terms deriving from key SPIDER concepts (see Table 1).

Table 1

SPIDER Concepts and Search Strategy

Sample	Phenomenon of interest	Design	Evaluation	Type of Research
Perinatal women and their families with existing mental health difficulties or identified psychosocial risk factors for mental health difficulties	Psychosocial interventions for perinatal mental health	Any design including qualitative data - Interviews, case studies, focus groups, open-ended questionnaires	Sample participant experience of the psychosocial intervention	Qualitative studies, or mixed methods where qualitative data could be extracted, with no restrictions on the type of qualitative analysis used (e.g. thematic analysis, interpretive phenomenological analysis, content analysis).
Synonyms: perinatal/ pregnancy/postnatal/ prenatal/ postpartum /maternal/antenatal /mother*	Synonyms: psychosocial/ psycholog*/ therap*/ support group/peer support/psychoeducation/psycho-education/ intervention /program/programme/treatment	Synonyms: Qualitative Methods/Focus Group/Grounded Theory/Interpretative Phenomenological Analysis/Narrative Analysis/Semi-Structured Interview/Thematic Analysis	Synonyms: Mental health/anxiety/depression/psychosis /stress	Synonyms: Qualitative research/ qualitative methods

Inclusion and Exclusion Criteria

Studies were included if they were qualitative and focused on the experiences of perinatal women and their families who engaged in a psychosocial intervention for perinatal mental health needs. Mixed methods studies were included when the qualitative results were distinctly presented from quantitative findings and data was extractable. Studies were included if they were peer-reviewed journal articles written in English. Studies were excluded if they did not meet the above criteria, were non-empirical studies, and reported non-psychosocial outcomes only, such as pharmacological outcomes. No publication date restrictions were applied since no previous systematic review on this topic was available, reducing potential bias.

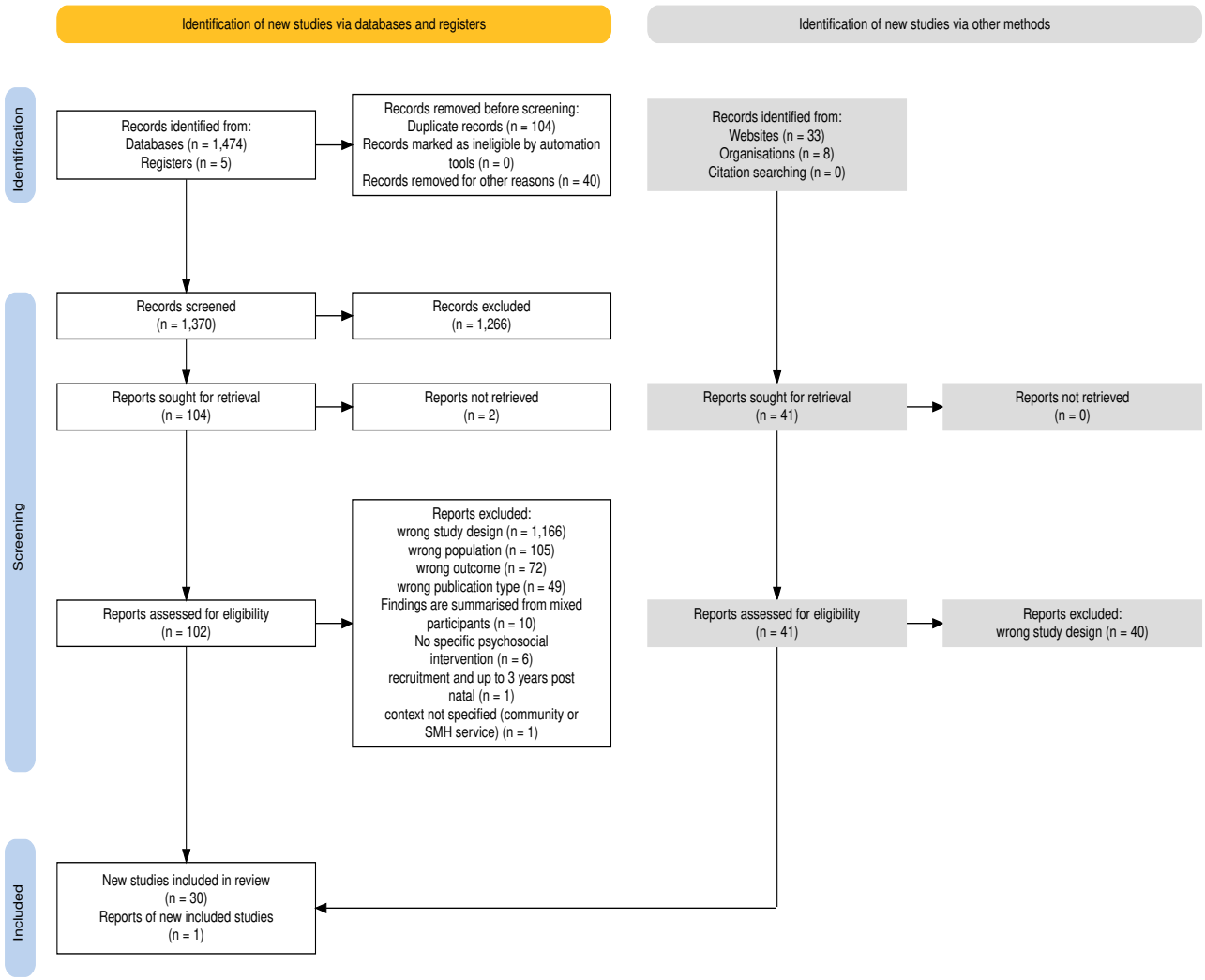
Study Selection

Records were identified from five databases (N= 1474) and an initial screening, resulted in the removal of duplicates, and other papers such as review studies using Rayann software (n= 144). The primary author then screened all titles and abstracts (n=1370). The primary author conducted a search of grey literature, and this returned reports (n=41). Upon screening, reports were excluded due to wrong study design (n=40), resulting in the inclusion of one report. The reference lists of key papers and key systematic reviews referenced in the introductory paragraph were screened for potential additional references. The fourth author screened 20% of titles and abstracts where conflicts occurred (n=7) were resolved through discussion. The primary author screened the remaining full texts (n=102), and 50% of the full texts were screened by the second and third author. Conflicts that arose (n=18) were discussed and resulted in an additional three papers meeting inclusion (see Appendix C). A total of 31 papers met the criteria for inclusion in this review (see Table 2). Data extraction was performed to provide a summary of the methodological characteristics on included texts

as per PRISMA guidelines extension PRISMA-S, which resulted in a PRISMA flow diagram (Haddaway et al., 2022; Page et al., 2021) (see Figure 2).

Figure 2

Prisma Flow Diagram



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffman TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021; 372:N71. Doi: 10.1136/bmj.n7

Table 2

Demographic and Methodological Information

No.	Reference	Setting	Intervention	Participants	Aim and design	Analysis	Key themes
S1	Anolak et al. (2023)	Mental health inpatient ward, SA	MDN therapy (6 sessions, 2 per participant)	Pregnant women (N = 12) with PND	Describe women's experiences in MDN therapy; Interviews	TA	(1) Impact of MDN on experience (2) Therapeutic process
S2	Baylis et al. (2020)	Internet-based (U-CARE), Sweden	Guided iCBT, 8-week self-help with psychologist support	Perinatal women (N = 127)	Explore experience and content of fear; Semi-structured interviews	TA	(1) Impact of iCBT on FOB (2) Online relationship
S3	Broberg et al. (2020)	Copenhagen University Hospital, Denmark	Supervised group exercise (2x weekly, 12 weeks)	Pregnant women (N = 19) with depression	Explore experiences of supervised exercise; Interviews	TA	(1) Vulnerable yet strong (2) Nine sub-themes
S4	Buultjens et al. (2008)	Counselling unit in hospital, Australia	"EPIC", holistic psychosocial intervention	Perinatal women (N = 10) with PND	Pilot to identify perceptions of "EPIC"; Interviews	TA	(1) Attachment (2) Views on play (3) Appraisals of EPIC
S5	Carter et al. (2020)	Homes, UK	Peer support visits (6-weekly) + routine care	Pregnant women (N = 20) with antenatal depression	Feasibility of peer support; Interviews, logbooks	TA	7 themes including empathy, fear of end, making a difference
S6	Chakkalackal et al. (2021)	Homes, UK	Video Interaction Guidance (VIG)	Families (N = 23) with infants <12 months	Acceptability and impact of VIG; Semi-structured interviews	TA	8 themes e.g., being under spotlight, me & baby, trust

S7	Chartier et al. (2015)	Homes, Canada	Families First home visiting program	Postpartum women (N = 13)	Case study on mental health strategy; Interviews	TA	(1) Mental health discussion (2) Strategy usefulness (3) Early impacts
S8	Corey et al. (2019)	Urban hospital, USA	Bedside music therapy session	Women (N = 210) antepartum/postpartum	Assess feasibility of music therapy; Questionnaire	MTC	(1) Mental/emotional effects (2) Infant soothing
S9	Forsyth et al. (2017)	Community, UK	Exercise counselling & group/self-exercise	Postpartum women (N = 22) with PND	Effectiveness of exercise; Focus group, RCT	TFA	4 benefits, 4 barriers e.g., resilience, motivation, weather
S10	Goodman et al. (2014)	Prenatal clinic, USA	CALM Pregnancy (adapted MBCT)	Pregnant women (N = 24) with GAD	Feasibility and outcomes of CALM; Questionnaire	CA	7 themes e.g., skill-building, universality, insight
S11	Hall et al. (2021)	Antenatal clinic, Australia	Partner massage vs. self-help stress training	Dyads (N = 27) with mild/mod anxiety	Feasibility of partner massage; Interviews	TA	Themes by group: e.g., connecting, valuing mental health
S12	Howard et al. (2023)	NHS services, UK	One-session ACT + routine care	First-time pregnant women (N = 15) with FOB	Feasibility of ACT; Feedback form	LCA	13 coded themes e.g., gratitude, helpful, relaxing
S13	Ingram et al. (2021)	NHS, UK	IPC & CBT	Pregnant women (N = 32) with mild/mod depression	Nested qualitative study; Interviews	TA	Themes around expectations and IPC content
S14	Jallo et al. (2015)	Homes, USA	12-week GI	Pregnant African-American women (N = 36)	Perceptions of GI for stress; Logs & interviews	CA	(1) Managing stress (2) Barriers (3) Connecting with baby

S15	Kinser et al. (2021)	Community, USA	Mindful Moms (yoga, 12 weeks)	Pregnant women (N = 26) with mod-severe depression	Pilot evaluation; Interviews	QD	(1) Enjoyment (2) Connectedness (3) Challenges attending
S16	Le et al. (2021)	Community WIC Centre, USA	Mothers and Babies CBT-based course (6-week)	Latina women (N = 86) at risk	Prevention study using mixed methods; Interviews	TA	4 themes incl. CBT skills, emotional awareness, support
S17	Lönnberg et al. (2018)	Stockholm, Sweden	MBCP program (8 sessions + reunion)	Pregnant women & partners (N = 16)	Phenomenological qualitative study; Interviews	TA	(1) Acceptability (2) New ways of relating
S18	Masood et al. (2015)	Sure Start Centre, UK	PHP	South Asian women (N = 17) with PND	Feasibility of culturally-adapted PHP; Interviews	TA	6 themes e.g., cultural needs, empowerment, barriers
S19	Mendelson et al. (2018)	NICU, USA	Mindfulness video + audio practices	Postpartum NICU mothers (N = 27)	Feasibility of mindfulness; Interviews	TA	3 themes incl. self-care, stress, relationships
S20	Ockhuijsen et al. (2015)	EPU/RMC Clinics, Netherlands	PRCI + DRK chart	Pregnant women (N = 13) with miscarriage history	Appropriateness of PRCI/DRK; Interviews	TA	(1) Adapted use (2) Feasibility
S21	Parry et al. (2016)	Community, Australia	4-part CfC program	Perinatal women and families (N = 25) with PND/ risk of PND	Mixed methods on SDH & outcomes; Focus groups	TA	8 themes incl. stigma, return to work, care of children
S22	Perkins et al. (2018)	Community Centre, UK	Group singing vs. creative play (10 weeks)	Mothers (N = 54) with PND	Mechanisms of singing for recovery; Focus groups	TA	5 themes incl. identity, mother-infant bond

S23	Platt et al. (2024)	Homes, USA	Virtual psychoeducation group	Latina women (N = 19) with PPD risks	Pilot of virtual support; Interviews	TA	(1) Expanding knowledge (2) Shared experiences
S24	Pritchett et al. (2020)	Home + phone	Exercise counselling	Postnatal women (N = 94) with depression	Nested RCT study; Interviews	FA	(1) Barriers/facilitators (2) Exercise attitudes
S25	Pulliainen et al. (2019)	Hospital	3/4D Ultrasound with psychologist	Pregnant women (N = 12) at risk of preterm birth	Experience of ultrasound support; Interviews	TA	(1) Foetus as real (2) Equal participation
S26	Rubio et al. (2021)	Homes	CRT home treatment	Postnatal women (N = 15) with MH diagnoses	CRT acceptability; Interviews	TA	3 themes incl. risk focus, service choice
S27	Russell et al. (2020)	Not specified	Mindful Moms (yoga + motivation)	Pregnant women (N = 25) with depression	Experiences in 12-week group; Interviews	IPA	5 themes incl. empowerment, shared space
S28	Seshu et al. (2021)	Phone	Mobile IVRS intervention	Perinatal women (N = 20) with PND	Experience using IVRS; Interviews, FGDs	TA	4 themes incl. accessibility, cost, usability
S29	Shakespeare et al. (2006)	Primary care, UK	Listening Visits	Postnatal women (N = 39) with PND	Experience of Listening Visits; Interviews	TA	4 themes incl. choice, health visitor relationship
S30	Turner et al. (2010)	Homes, UK	4+ Listening Visits	Postnatal women (N = 22) with depression	Women's experience of RHV visits; Interviews	FApp	5 themes incl. talking, support, closure
S31	Varambally et al. (2024)	In-person/online	One-day CBT-based workshop	Postnatal women (N = 603) with PND	Compare online vs. in-person; Open-ended survey	CA	Experiences, satisfaction, preferences

Note. CA= Content Analysis; CBT = Cognitive Behavioural Therapy; CfC= Communities for Children; CRT= Crisis Resolution Team; DRK = Daily Record Keeping; EPIC = Educating to Facilitate a Positive and Interactive Connection; EPU= Early Pregnancy Unit; FA= Framework Analysis; FApp= Framework Approach GAD = Generalized Anxiety Disorder; GI-= Guided Imagery; iCBT= Internet delivered Cognitive Behavioural Therapy; IPA= Interpretive Phenomenological Analysis; IPC = Interpersonal Counselling; IVRS= Interactive Voice Response

System ; LCA = Latent Content Analysis; MTC = Manual Thematic Coding; MBCT = Mindfulness-Based Cognitive Therapy; MBCT = Mindfulness-Based Cognitive Therapy; MBCP = Mindfulness-Based Childbirth and Parenting; MDN= Music, Drawing, and Narrative; NICU = Neonatal Intensive Care Unit; PHP = Positive Health Programme ; PND = Postnatal depression; PPs = Participants; PRCI = Positive Reappraisal Coping Intervention; PSWs = Peer support workers; QD = Qualitative Description; RHV= Research Health Visitor; RCT= Randomised Control Trial; RMC= Recurrent Miscarriage Clinic; SDH= Social Determinants of Health; TA= Thematic Analysis; TFA= Thematic Framework Analysis

Quality Assessment

A quality assessment was conducted of all peer-reviewed included papers using the Joanna Briggs Institute (JBI) critical appraisal checklist for qualitative research (see Appendix D). The JBI checklist consists of targeted questions addressing key methodological components of the study design to highlight strengths, limitations, and minimise potential bias on reported results of each study (Aromataris et al., 2024). The majority of studies met criteria for 8 of the 10 checklist items. Notably, only 4 of the papers included a statement locating the researcher culturally or theoretically, and 6 papers addressed the role and influence of the researcher. Five of the studies did not evidence ethical approval within their publication. The one included grey-literature study was evaluated using the AACODS (Authority, Accuracy, Coverage, Objectivity, Date, Significance) checklist and demonstrated all checklist items (see Appendix D; Tyndall, 2010).

Thematic Synthesis

The results section from included texts was extracted into N-Vivo software for an inductive thematic synthesis. Thematic synthesis is an integrative and interpretive method of synthesising themes across a number of publications and has been previously demonstrated in reviewing the acceptability and appropriateness of health interventions (Thomas & Harden, 2008). Thomas and Harden's (2008) approach to thematic synthesis informed the three-step process, beginning with line-by-line coding of the text, where new codes were created as needed or data was allocated to existing codes. This process resulted in 923 codes, which enabled an initial synthesis across studies. These codes were grouped into descriptive codes, while retaining their similarities and differences, an important aspect of thematic synthesis (see Appendix E; Thomas & Harden, 2008). These descriptive themes were then grouped further to form analytical themes, creating meaning in relation to this review question. This

process enabled the interpretive method of thematic synthesis, whereby the lead researcher not only integrates existing themes, but creates analytic themes to develop concepts and ideas relevant to the research question of this review. The research team reviewed, discussed and gave feedback on these themes to support a robust process of quality assurance.

Results

Thirty one studies were included in the review. A variety of psychosocial interventions were reflected in the included studies, such as technology-based interventions, psychoeducation, psychological intervention using a specific model or adapted model (e.g., Acceptance and Commitment Therapy (ACT] and CBT studies using alternative/complimentary therapeutic modalities such as music therapy, singing, yoga, play, mindfulness, guided imagery and exercise, listening visits, and home visits. Several interventions were delivered in group modality. Included studies were described as either preventative or treating existing mental health difficulties. A small number of studies included wider family system with some studies focused on the parent/child dyad as part of the mental health intervention (e.g. circle of security group, interactive ultrasound study, video interactive guidance). Twenty-two studies used interviews to collect data. The remaining nine studies used focus groups, logbooks, open ended questionnaires/surveys, and bespoke feedback form. Studies were predominantly conducted with adults located in Western Countries, with one study located in India.

Thematic Synthesis

Following the creation of descriptive themes, six core themes, consisting of 21 subthemes were identified (see Table 3).

Table 3

Core Themes and Subthemes Generated Across Studies

Core Theme	Subthemes
1. Navigating matrescence	Improved coping, Mental health, Perinatal adjustment
2. A tapestry of relationships	Relationship with baby, Wider familial system, Social system
3. The influence of a therapeutic facilitator	Connection and trust, Supportive and encouraging, Expertise
4. Invisible walls faced by participants	Personal/interpersonal barriers, Perinatal factors, Environmental, Intervention-specific barriers
5. What works for perinatal women?	Motivation, Intervention-specific facilitators, Environmental, Systemic support, Person-centred approach, Accessibility and cultural sensitivity
6. "Left hanging"	Helpful but not enough, Feedback and recommendations

Navigating Matrescence

Participants described the positive impact of the intervention on their individual journey through matrescence (S2, S5, S6, S10, S11, S15, S20, S21, S23, S26), describing feeling understood within their journey: *"...I felt that the PSW had been exactly where I am now. She really understood me, and I felt that she could genuinely feel the absolute turmoil that I was living every day"* (S5). *Improved coping, mental health*, and *perinatal adjustment* were identified as subthemes.

Improved Coping.

Self-compassion and acceptance of perinatal mental health needs were highlighted as coping mechanisms: *"..I am doing a good job"* (S6). Post-intervention, some participants expressed self-acceptance and understanding (S5, S6, S10, S20, S21, S23). Yoga and exercise interventions fostered body connection and acceptance, particularly for pregnant and postpartum participants with depression and low psychological well-being. This shift from

body judgment to appreciation led to improved body image and positively impacted mental health and self-esteem (S3, S24). Compassionate statements about mental health were evident (S10, S12, S17, S24, S27, S31). Participants prioritised self-care and accountable mental health support, acknowledging the challenges, and working towards improvement. This compassion stemmed from psychoeducation, mindfulness, shared experiences with group members, and peer support (S5, S10, S17, S24, S27, S31): *"...there are people here who have issues like you" (S21)*

Mental health.

Participants described the interventions' impact on their mental health, improving daily functioning, sleep, exercise, and diet (S3, S9, S24). Psychologically, they showed improved resilience, reduced shame and guilt, and decreased stigma, especially in partner, peer support worker (PSW), and group interventions (S3, S5, S6, S7, S10, S11, S17, S21, S24, S31). A participant describes how the inclusion of a partner improved mental health communication: *"...It opened up a bit more communication and talking about things that we wouldn't normally talk about ..anxiety..."(*S11).

Participants repeatedly evidenced the expanded knowledge and skills they gained, particularly interventions that included psychoeducation (S7, S13, S17, S23, S31). Participants from one study highlighted the absence of perinatal specific psychoeducation (S26).

Participants demonstrated skills in identifying cognitive distortions and associated emotions and behaviours: *"..I've realized that not all my thoughts are factual. Many times those thoughts create unpleasant feelings and reactions"* (S10). This expanded knowledge increased emotional, cognitive, and behavioural understanding linked to their mental health. Interventions improved the social functioning of participants, particularly interventions that had a group format as participants connected with peers (S15). This was also evident in

interventions delivered via an activity such as exercise or yoga (S15, S21, S22, S27, S28, S31). Additionally, the in-person intervention format resulted in behavioural activation for participants by providing a structure and routine (S22).

Perinatal adjustment.

Finally, the subtheme of perinatal adjustment was evidenced by participants who engaged in interventions during pregnancy and spoke of the aspects of the intervention supporting readiness for giving birth such as exercise or mindfulness to help cope with the physical nature of childbirth (S3, S17). For one participant, improved psychological wellbeing left them feeling stronger, and the mental health support allowed them imagine their baby: "*...I feel much stronger now and I am actually looking forward to meeting my baby*" (S5). Some women accessing a self-help intervention for miscarriage history, highlighted the difficulty in using the rating tool to distinguish emotional experiences in pregnancy: *"...So when completing emotions...yes I'm really sad, but not because of the pregnancy"* (S20). This captures the need for a biopsychosocial approach within the perinatal period. For participants participating post-partum they spoke of their increased confidence in their role, facilitated by the video and facilitator feedback (S6).

A tapestry of relationships.

This theme highlights how psychosocial interventions impacted the wider systems through direct and indirect involvement. This theme consists of subthemes *Relationship with baby*, the *wider familial system* and *social system.*

Relationship with baby.

The influence of attachment-based components within psychosocial interventions was apparent among perinatal women, as reflected in a participant's account of developing a stronger connection with their baby*: "..I became sensitive..this session strengthened the relationship between me and my baby"* (S25). This was facilitated in a variety of ways such

as through interactive ultrasound, music, group singing, supervised group exercise and guided imagery (GI) (S3, S14, S22, S25).

The use of technology in the interactive 3D ultrasound intervention facilitated participants to create a mental image of their babies, and seeing their foetus as a real person (S25). One participant described this vividly: *"It was very nice, especially when I could see for a first time that the baby was sucking his thumb…I have never been able to see in my previous ultrasound examinations"*(S25). Participants in this study also felt active and empowered in this interactive scan which supported them in the context of a stressful, anxiety-provoking hospital admission. This was in comparison to healthcare interactions where they reported to feel unable to ask healthcare professionals about their worries, and described their previous ultrasounds as professional-centered events rather than person-centered (S25).

Wider familial system.

Interventions with partner involvement enhanced relationships and were emotionally beneficial for the dyad. One participant described how family participation in VIG improved her partner's understanding of her mental health: "*…and he could see how I was after the sessions, it definitely improved our relationship"* (S6). Some participants also referenced improved partner relationships which had been negatively impacted by their mental health difficulties (S6). Participants spoke about the positive impact interventions such as supervised group exercise, VIG and GI (S3, S6, S14) had on their wider familial system, such as other parent-child relationships, where they felt better able to care for their children and an improvement in their role as parent, and spouse. Women with severe mental health difficulties who received CRT home visits (S26), reported that although their wider familial systems were perceived as influential in their mental health, the opportunity to involve these systems was missed (S26).

Social system.

The participants also evidenced increased use of their wider social systems to cope. Half of the participants in the mobile based intervention for perinatal depression in rural India demonstrated their own initiative of sharing the intervention content with their wider social system (S28).

The Influence Of A Therapeutic Facilitator

The role of the facilitator was a core component across psychosocial interventions. This consisted of three subthemes: *connection and trust, supportive and encouraging*, and *expertise*.

Connection and Trust.

To build connection and trust with the facilitator, continuity was key in facilitating this (S6, S27). In iCBT (S2), some participants were positive about their therapeutic relationship online, but the majority of participants found this difficult, impacting their application of the intervention for tokophobia. (S2). One participant described the negative impact of this format on their engagement ; *"..If you have a meeting with another person it gives you the motivation to actually work and think."* (S2). Where continuity was absent and replaced by changing professionals, unfamiliar professionals, or multiple professionals at once, this impacted negatively on the ability of the participants to forge a connection and trust. Within one home visit intervention (S6), one participant highlighted multiple HCPs entering their home*; "It's very difficult when you've got a different person coming to your house every day"* (S6). This exacerbated feelings of being overwhelmed in the context of their mental health difficulties and being home with a newborn (S6).

Supportive and Encouraging.

Facilitator qualities of being supportive and encouraging positively impacted the participants' mental health where they felt encouraged to be open and communicate their

experiences. One participant attending a mindfulness and yoga intervention (S27) describes this consistent skill of the facilitator : "*She definitely was good at creating that safe space every single time... to share our stories…"* (S27). This created a sense of hope and care for some participants who appreciated the feedback from the facilitator. This feedback was experienced as attuned and used a strengths-based approach (S27). The facilitator feedback reduced feelings of anxiety, guilt and judgement for participants which enabled them to increase their application of skills outside of the intervention (S6, S14).

Expertise.

The professional expertise of the facilitator was important to participants, and this related to their ability to be flexible in their approach, attuned to participants, and qualified to facilitate effective interventions (S8, S21, S22, S27, S30, S31). This expertise extended to mother and infant, where the participant compared facilitator expertise in comparison to other music classes which were not PND focused*: "…I like how [leader] really pays attention to reading all the babies and calming things down when she needs"* (S22). For some women accessing the CRT intervention, they felt that staff lacked perinatal expertise to understand their mental health presentation within the context of a caring for a newborn (S26).

Invisible Walls Faced by Participants

Across all studies participants spoke about 'invisible walls'. Four subthemes: *personal and interpersonal barriers, perinatal factors, environmental and intervention specific barriers* capture nuance across their experiences.

Personal and Interpersonal Barriers.

For some women receiving listening visits (S30) internal barriers like fear of expressing their difficulties led to further isolation: *"…with my health visitor, I try not to let too much out because then she won't think I'm a bad mum".* Women receiving CRT intervention (S26) also feared being honest with healthcare professionals as they feared being

hospitalized or having their baby removed into care. One participant who had social services input spoke of her concerns: *"..I just said I was all right. I was better, basically. Even though I wasn't. I just had to lie to them to get them away from me'* (S26).They perceived negative judgment that impacted their engagement and fear of the intervention ending (S5, S24, S26, S30).Women also faced interpersonal barriers such as lack of understanding and support from partners, excessive domestic duties and conflicting views from their partner on the usefulness of the intervention (S17, S18).

Perinatal Factors.

Being in the perinatal period led to barriers impacting use of skills such as physicality of pregnancy, fatigue, lack of sleep, reluctance to breastfeed in public (S11, S17, S24). For some women they faced absence of childcare and limited support in their wider systems (S18, S24, S31): "*My husband did not want me to go; he did not let me go anywhere. I had to look after my children" (S18).* Finally, attending the intervention in the postnatal period caused disruption for some women where their priority was to manage and care for their newborn, and they felt this was negatively impacted by the frequency and intensity of home visits which were not adapted to meet this perinatal context (S26).

Environmental Barriers.

Environmental barriers related to the unsuitability of the setting, such as hospitals, the unplanned and inconvenient times of the intervention (S15, S18, S26). One participant highlighted the challenge of this while minding a newborn: *"They couldn't tell me when they were going to come and I had a newborn baby and they would rock up whenever…"* (S26).

Intervention Specific Barriers.

Intervention specific barriers mainly related to technology facilitated interventions where some women did not have access or had equipment barriers (S14). For women with a history of miscarriage using PRCI and DRK instruments, they found the practicality of these

to be an issue (S20). In technology led interventions (S2 S14), some participants were also concerned about the safety of online platforms used, primarily privacy: *"It was fairly easy to have it over the internet. It was quite private…"* (S2). The lack of connection to other mothers and babies, and the time-consuming nature of technology-facilitated communication was a barrier for some women (S2).

What Works for Perinatal Women?

Women articulated many facilitators to engagement in psychosocial interventions for their mental health. These consisted of 6 subthemes: *Motivation, Intervention-specific facilitators, environmental, Systemic support, Person-centred approach, Accessibility and cultural sensitivity.*

Motivation.

Some women spoke about their internal motivation to engage and a desire to improve their PND (S24). Family also supported women to engage and overcome practical barriers (S11, S18, S24, S27, S28). This family support extended to the wider family system: *"I wouldn't be able to do anything . . . if I didn't have support like of my parents"* (S11). Where interventions included check-ins and reminders, participants expressed increased motivation, accountability and a prioritization of supporting their mental health (S11, S15).

Intervention Specific Facilitators.

There were many factors that supported participants such as engagement through music, social cohesion through singing, a lived experience testimonial and creating a trusting space through play (S6, S8, S22). These activities to indirectly explore mental health were preferred by some participants: *"...these open discussions gave me the confidence to interact and overcome my depression"* (S18)

Environmental.

Environmental factors such as feeling safe and at peace were important to participants and the venue itself was viewed as important to participants when they were feeling vulnerable (S21). Having an accessible, community-based physical space reduced stigma for participants, where community location evoked a similar feeling: *"...It feels like a community"* (S21). Where transport was financially supported and childcare provided, or children included in the intervention, this also supported women on a practical level but also supported them in coping with separation anxiety (S18, S21, S27, S31).

Systemic Support.

Systemic support mainly consisted of family support to attend the groups and implement the skills. For some women, family and financial support from intervention providers overcame barriers to attending such as transport (S15). Where the intervention involved the partner/family, participants felt this supported both mother and father (S6, S11, S17). A partner delivered massage intervention (S11) supported bonding: "*Having that bonding time gave him the opportunity to help during the pregnancy . . . and I think that he really appreciated that he had a way to help me"* (S11).

Person Centered Approach.

A person centered approach facilitated women where the intervention was flexible, and skills were personalized to their needs. Women who engaged in person-centered goal setting in IPC found this facilitated their engagement (S13).

Accessibility And Cultural Sensitivity.

Accessibility and cultural sensitivity were a feature of a small number of papers (S18 , S22, S23, S28). Participants reported on the materials being easy to read and accessible (S22 S23, S28). However where handouts were not translated, facilitators and group members addressed barrier: *"...but I feel for women who could not read English handouts need to be written in Urdu"* (S18). Where the group facilitator delivered the intervention in the language

of participants, this increased engagement (S18). The cultural sensitivity and knowledge of the facilitator was important, as was the diversity of the group and video testimonial, which participants felt increased their learning and overcame gender and cultural expectations regarding mental health (S18, S23). In one intervention, facilitators included culturally-diverse songs and materials which other participants found beneficial to their own learning (S22).

"Left Hanging"

It was clear that while participants benefited from psychosocial interventions for perinatal mental health they were left with outstanding needs *(S2, S6, S16, S18, S27, S30).* Two subthemes were identified: *helpful but not enough* and *feedback and recommendations.*

Helpful But Not Enough.

Participants with PND, complex psychosocial factors or existing mental health difficulties prior to the perinatal period felt the length of intervention was not sufficient enough to meet their needs (S18, S30). One participant highlights this concern after disclosing her mental health difficulties *''Just me thinking about it ...now makes me feel quite panicky... what would have been the point of ripping off the plaster and starting to abrade the wound, only to then just say, oh well''* (S30). The lack of follow up, or top up, was highlighted and negatively impacted the long-term implementation of skills (S18, S27, S31).

Feedback And Recommendations.

Participants vocalised a need for psychological support, in addition to the medical treatment they receive, with the psychosocial intervention a preferable alternative to hospitalization for some (S25, S26). Some participants sought alternative or additional support themselves after the intervention (S2).

Participants made a variety of suggestions about adjustments, with some commonalities such as increased access to materials and individualisation of the resources

S12, S15, S31). Many participants valued peer engagement, and this was recommended for inclusion after the group (S1, S15, S21, S22, S27, S28, S31). One participant suggested this as she missed the peer support: *"It was hard leaving that safe space, where I looked forward every week to seeing how everyone was doing"* (S27)

Discussion

This thematic synthesis highlighted the potential of psychosocial interventions to offer a diverse range of interventions for perinatal mental health women and their families. This was achieved across a variety of methods that addressed the complexity of adjustment within the perinatal period, to managing complex mental health difficulties and supporting the wider familial system. A unique contribution of this systematic review is the identification and synthesis of a broad range of existing qualitative studies within a predominantly quantitative evidence base. This is reflective of the broad definition of psychosocial intervention used and inclusion criteria of mental health needs beyond diagnostic classifications, including women identified as at risk of developing PMHD. As previously discussed, adopting this flexible understanding of perinatal mental health reflects diversity of experience and populations.

Findings suggest that supporting women navigate matrescence positively impacted adjustment to the perinatal period through mental health understanding, and enhanced coping through use of acceptance and self-compassion strategies. This may have been achieved through two avenues; increased understanding of perinatal mental health and/or the shared group experience reducing shame and self-criticism. Dominant societal narratives around idealised motherhood, and social construction of 'the good mother' exist (Schmied et al., 2018). This idealised narrative can pathologise perinatal women who experience distress, contribute to PMHD and shame women with PMHD (Law et al., 2021; Staneva et al., 2017; Staneva & Wigginton, 2018). Perinatal women can be supported to dismantle this narrative through mental health literacy and psychoeducation to normalise varying emotions, emotional distress and PMHD (Daehn et al., 2022; Kutcher et al., 2016; Schmied et al., 2018). By engaging in psychosocial interventions with psychoeducation, participants may have been supported to normalise their distress and gain knowledge on coping skills for

PMHD (Mhango et al., 2023; Steardo et al., 2019). Inclusion of partners was positively perceived within the findings from this review and may further support the effectiveness of psychoeducation rooted in a solid social support system (Ong et al., 2023; Park et al., 2020; Wang et al., 2023).

The importance of support systems in psychosocial interventions were highlighted in this review through family and partner participation in the intervention, relational interventions with mother and baby, and peer connections. Given a small number of studies included the wider support system, the findings predominantly reflect individualised approaches centred on the perinatal woman, thereby limiting the exploration of the potentially valuable contributions that familial and partner perspectives may offer to both the intervention process and outcomes. Psychosocial interventions which involved support systems may have addressed lack of partner and social support that are repeatedly identified as a risk factor (Lancaster et al., 2010; Longoria et al., 2024). While some studies included the perinatal relational ecosystem, outstanding needs and recommendations within the findings, suggest a need for further involvement of support systems in psychosocial interventions would benefit perinatal women with PMHD (Barimani et al., 2017; Jeong et al., 2023; Noonan et al., 2021). Exclusion of the wider familial system may also perpetuate the expectations of the perinatal woman to meet all the needs of her family system, including her own mental health, without the expectation that the wider family system support her to navigate this peri (Ennis, 2014; Goodwin & Huppatz, 2010).

Findings from this review support previous research which demonstrates the importance of social support, the most explored mediator and moderator of psychosocial stress, with high social support moderating second semester stress such as partner conflict and life events (Quatraro & Grussu, 2020). However it should be noted that social support acts as a buffer to stressors, rather than removing or preventing them. As such, incorporation

of social supports into psychosocial interventions may buffer presenting psychosocial risk factors and complement existing interventions in clinical practice (De Sousa Machado et al., 2020).

Group interventions may have contributed to reduction in PMHD related stigma through the development of a support network. Group format can evoke a shared experience, reducing shame and stigma for many participants (Leaviss & Uttley, 2015). The reduction of this shame and stigma is powerful given the impact this has on self-esteem and self-efficacy, which can contribute to lower mood, contributing to postpartum depression (McLoughlin, 2013).

It is valuable to consider recent evaluations of CFT within perinatal services, which demonstrate the effectiveness of group-based compassion interventions in addressing shame and self-criticism across diverse clinical presentations (Craig et al., 2020; Lawrence et al., 2024). Growing evidence supports the benefits of compassion for well-being and as an effective emotion regulation strategy for self-criticism, shame, and feelings of worthlessness (Gilbert, 2009). These components may be especially valuable in psychosocial interventions for perinatal women, given the current findings and previous research highlighting the prevalence of these experiences during the perinatal period and their impact on help-seeking (Ayres et al., 2019; Ford et al., 2019; Gilbert, 2009).

The psychosocial interventions reviewed reflected a broad and diverse range of approaches, mirroring the complexity and variation in PMHD. This aligns with recommendations set out in the NICE guidelines, which advocate for flexible, accessible, and contextually sensitive approaches to perinatal mental health care (NICE, 2021). These included structured psychological therapies based on specific models such as ACT, CBT, mindfulness, and attachment theory, as well as interventions informed by psychological principles and psychoeducation. Several studies incorporated complementary therapies like

yoga and massage, however prior quantitative reviews of these approaches have yielded inconclusive findings (Dennis & Dowswell, 2013). Although these findings have been inconclusive, this thematic synthesis suggests that women experience them as meaningful and supportive in diverse ways. These findings invite reflection on how we conceptualise and measure outcomes in perinatal mental health research. They raise important questions about whether current research methods capture the nuances of women's experiences, and how we determine what constitutes effective practice (Huschke et al., 2020; Kennedy et al., 2018). There may be value in reconsidering the balance between quantitative and qualitative evidence, and in exploring how a more integrated, experience-informed approach with initiatives such as lived experience involvement, could shape clinically meaningful understandings of intervention and practice based evidence (Brown-Bowers et al., 2015; Schleider, 2023).

Many studies within the findings utilised listening visits, intensive home visits, telephone support and peer support for perinatal women, in combination with routine care (Carter et al., 2020; Rubio et al., 2021; Seshu et al., 2021; Shakespeare, et al., 2006; Turner et al., 2010). These outreach methods of psychosocial intervention may be most suitable for clinical application with women and families who face barriers to access due to social determinants of health, and low-middle income countries. Home visits in the early postpartum period have mixed reviews on their effectiveness on maternal and neonatal mortality (Mori et al., 2021). Insights from this review regarding women's experiences of home visits may offer clarity on previously mixed findings. Perceptions of home visits as predominantly risk focused, particularly in the absence of continuity of care from HCPs, which supports rapport and disclosure, may have contributed to the barriers experienced by participants (Mule et al., 2022). This continuity of care from non-judgemental open and reassuring clinicians is especially important for perinatal women with complex needs who are

also least likely to disclose PMHD due to stigma and fear (Forder et al., 2020; Mule et al., 2022). Fear of being a 'bad mother' is demonstrated as a barrier in this context too, supporting the concept of 'the good mother' (Kingston et al., 2015; Schmied et al., 2018). The need for a sense of security in the postpartum period is key for healthcare provision, particularly in the initial period following birth. This sense of security has been conceptualised into three dimensions; staff supporting the mother as "good enough", family support, and thirdly the possibility of being helped to take care of herself and baby (Quatraro & Grussu, 2020). Sensitive assessment of risk within the caregiver relationship may also support home visits, as it may highlight neglect that occurs due to the mental state of the perinatal mother, rather than risk of physical abuse or safety (Baradon & Broughton, 2005).

It is concerning that so few papers were focused on marginalised or at-risk groups, given the clear evidence base pointing to psychosocial risk factors (Felker et al., 2024). Where papers did focus on marginalised and at-risk groups, engagement was facilitated by the cultural sensitivity and adaptations of the facilitators to the intervention. The inclusion of a peer support worker with lived experience enriched participant engagement and could be implemented by facilitators with a different cultural background to participants in future interventions. In the presence of barriers such as environmental constraints, lack of childcare, and financial costs, participants articulated a clear need for services to implement supportive measures, including the provision of childcare, accessible service locations, and financial assistance for transportation. Internet-delivered psychosocial interventions were perceived as beneficial by some participants, particularly in mitigating previously identified access barriers. However, the findings also highlighted a loss of valuable in-person elements such as group interaction, peer support, and relational connection with facilitators which were considered meaningful aspects of the interventions. This nuance provides further context to quantitative findings supporting the effectiveness of digital interventions in improving access,

particularly in rural areas (Cluxton-Keller et al., 2023). These results underscore the importance of adopting flexible, person-centred approaches in both research and clinical practice, to ensure that interventions are appropriately matched to the diverse needs and preferences of perinatal populations (Kennedy et al., 2018; NICE, 2021).

Finally, across all intervention types, the role of the facilitator emerged as a pivotal component shaping the experience of perinatal women engaging in psychosocial interventions. Facilitator attributes such as warmth, empathy, and clinical expertise supported participants to feel understood, build trust, and engage meaningfully in the intervention. The skilled and purposeful implementation of therapeutic techniques within the therapeutic relationship are not to be underestimated (Steindl et al., 2023) This underscores the fundamental importance of the therapeutic relationship, particularly when supporting perinatal distress (Kleiman & Wenzel, 2017). It also points to the need for all professionals working with mothers and families across the perinatal pathway to demonstrate both clinical competence and relational attunement in order to deliver effective, compassionate care (Austin et al., 2017). These relational skills are promising for delivery of psychosocial interventions by mental health professionals who may not have extensive training in delivery of specific therapies, but can be supported by training and supervision (Waters et al., 2020)

Implications for Clinical Practice

Findings from this systematic review indicate that psychosocial interventions were positively experienced by both perinatal women with existing mental health difficulties and those at risk. Positive outcomes extended to the infant and wider family, particularly when these systems were actively involved. This underscores the importance of including the familial context within interventions, aligning with recommendations for stepped care and universal perinatal psychoeducation (NICE, 2021; Quatraro & Grussu, 2020). These findings have global clinical applicability, provided they are contextualised within existing evidence

on social determinants of health and their impact on target populations, for example, when community-based healthcare professionals deliver psychosocial interventions to address access barriers.

In addition to limited healthcare resources, persistent barriers to engagement exacerbated stress for an already vulnerable population. Addressing these challenges through family-appropriate community settings, culturally sensitive adaptations, and alternative formats such as exercise or creative arts may help reduce stigma and improve access.

Participants also highlighted the need for longer interventions and stronger support networks, pointing to a gap in continuity of care. The role of the facilitator was central to the intervention's success. Women valued providers who were skilled in therapeutic approaches and perinatal-specific knowledge, and who could offer safety, empathy, and continuity. In contrast, medically-driven, risk-focused care models were perceived as inadequate for meeting women's emotional and psychological needs. This suggests a need for specialist staff trained in both perinatal and infant mental health an area where clinical psychologists could provide leadership in both intervention design and workforce development (O'Brien et al., 2023b).

Finally, the thematic synthesis emphasises the centrality of the mother-infant dyad throughout the perinatal period. Interventions underpinned by this dyad can support both maternal and infant mental health at this critical stage. HCPs can be facilitated and encouraged to provide such interventions for perinatal women and their children who are at their most vulnerable during the perinatal period. The positive long term implications for early intervention service provision has been well documented (Felker et al., 2024).

Implications for Future Research

Further qualitative research is warranted to explore women's experiences of psychosocial interventions when known barriers such as access, continuity of care, and

culture are adequately addressed, as these factors were found to significantly influence engagement. While only one study explicitly focused on acceptance-based approaches, themes of acceptance and compassion were evident across the review. This highlights the value of further examining compassion-focused interventions and their potential role in reducing shame and stigma commonly experienced in perinatal mental health.

Strengths and Limitations

A key limitation of this review is the breadth of included studies, which, while necessary to reflect the diversity of psychosocial interventions, may have reduced the specificity of synthesis. The included studies did not consistently specify the severity of mental health presentation or stage of the perinatal period, limiting conclusions about application of the intervention across different needs. Future research may benefit from more targeted sampling by perinatal stage and clinical profile. Additionally, many studies lacked reflexivity of potential researcher bias, an important consideration in qualitative research, especially when working with psychosocially vulnerable or minority populations (Chakkalackal et al., 2021; Forsyth et al., 2017; Jallo et al., 2015; Le et al., 2021; Masood et al., 2015; Platt et al., 2023; Seshu et al., 2021). A notable strength, however, is the consistent representation of participants' voices across studies through direct quotes, enhancing transparency and aiding the interpretation of findings.

Conclusion

This review underscores the meaningful impact of psychosocial interventions across diverse perinatal stages and presentations. It identifies clear facilitators, barriers, and unmet needs that HCPs can address to better support women and their families. Many of these needs have been recognised in previous research, raising important questions about their continued

neglect in current provision of perinatal mental healthcare (Austin et al., 2017; Health Service Executive, 2017; 2023; NICE, 2021; Quatraro & Grussu, 2020).

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Chapter Three

Empirical Study

Title: The Experiences of Perinatal Women Seeking Mental Health Support from Health Care Professionals

Prepared in accordance with submission guidelines of Women's Health (see Appendix B)

Word count: 10,705 (excluding abstract, tables, figures and references)[3]

[3] Although all figures and tables are usually included as separate files for the journal, they are included in the text for ease of examination. APA referencing is used for the purpose of thesis submission.

The Experiences of Perinatal Women Seeking Mental Health Support from Health Care Professionals

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The Experiences of Perinatal Women Seeking Mental Health Support from Health Care Professionals

Abstract

Background: The perinatal period is a life transition with increased vulnerability to mental health difficulties. Seeking support for PMHD involves a complex interplay of individual and system-level factors.

There is an absence of qualitative research to understand women's experiences of seeking support for PMHD. This understanding is essential in healthcare systems, such as Ireland, where service provision is structured around women recognising their own mental health needs and actively seeking support from HCPs.

Aim: The aim of this study is to understand the experience of perinatal women who experienced changes in their mental health and sought support for these difficulties from HCPs.

Methods: A qualitative research design was used, conducting semi-structured interviews with 10 female participants. Findings were analysed using Interpretive Phenomenological Analysis (IPA). Public Patient involvement was implemented throughout the research.

Results: Three Group Experiential Themes and seven subthemes were identified: (1) Navigating matrescence and perinatal mental health (*Ghosts on the journey; The 'Do-It-All Mother'; Stigma and shame*), (2) A fragmented system (*Barriers, barriers everywhere!; Healthcare professionals*), and (3) Transforming perinatal mental health ("*She sat in the bed, and she just listened to me."; Seeking justice and change*).

Conclusion: Participants' data demonstrated mental health challenges faced in the perinatal period, facilitators and barriers they experienced in seeking and accessing

support, and their recommendations to improve care . Findings are considered within the context of existing research on perinatal mental health, with recommendations for clinical practice.

Keywords: perinatal mental health; healthcare professionals; Interpretative Phenomenological Analysis; support; healthcare

Introduction

The perinatal period refers to the time from when a woman becomes pregnant up to a year after giving birth (Garcia & Yim, 2017). The perinatal period is a time of both physical and psychological change for women, and while the physical aspects of pregnancy are prioritised by healthcare, mental health issues often go undetected and untreated (Howard & Khalifeh, 2020; Huschke et al., 2020; Webb et al., 2022). The prioritisation of perinatal mental health needs is of equal importance, given prevalence and impact, both on mother and child (Bauer et al., 2022; Felker et al., 2024; Pope et al., 2023; Wenzel, 2016). It is estimated that one in five women will experience a mental health condition during the perinatal period (WHO, 2022).

During the perinatal period women have multiple interactions with healthcare systems and HCPs. These interactions are of particular importance in healthcare systems, structured for women to access mental health support through HCPs at a community level prior to specialist intervention, such as the Health Service Executive (HSE), Ireland, and the National Health System (NHS), UK (Health Service Executive, 2017; NICE, 2020). These models of care identify the HCP as responsible for mental health screening and assessment, to identify mental health difficulties, and task the individual with responsibility to disclose and seek support. It is acknowledged, however, that women may, or may not, disclose their distress at this point of contact (Button et al., 2017). Given PMHD can arise from a variety of biopsychosocial factors, it can be reasoned that these factors may impact on the individual's ability to recognise and communicate their needs within healthcare settings. A meta-synthesis exploring the factors which influence women's decision to seek help for perinatal distress identified three main themes; identifying a problem, influence of the HCP, and stigma (Button et al., 2017). Additionally, the role of stigma and medical mistrust is significantly associated with decreased care seeking and treatment acceptance in black, African-

American, Hispanic women due to numerous risk factors and systemic issues in healthcare (Bodnar-Deren et al., 2017; Cannon & Nasrallah, 2019; Pederson et al., 2025). When the decision to seek help has been made, the individual and HCP find themselves situated within a complex interplay of factors both on an interpersonal and systemic level (Ayers et al., 2023). These factors such as time constraints, perceived stigma, cultural implications, women's inability to identify their symptoms, and the attitudes of family, friends, and HCPs can affect engagement with perinatal mental health services (Ayers et al., 2023; Daehn et al., 2022). Other internal barriers such as inability to disclose feelings and mental health knowledge exist (Dennis & Chung-Lee, 2006). In conditions such as postpartum psychosis, family and friends are critical in driving help seeking behaviours (Kobylski et al., 2024). This interplay of factors can become barriers and facilitators to accessing perinatal mental health care. When the individual overcomes internal barriers to seek support, it is necessary to understand their experience.

Existing research indicates that many women are not asked about their mental health or not asked in the right way (Huschke et al., 2020). Recent research with HCPs in Ireland has highlighted their role in providing emotional support and advocacy as part of relational interventions, however implementing these in the context of high care ratios remains a challenge for HCPs (Curtin et al., 2020; Pope et al., 2023). HCPs highlighted additional systemic barriers to care provision such as clinical culture and hierarchy (e.g. power dynamics and healthcare related psychological harm), organisational deprivation (e.g. low staffing and waitlists) and social barriers to support access (e.g. socioeconomic status and language) (Pope et al., 2023). These findings are reflective of prior research with GPs who reported challenges in identification, management and barriers to care provision (Noonan et al., ; Noonanet al., 2018b). This is also reflective of an extended body of literature that highlights the range of factors impacting help-seeking, from organisational and systemic

barriers, to the HCP's own personal experiences or attitudes towards mental health (Pope et al., 2023).

While HCPs are clearly documented as being responsible for perinatal mental healthcare pathways, they face numerous barriers to implementation (Higgins, 2017; Huschke et al., 2020; Noonan et al., 2018a) . In consideration of this, and the interpersonal relationship between HCP and individual, understanding how women experience this interaction in the perinatal period is fundamental. To date, there is limited research on this subject, with existing research focused on the immediate postpartum period, and/or using quantitative methods (Huschke et al., 2020; Nagle & Farrelly, 2018). The most recently available scoping review of perinatal mental health in Ireland highlights a predominantly quantitative literature base, focused on the medicalisation of perinatal mental health, resulting in an absence of women's lived experience (Huschke et al., 2020; Lever Taylor et al., 2021). This study explores the subjective experience of women seeking support for their perinatal mental health needs from healthcare professionals, and it addresses the call for qualitative, woman-centred research in a predominantly quantitative field.

Method

Design

A qualitative research design, using semi-structured interviews, was adopted to explore and understand the meaning participants assign to the experience of the research question (Tuffour, 2017). Public patient involvement (PPI) was a core facet of methodological design in this research. PPI was implemented in line with PPI contributor training companion manual designed by PPI Ignite Network (Dorris & Kroll, 2023). Four key areas were identified for collaboration with the PPI contributor (see Appendix F). Following collaboration with Senior Clinical Psychologist, SPMHS, Cork University Maternity Hospital, a PPI contributor was invited and consented to participate in the research.

PPI fosters collaboration between people with lived experience, researchers, and research institutions (Dorris & Kroll, 2023). PPI aimed to enrich the personal and epistemological reflexivity of the researcher by drawing reflection of the assumptions and knowledge the researcher brings to the study (Frost, 2016). The researcher as an instrument is reflected upon further below. Engaging with an expert-by-experience who has experienced PMHD aims to bridge the gap between direct participant experience and researchers' interpretation, and ultimately lead to a high quality, effective project (Hemming et al., 2021). For quality assurance within the analysis, researcher reflexivity and supervision were used throughout to highlight the hermeneutic process. Research has categorised PPI involvement across low-medium-high levels, with this research occupying a low-medium level of contribution. This consisted of; PPI views informing decision making, such as refinement of theme labels, and a collaborative approach to dissemination (Jennings et al., 2018).

Data Sample and Procedure

After institutional ethical approval was granted for the study (see Appendix G), a pilot interview was undertaken which resulted in refinement of questions and pacing of interview technique. Next, a purposive, homogeneous sample of participants was recruited using specific inclusion and exclusion criteria (Smith, 2017). Participants met the inclusion criteria if they had given birth to a live baby within the last 12 to 24 months, and if they had a mild-moderate mental health difficulties or diagnoses. An official diagnosis was not specified as an inclusion criterion as this may have excluded women without access to, or who chose not to seek, a psychiatric diagnosis. Participants experienced changes in their mental health in the perinatal period and tried to seek support for this from a HCP. A sufficient level of English was required to participate in interview. Exclusion criteria consisted of women with a severe mental health diagnosis who were currently under the care of a SPMHS, as their pathways to accessing mental health care were likely to have been different, with more proactive signposting by HCPs.

Potential participants were recruited via study public and online advertisements (see Appendix H). Targeted, inclusive recruitment was conducted via General Practitioners (GPs) and community organisations supporting parents, diverse and marginalised populations (e.g. infant mental health organisations, organisations supporting women with addiction, family resource centres). Interested participants were furnished with an information sheet (see Appendix I) and consent form for completion (see Appendix J). Contact details of the researcher were provided with opportunity for questions, clarifications and further information with interested participants prior to consenting. A semi-structured interview guide was developed (see Appendix K) .This was based on three anchor points (Mental health during the perinatal period, Support during pregnancy, and Conversations regarding mental health) aimed at exploring the participant's experience of perinatal mental health and seeking HCP support. This semi-structured style allowed for flexibility in exploring

participant ideas and experiences throughout the interview. Interviews were conducted in person and online, and included a demographic questionnaire (see Appendix L). Each interview lasted approximately one hour, and all were audio recorded and transcribed. Reflective journal entries were kept by the lead researcher throughout the interviews (see Appendix M).

Data Analysis

Interpretive phenomenological analysis (IPA) was undertaken. Analysis was guided by (Smith et al., 2022). This inductive analytic approach seeks to understand how individuals make sense of their experiences, and is informed by the theoretical underpinnings of phenomenology, hermeneutics, and idiography (Smith, 2017). Following audio transcription, seven key steps outlined by Smith et al. (2022) were followed case-by-case using on screen and paper methods to support a trail of analysis. Case by case reflections were noted on transcripts throughout the analysis to highlight the researcher's own subjective experiences and hermeneutic approach, thus supporting reflexivity (see Appendix N; Tuffour, 2017). Following the analysis of the first case, feedback was sought from the PPI contributor on the analysis, and this was documented within a reflective column. This process supported reflection on language and contributed to the hermeneutic circle of the lead researcher, by encouraging deeper reflection on the language used to name themes.

Personal Experiential Themes (PETs) were identified by creating larger analytical entities from statements, and further organised into subthemes using a creative and high-level approach of analysis (see Appendix O). This was achieved by using a narrative organisation of themes based on the unfolding nature of perinatal mental health difficulties and sequence of events in seeking support from HCPs. Within these PETs and subthemes, similarities and polarisation were also used to highlight related and conflictual experiences. This approach was used to capture the complex, conflictual experiences within the data and phenomenon (J.

A. Smith et al., 2022). Group Experiential Themes (GETs) were created by highlighting the shared and unique features of the experience across the participants (see Appendix P). Given the large sample, GETs were reflective of the majority of participants, presenting mainly shared elements, with quotations reflecting the context and divergence of participants.

Researcher as an Instrument

As a 34-year-old female psychologist in clinical training, I recognize that my professional identity and personal experiences inevitably shape my research perspective. At the time of data analysis, I commenced a clinical placement with a SPMHS. This change in professional role influenced my interpretations, particularly when analysing themes related to HCPs working within similar services. Consistent with hermeneutic and interpretative philosophies, I acknowledge that complete bracketing of personal perspectives is unattainable; instead, I embraced reflexivity as a means to critically engage with my subjectivity (Smith, 2017; Smith et al., 2022; Tuffour, 2017). As aforementioned, I maintained a reflective log during data analysis and a comprehensive journal throughout the research process to support my navigation of the interplay between my clinical knowledge and research interpretations (see Appendix K). Where I felt my views, personal or professional experiences required additional reflection, I used research supervision. This reflexive practice was particularly pertinent during the PPI process, where balancing clinical and research roles necessitated careful consideration as a psychologist in clinical training. For example, during analysis of themes around HCPs, I noticed my own clinical knowledge and assumptions shaping my interpretations. Through bracketing and reflective journal, I re-examined the data allowing the participant experience to take precedence. This approach aligns with the hermeneutic circle's emphasis on iterative interpretation and the co-construction of meaning when working with multiple perspectives, such as this somewhat novel process of involving PPI within IPA (Montague et al., 2020). The research team, which

includes the PPI contributor and two supervisors, engaged in sense-checking of themes (McParland et al., 2011). I presented the development of conceptual themes, facilitating discussions that challenged and refined our interpretations. Revisiting full transcripts ensured that our analyses remained grounded in participants' narratives. This collaborative reflexivity fostered a 'multiple hermeneutic' approach, enriching the depth and authenticity of our findings (Montague et al., 2020). A transparent audit trail, comprising of my own reflective notes and those of the PPI contributor, was maintained throughout the process.

Participant Characteristics

Seventeen individuals expressed interest in participating. To minimise selection bias, participants were recruited on a first-come, first-served basis. Once the target sample size was reached, remaining individuals were thanked and signposted to appropriate mental health support services. Participants consisted of ten females who had given birth to a live baby in Ireland and were between 12-24 months post birth. Participants were Irish and Spanish, with a high level of educational attainment. Each participant was given a pseudonym to protect their anonymity and enhance narrative flow. A summary of participant characteristics is shown in Table 4.

Table 4

Summary of participant characteristics

Pseudonym	Age	Nationality	Education	Working Outside Home	Relationship Status	Previously Pregnant	Other Children
Aoife	31	Irish	Third level degree	Working full time	Partnership	Yes	No
Bríd	33	Irish	Master's qualification	Working full time	Married	Yes	Yes
Eve	41	Spanish	Third level degree	Working full time	Yes	Yes	Yes
Deirdre	36	Irish	Third level degree	Working full time	Married	Yes	Yes
Helen	34	Irish	Master's qualification	Working full time	Married	No	No
Frances	36	Irish	Third level degree	Working full time	Married	No	No
Kate	42	Irish	Master's qualification	Working full time	Married	Yes	Yes
Ciara	37	Irish	Master's qualification	Working full time	Married	Yes	Yes
Jane	43	Irish	Third level degree	Full-time caregiver and student	Married	Yes	Yes
Lucy	38	Irish	Third level degree	Working full time	Married	Yes	Yes

Results

This study explored the experience of perinatal women seeking mental health support from Health Care Professionals. Through IPA, three GETs with seven subthemes were developed (see Table 5).

Table 5

Group Experiential Themes

Group Experiential Themes	Description
GET 1: Navigating matrescence and perinatal mental health Subtheme 1: Ghosts on the journey Subtheme 2: The'Do-It-All Mother' Subtheme 3: Stigma & Shame	This theme depicts the emotional distress in becoming perinatal, while also experiencing societal pressures in motherhood and identity struggles. Within the theme there is nuance in personal perinatal journeys and coping strategies.
GET 2: A fragmented system Subtheme 1: Barriers, barriers everywhere! Subtheme 2: HCPs	This theme depicts the experience of navigating a healthcare system, consisting of both systemic and interpersonal barriers which limit access to care. How these systems interact with the individual, their own internal barriers and resources to support seeking are demonstrated.
GET 3: Transforming Perinatal Mental Health Subtheme 1: "she sat in the bed, and she just listened to me." Subtheme 2: Seeking justice and change	This theme relates to the need for comprehensive care, that supports a relational and holistic mode of perinatal mental health. Participants' desire for change was apparent in their experiences.

GET 1: Navigating Matrescence and Perinatal Mental Health

Across the participants, the perinatal period was a complex time, navigating a variety of emotional, biological, and psychological changes. Previous experiences and mental health difficulties were evoked, and participants experienced demanding societal expectations causing distress.

Ghosts on the Journey

Kate speaks about the physical impact of pregnancy leading to a medical condition: *"total strain like my, ankles were really swollen and my legs were swollen and I ended up having preeclampsia*". Participants, such as Jane, portrayed the emotional impact of managing her own physical health and the health of her unborn baby. Jane describes, in the following quotation, how fear that she will not manage this will lead to harm and blame:

> *this constant fear and worry that I am going to do something to... Something's going to happen to this baby. He's going to actually be? born now because I can't. My blood pressure won't come down, and it's all.... it's my fault.*

Bríd spoke of the emotional landscape of pregnancy, marked by ambivalent feelings, and her sense of PMHD differing from previous mental health difficulties. Bríd's use of "*really anxious and really upset",* conveys a sense of polarised feelings: *"even though I'm really anxious and really upset, I still like, couldn't wait for this baby to be born….But there was something going on that hadn't been going on prior, and I couldn't identify what that was".*

The transition to the perinatal period was a key feature in participants' experience, and how this began to set the scene for their mental health difficulties. Participants spoke of how they became pregnant, and for many this occurred in the context of previous miscarriages, or navigating fertility treatment, that left them entering the pregnancy emotionally and physically depleted. Aoife describes miscarriage as the *"crux"* of her perinatal mental health difficulties: *"OK... well, you'll find out it, was kind of the crux of the issue when it came to this…most recent, but like the successful pregnancy*". Aoife uses powerful language to describe how this crux "*haunted"* her. She describes the physical changes of pregnancy, but feeling disconnected from herself, experiencing doubt and anxiety. Body checking became her way of coping. For example, she noted that:

> *I found it very hard to get in touch with, you know, the fact that I actually was pregnant. There were very physical changes going on. I spent every day body*

> *checking like I could have spent hours in front of the mirror being like, is there a bump? Is there not a bump?*

For Deirdre, pregnancy triggered past mental health issues linked to her relationship with her mother, and she now experiences this differently as a mother. Deirdre's language of *"reared its ugly head*" gives the sense that these experiences had been under the surface:

> *I think it was like the two main factors for me was one, like all my mom's stuff kind of just reared its ugly head, you know, and that, sorry, thinking back, that did actually crop up around the 18-to-22-week mark when I was pregnant.*

These contextual factors in pregnancy led to conflicting emotional experiences. The pregnancy was desired and planned but brought negative emotions such as anxiety and depression. This caused confusion and emotional overwhelm for participants.

To cope with this, overwhelm, participants described various responses such as avoidance, disconnect, anxiety, and efforts to gain control. Ciara describes how fear and anxiety led her to be *"clinical"* about pregnancy, which may have reflected a disconnect from her pregnancy, self, and her emotional experience: *"...But I said you might just be wasting your time because you're like the baby could be dead already".* This disconnect led to avoidance in seeking and accepting mental health support: *"I was sitting there thinking, oh. For God's sake. She's making this big deal".*

Participants shared a conflict between wanting the pregnancy and experiencing negative emotions like anxiety, depression, self-criticism, and self-doubt. Helen spoke about how this inner conflict left her feeling out of control:

> *And I was just in this place of, like, really, I don't know, a bit kind of confused myself because I really wanted it. I had been pushing for it and yet what had happened? I just didn't even like, started to kind of feel really out of control for myself .*

This feeling of "*out of control"* led to "*all consuming"* anxiety and a desire to gain control throughout the pregnancy, which negatively impacted her mental and physical health. Helen further expanded by saying: "*I'm so dead set on like doing it my way, to my detriment, because I put myself through a lot of pain and probably, unnecessary, you know, stress*". Eve shared this experience of conflicting feelings, although her experience focused on the impact on her baby. Eve gives a sense of coping with her sadness while also trying to protect her baby from this difficult emotional experience:

> *But at the same time, you feel guilty because I was feeling, Oh my God, and maybe the baby inside is feeling all my sadness, you know? And I was worried that that was gonna impact the baby, you know'.*

As the participants recounted their experiences, they described the evolution of their mental health difficulties in varied ways. Some situated these changes within the context of physical and hormonal shifts, others framed them around specific antenatal or postnatal stages. While for others, mental health difficulties were intertwined with medical appointments and interventions. This diversity in experiences highlighted the dynamic and evolving nature of mental health needs throughout pregnancy.

Participants described the emotional overwhelm they experienced while pregnant or postnatal with a new infant, as they coped with their mental health difficulties. While the coping styles differed across participants, the emotional distress was a common experience. Aoife described this in the context of returning home from work*: "but then you were coming home exhausted, So like already you have those mental barriers quite low, then lying in bed at night trying to fall asleep. That's when you know I was getting those intrusive thoughts".* Deirdre describes the factors that influenced her experience: *"I suppose to maybe need to discuss the mum stuff and just the transition in general, just becoming a mum and the*

overwhelming feelings that I had about my own mom and anger and empathy". Deirdre then describes the impact of this emotional overwhelm:

> *Like just my head was just constantly like, it was like someone was constantly just playing tennis in there… and I just needed to just someone to just go yeah…And just like help me talk through it all…Like, yeah, just point in my head, just get my head to shut up.*

The rich metaphor Deirdre uses reflects a mental volley in her head, that feels controlled by someone else. She desperately wants support to make sense of her experiences and stop the tennis match in her head. As described by Lucy, in addition to managing the overwhelm and being consumed by PMHD: *"I took that time for granted, I suppose, but I'm so consumed with how I was feeling that I couldn't see anything else"*, these difficulties were often spoken about by the participants in the context of their identity as a mother, which leads to subtheme 2.

The 'Do-It-All Mother'

Most participants held multiple roles as mothers, partners, professionals, and friends within their support networks. The demands of these roles varied across the perinatal period, with certain aspects being more prominent at different stages. These demands were closely linked to participants' mental health difficulties. For example, Aoife navigated her professional self while often concealing her pregnancy due to anxiety about miscarriage: *"So you're kind of taking on board there trying to regulate their emotions while also trying to regulate my own. And making sure that no one thought that something was amiss…"*

Managing multiple identities and roles was highlighted in the context of seeking mental health support. For Bríd being a healthcare professional seeking support from colleagues for PMHD, was difficult to navigate: *"And initially I'd had the experience, like I said of saying, I don't really want to talk to her because I know her, umm, professionally, not*

personally". In the postnatal period when baby had arrived, there was a stronger sense of the identity shift within the infant relationship for Deirdre: *"So kind of one about your yourself as a mum and a person in that time".*

Societal expectations of the perinatal period and motherhood compounded these difficulties, and Kate describes by reflecting on her own mother: *"So yeah, like you just, you just learn to get on with it. Really. Like when I think about my mom, like, she had seven of us and she pretty much did everything as well".* While participants acknowledged and understood the societal origin of these expectations, they still carried emotional weight, evoked frustration and challenges for some participants in navigating these, particularly while they tried to manage their mental health. Eve articulates the disconnect between her internal feelings, of low motivation, energy and external expectations to be happy. Eve gives a sense of being deemed a failure as a mother by society, before she has had the chance to occupy this role. Eve's account gives a sense of hopelessness:

> *And I don't have the motivation and the energy to be happy, you know? So you really feel like a failure. You feel like a. Yeah. Like you're not being a good mother even, you know, before your son has been born.*

For other participants, these expectations of them as a mother were intertwined with their role as a mother to existing children and managing the birth of a new baby. Lucy spoke about the positive perception of a short labour and quick return home from hospital: *"It was like 7:00 in the evening and I was home by like 12 the next day".* Lucy emphasises her uncomplicated labour and birth, which may have met medical and societal expectations. However, Lucy's decision was influenced by feelings of guilt, separation from her other child, and desire to prioritise them, neglecting her physical and psychological needs. Upon reflection this marked the deterioration of her mental health:

> *And the next day, I just was so focused on, I think I felt bad for him (baby) and, you know, it was like I need to get back to him and this and that. And I didn't. And I really should have stayed because I needed the rest…Because I think it all kind of went like mentally went downhill then.*

Stigma & Shame

Participants experienced stigma and shame through two main processes: experiencing PMHD and seeking support from HCPs. The pressure to hide their mental health challenges during a time of significant expectations, as depicted in *the do-it-all mother*, caused significant shame.

Eve describes this in the context of wanting to return home from a holiday: *"to my safe place to my house where I didn't have to be pretending to be well".* For Deirdre, this shame transpired within the expectation to bond with her baby and experiencing shame when her experiencing of bonding with her infant was not as society had depicted:

> *And I was like, not that I didn't love the baby, but it just felt like a duty. And I was like, and then we'd so many visitors and they were like, are you just obsessed?...feeling shame and fear that I was a monster…I just felt such a shame. Like didn't tell anyone, didn't vocalize it for weeks.*

Deirdre's use of the word *"monster"* depicts the intensity and monstrosity of the judgement she felt. This description also conveys a sense of disapproval for experiencing feelings that did not align with societal expectations. This shame impacted on her ability to confide in a trusted HCP, highlighting how pervasive it was. Deirdre's account conveys her ability to confide in a HCP for some of her needs, but not those that were most shameful: *"So, yeah, like, I'm like, literally the only thing that I held in was about the bond thing*". It is noteworthy that Deirdre's shame and fears about disconnection prevent her from potential connection with the HCP. This concealment of mental health difficulties due to shame was echoed by

Ciara within the context of her marital relationship: *"And I had very, very anxious behaviours that I were kind of covering up. I was hiding from my husband*". Both accounts indicated that even in the context of supportive relationships, shame impacted on disclosure. Eve used the anonymity of the internet to search for perinatal women with similar experiences, following the drought of information and representation of this experience: *"I was really, really thirsty to see other people experiences. You know, I wanted to know that I wasn't the only one feeling that way".*

Jane described this shame of having mental health difficulties in the context of IVF treatment, and the expectation to feel grateful: *"Nearly like. Well, you should. Really. You know, you're very lucky now that it worked"*. For Jane she felt there was *"no room"* to express these feelings and the constant messaging she was receiving regarding her physical health risk factors: *"You know, this is always hammered into you. You know you're very lucky now that it worked",* giving a sense of blame should she express contradictory feelings".

Stigma and shame were also experienced by participants when seeking support for PMHD. Participants who were also HCPs themselves experienced an additional layer of stigma in experiencing mental health difficulties. Bríd spoke about her conflict of needing support, only available from a known colleague*: "For me it was kind of a conflict of interest, but I think maybe I was a little bit I don't know...Is it like ashamed?".* Aoife uses the word ironic which suggests her experience of mental health difficulties as a mental health nurse was unexpected: *"Actually I kept thinking how ironic it was, that I was like a mental health nurse and I was struggling so much to like".*

For other participants this shame and stigma impacted on their ability to seek support. Ciara described this in the context of putting on a *"poker face"* after being refused support: *"What was it for? I suppose like self-protection, shame*". Aoife describes how she did not

disclose her needs to impress that she was coping :*"Lied just to make it feel like you know… like here. I have things under control".* This stigma also transpired for Frances who sought medication for anxiety in pregnancy and felt judgement from a HCP: *"and I was probably in a heightened state of anxiety purely because she had put me down so much"*. Stigma evolved to include decisions made as a new parent to support their mental health, such as Helen who tried to improve her sleep through professional support for her baby: *"I couldn't even admit that I was getting sleep trainers"* .

GET 2: A fragmented System

Participants shared their experience of fragmented healthcare, marked by systemic and interpersonal barriers. Narrating their physical and psychological perinatal mental health difficulties, they highlighted the fragmented systems faced when seeking support at different time points. The confusing nature of the system left them uncertain about available support and where to express their mental health needs.

Barriers, Barriers Everywhere!

When participants wanted to seek support, they faced barriers in seeking the support and receiving the support. Aoife spoke about environmental barriers negatively impacting her disclosure: *"I don't know whether sitting in those scan rooms, whether it was the place that I would have been honest".* Ciara spoke about service provision barriers when she decided to seek care: "*Looked up the public health nurse like they only accept voicemails for one hour in the morning and I was like, what?".*

It is noteworthy that participants differed in when they sought support, reflecting variation in how they made sense of their needs over time. Some participants such as Ciara reached a point of overwhelm following repeated encouragement to access support from HCPs and her husband: *"I paused and I remember it felt like I paused for ages and I just*

said, yeah, yeah, it's really urgent". Other participants, such as Frances, sought support at their first antenatal or GP visit: "*when I initially got pregnant in my visit to the doctor first, she put me right like 5 milligrams or something".*

While some of the barriers were intrapersonal e.g. stigma and shame, some participants also experienced barriers with HCPs and healthcare systems. Notably, in the following quotation, Helen whose sensory needs ran throughout her narrative, highlights attunement to barriers within the physical environment:

> *You're kinda on a rotation belt since in and out and it's you know like you're sitting in your waiting room for ages, you know like it's tough...type of environment to be in when you're vulnerable… definitely not a safe enough space to feel like you could get into anything you know, like you're in a tiny room and you're flying through questions.*

The relationship between participants' mental health difficulties and how these were exacerbated by navigating fragmented systems of care were apparent.

Participants such as Jane observed the overwhelm and understaffed systems, at a time of vulnerability: "*So it was a completely new set of doctors, couldn't even find their way around the hospital, let alone anything else...this baby has to come out… we have no room for you"*. The sense of panic is pertinent to Jane who subsequently attributed this systemic barrier as responsible for her traumatic birth. For Bríd, she described how her multiple attempts to engage with a HCP who initially assessed her mental health were left without any response, and how she originally personalised this before seeing it as a systemic failure:

> *she explained that like, unfortunately…that I wasn't the only person would be left like that… and while that sounds awful, that for me was really reassuring because it's not just me or she didn't just not care about me.*

Jane described how these systemic barriers limited her access to SPMHS, as she also attended a private counsellor and therefore could not access the SPMHS. The complexity of Jane's

perinatal mental health needs was subsequently impacted by a traumatic birth, by which stage she had no access to specialist support: *"And so they didn't want to overlap with that, ... unfortunately, when it came to having him, things just didn't work out and I had a really traumatic experience".*

HCPs often communicated these systemic barriers to participants, which left participants managing feelings of hopelessness, and suppressing their mental health needs, as described by Lucy: *"He was just being real, and you know, I wasn't going to waste my time because as I said, I still haven't heard back from the other one".* Interestingly, this coping mechanism of adjusting and suppressing her needs due to systemic barriers featured throughout Lucy's narrative: *"I kind of didn't really feel like, I mean, like, I was going to get anywhere…I was there for one thing only, and that was the tablet".*

Six of the participants used financial means to overcome the barriers of the public healthcare system, demonstrating the role of financial support in accessing support. Frances highlighted the role of private insurance in easing her access to support: *"because I have insurance, it was quite easy for me to get synced up with somebody and pay".* However, it is important to highlight that this financial access often came following significant distress from systemic barriers.

HCPs

While participants highlighted the systemic barriers to support, a core part of their experiences related to HCPs. Many support-seeking interactions with HCPs left participants experiencing trust and mistrust, and interactions occurred on a continuum from validation to dismissal. As the point of contact for participants seeking support, the HCPs were viewed as gatekeeper. Ciara later questioned this gatekeeping of resources: *"If you're here, that you're entitled to perinatal support…so like they're not in charge of the allocation of funds or whatever".*

This gatekeeping highlighted the power dynamic that existed for participants as they needed support, and access depended on their interaction with the HCP. When the HCP supported the participant, this brought a sense of relief, and when they did not, this negatively impacted their mental health and access to support. Eve describes the relief she experienced when the HCP acknowledged her needs*: "And I remember feeling so nervous, and the moment that she was so supportive, it was like a huge relief, really, for me. A huge relief, like, Oh my God". This* experience was different for Ciara who describes her unmet needs from a HCP who she empathises with:

> *I know this poor midwife is probably like a burnt-out compassion fatigue the least. But after I had asked her help and said that I was struggling, she handed me a piece of paper with an e-mail on it and said, you know, if you e-mail this midwife.*

It is poignant for Ciara that she later states: *"I have impostor syndrome about my postnatal depression because I don't feel like I'm a good enough depressed person"* on the backdrop of being told this by HCPs :"*she said, you know, said you don't seem depressed".*

Interestingly, when HCPs verbalised lack of resources to participants, they often gave responsibility to the participant to address this, through financial means, complaints or supressing their own care needs which became an additional burden. Participants such as Jane were encouraged to make a complaint on behalf of HCPs: *"In their own words, they told me that they are. Nobody listens to them, and they're all stretched".* For other participants such as Aoife she views her needs as less important when she is told she needs support which is unavailable: *"I think that you could benefit from some therapy, but they just didn't have anyone available. And I can understand, like, there were a lot sicker people".*

When participants experienced validating and trusting interactions with HCPs, they articulated these encounters with clarity and emotion, expressing a strong desire for continuity in such care. For Deirdre, it was the HCP's genuine curiosity and willingness to

remain present with her distress that fostered a sense of trust: *"And then I just start to cry like, you know, but like, I really felt like it wasn't just a box tick exercise".* This experience was not only about having her own needs acknowledged, but also those of her newborn: *"She picked up on us."* When Jane received attuned care, she describes her desire for continuity: *"She just really was so tuned into me that day…every time I used to go into the clinic, I still hope she'd be there, too".*

Given the nature of the perinatal period, participants engaged with multiple HCPs and strikingly, each recalled specific individuals and interactions with clarity. For Frances, these were differentiated by experiences of trust and mistrust: *"It's like the initial doctor...I just didn't trust her opinion. But with him, I felt like this is somebody I could trust".* Trust appeared to be shaped by a constellation of interpersonal factors, such as the HCP's gender, perceived expertise, and age. It is interesting that participants did not attribute trust to a single factor but rather described these factors within the context of multiple factors, which may indicate an amalgamation of factors. For Helen these factors culminated to an absence of trust sense with the HCP:

> *She was like, very young. She was a student. Like doesn't feel like there's a time to get into it like everything's been like you're flicking through boxes…would they have been trained to even know how to respond to it.. I know my mental health is as important as every other part of me, it definitely doesn't feel that way, though it doesn't feel like it gets the same weight as all the other questions about your health.*

Similarly, this combination of factors was reflected by Lucy. The gender and "*very wooden"* manner of a HCP who communicated "*no kind of empathy"* in understanding her perinatal experience, created mistrust in disclosing suicidal thoughts she was experiencing: "*Yeah, but I wasn't going to tell him that".* This experience of mistrust is notable for Lucy who experienced a lack of consistency in HCPs throughout her perinatal period. Lucy experienced

surprise and disappointment within close succession of seeking support: *"I was so surprised at the conversation that I had…unfortunately, when I tried to go back again, he was gone".*

Finally, for Ciara, her experience of seeking support from a HCP became an experience clouded by dismissal and mistrust. Ciara details in a powerful section of her narrative how she reached a *"turning point*" in seeking support, before being refused this:

> *So I like, I heard the whole conversation, I heard the doctor saying. Could you just ring the team and say it to them? And I heard them talking about me, and then a midwife came into the room…she didn't introduce herself or anything, or she just looked at me and said is it because the birth trauma?...She walked away and then like just to tell you where my headspace was, then I stood up to, gathered myself... The shutters came down poker face on.*

Throughout her experience, Ciara found it difficult to accept she needed support, and it is particularly moving to see her return to this way of coping after taking the leap to seek support.

GET 3: Transforming Perinatal Mental Health

Within their individual experiences, participants powerfully and clearly articulated the perinatal mental health support they wanted. While it differed in the detail, the shared experience across participants was seeking holistic, relational care, which supported them in understanding and addressing their perinatal mental health needs.

"She Sat in the Bed, and She Just Listened to Me."

The care from HCPs that participants valued was repeatedly based on supporting their mental health needs on an emotional level, with the majority of these interactions taking place in the postnatal period. Jane describes the intimacy of the care she received by highlighting the midwife who cared for her while she was hospitalized: *"It was just nice to be able to talk and*

she really listened to me. She really listened to me. Yeah. You know, she sat in the bed, and she just listened to me". Helen describes how disorientated she felt, and her language emphasises her lack of connection to herself and context. Again, a similar description of the midwife at her bedside indicates the intimacy of this care when she was in a vulnerable state. Helen's repetition and questioning at the end conveys a sense of disbelief and worry:

> *I don't have any clue who I am. I've no idea what's just happened to me, you know? There was one brilliant midwife who initially got into the bed beside me and helped me and was like it's going to be OK, but I just thought how how it's going to be OK?*

Aoife speaks about the understanding she gained from attending a HCP for therapy and understanding the impact of perinatal mental health on the beliefs she held about herself and a more compassionate understanding of why her mental health difficulties evolved: *"You know you're not actually crazy….like your brain is in a roundabout way trying to protect you even though it makes you feel like you're doing worse. But no, that was super powerful*". The understanding Lucy gained regarding her mental health from a HCP appears to have supported a similar compassionate understanding of her feelings, however Lucy made sense of this differently, in relation to her own experience. This understanding seems to support a shift in her perception of her feelings towards her son towards a deeper understanding of these being part of matrescence, rather than viewing herself as a failure:

> *This makes more sense. It's not me crumbling…you know I don't regret my son, or, you know, she kind of just explained that this is why you feel the way you do. Like, this is a part of the other part of it is obviously being a new mom and stuff.*

While all participants included their partners and infants in their narratives of perinatal mental health, articulating the relational impacts of their difficulties, Kate's experience diverged in her emphasis on seeking support for her partner's needs, and feeling dismissed by the HCP. Kate articulates her experience of coping in contrast to her partner's suffering: "*... I*

was like, OK… but I think that my partner is not, you know, like suffering with some sort of postnatal depression". Kate shows the emotional impact this had on her and her baby, where she describes her desire to protect her child from feeling like a burden, with a sense of protecting their relationship. In doing this Kate describes taking on all the caring responsibilities: "*just because I didn't want to, I didn't want the child to feel like a burden on him. Yeah. Yeah. So I felt that if I did everything and just left him alone, then".*

When participants experienced positive, empathetic, and non-judgmental care, it often met their immediate needs but lacked the specialist or mental health expertise they required. Lucy speaks of the receiving support without follow up: *"I did have the public health nurse coming out and in fairness to her, she was so good… she did refer me to psychiatrists, which I still haven't heard of to this day".* Lucy use of the present tense emphasises she is still waiting beyond the perinatal period.

Seeking Justice and Change

Participants reflected on their individual needs such as anxiety, sensory sensitivities, with a common thread of wanting to change in the care they received to understand and be supported within this complex time.

Anger and advocacy were core features of women's experience. Helen vividly described the anger she felt due to her own inner turmoil and how this contrasted to her husband's experience: *"it's like you are just existing here beside me and I am..my world is completely split in half".* Some participants used anger as a tool to advocate for justice and change, for themselves and other women. Deirdre spoke about how understanding of her experience would have saved her directing anger inward: *"have saved me like 2 months of absolute, like beating myself up with a hammer…I was like, why the fuck didn't anyone tell me that?".* Bríd reflects on her own ability to seek support, which other women may not possess: "*But like I was so mad after everything because I can speak for myself, and I can go*

to the GP and say I'm really struggling…But like what about the cohort of women who can't do that?".

Notably, for some participants, anger evolved from internal to outward. Aoife describes this internal struggle, feeling this anger towards herself and her partner: *"I was so angry all the time, angry at myself mostly, angry at my partner".* In contrast, Jane's experience of anger became externalised, when she recovered from the initial shock of a traumatic birth. Jane described anger about her experience and towards the system who had left her unsupported:

> *I think I'm still in the state of shock for a long time, so I didn't, but I'm really angry about it…That there was nothing there for you in that side of the pregnancy. Just that there's really such a culture out there of. Here's your baby. Off you go. It makes me angry because. I just think of all the women who are really struggling.*

Finally for some participants the loss of their own perinatal journey still lingers and for many participants advocating for their needs extended beyond the perinatal period, suggesting that their unmet needs within the perinatal period had a longer-term impact. For Lucy, this advocacy extended to her child's needs. There is a sense of loss and sadness for her own perinatal experience, but also what she feels her child has lost due to her own difficulties: "*I accept the things were the way they were, but I suppose it I still do feel quite sad. I feel bad for him that you know, he was none the wiser. But I wasn't in the right headspace for him at the time".*

There is a profound sense of sadness in this description from Lucy, as she conveys accepting her own experience, while holding her baby in mind. Lucy articulates how intertwined her and her baby's needs are during this time.

Discussion

This phenomenological study offers a rich contribution to the study of women's experience of seeking mental health support from HCPs during the perinatal period. Although the study is situated within an Irish context, its grounding in a biopsychosocial framework supports the relevance of its findings to similar healthcare systems and to diverse international settings, given the universal challenges and transitions inherent in the perinatal period. Several of these participants reflected on their adjustment to the perinatal period, an increasingly stressful and adverse time, impacted by the onset and increase in perinatal mental health needs. This increase in PMHD reflects quantitative research which has previously shown an increase in mental health needs, with an estimated 20% of women globally affected by perinatal mental health disorders each year (Ussher et al., 2019).

The increased vulnerability and distress of biopsychosocial changes highlighted by participants is reflective of existing research on PMHD (Miller, 2016; Rallis et al., 2014; Silletti, 2023). Biopsychosocial factors participants perceived to contribute to their PMHD, highlighted the complexity and individuality of these and the journey to becoming pregnant (Quatraro & Grussu, 2020). A key strength of this study is its broad conceptualisation of the perinatal period, which enabled participants to focus on the specific temporal phases most significant to their personal experiences. This inclusive framing facilitated rich and idiographic accounts from participants which spanned from conception to postnatal, highlighting nuanced experiences of how participants made sense of their mental health difficulties and sought support from HCPs. This broad conceptualisation also supports previous recommendations to investigate early-onset perinatal mental health disorders, such as antenatal depression, which remains under-researched despite evidence that approximately 40% of postnatal depression episodes begin in the antenatal period (Bright et al., 2022).

These experiences of PMHD, manifested in internal conflict and ambivalent feelings for participants in the study. These findings point to previous research on understanding women's reproductive journey as a life juncture with complex and contradictory feelings of love, attachment, devotion, guilt, shame, anger and uncertainty (Bright et al., 2022). It is suggested that this conflict may stem from the disconnect between societal norms of perinatal experiences and the lived reality women find themselves occupying (Michaels & Kokanović, 2018). To make sense of these complex feelings, perinatal women may cope and seek support differently, for example, women who report perfectionist characteristics may also strive to meet ideals of the 'good mother', which may reveal why some participants sought support or tried to cope by asserting control over their experiences (Pedersen, 2012; Schmied et al., 2018). Experiences of control (internal and external) can contribute to psychological outcomes (Green & Baston, 2003). Findings in this study highlighted examples of this, such as control strategies during labour at a cost to physical and sensory needs, and overuse of ultrasounds to manage anxiety. This reflect previous quantitative research which has demonstrated higher levels of neuroticism are associated with increased use of publicly funded antenatal care among obstetric low-risk women, even after controlling for key factors influencing healthcare utilisation, including psychiatric morbidity. Other quantitative research has demonstrated an association between overuse of visits and ultrasounds, with factors such as primiparity, average to high income, less than good psychological well-being, and care by an obstetrician (Axfors et al., 2019; Merrer et al., 2021). The impact of sensory needs in childbirth, and the perinatal period has also been previously researched in both quantitative and qualitative research, demonstrating higher sensory sensitivity in Autistic women during the perinatal period, and higher autistic traits associated with higher depression symptomology (Demartini et al., 2024; Lewis et al., 2021). Taken together, these findings point to the complex interplay between psychological, sensory, and systemic factors

in shaping patterns of antenatal care use, highlighting the importance of nuanced, person-centred approaches that account for both emotional regulation and neurodiversity in perinatal support.

The experience of miscarriage underpinned the emotional and psychological vulnerabilities that participants brought to their pregnancy. This findings aligns with existing literature, which highlighting an increased risk of long-term mental health difficulties following miscarriage compared to non-complicated pregnancies and birth (Bodunde et al., 2025). Similarly, with In Vitro Fertilization (IVF), research has explored predictors of psychological distress in IVF patients with factors such as infertility specific, psychological characteristics and attachment pattern identified as moderating factors which can leave women (and couples) feeling distressed and powerless (Iordăchescu et al., 2022; Van Den Broeck et al., 2010).

The language used by participants to describe their experiences was particularly emotive (e.g., '*haunted', 'crux', 'battered*'), and interestingly links to seminal research on women 'haunted' by a desire for a baby, with the inability to reproduce having a profound emotional impact (Raphael-Leff, 1993). This is pertinent given the rise in artificial reproductive technology (ART) such as IVF within Ireland, although not comparable with other countries (Adamson et al., 2025; Naasan et al., 2012). While ART has brought positive medical advances, it potentially has effects on the recipient, both medical and psychological, as evidenced by participants experiences within this study. The treatment which often exists in the context of miscarriage, or reproductive difficulties, warrants a safe, therapeutic space to process these complex psychological experiences (Quatraro & Grussu, 2020).

Other experiences within the findings highlighted the transgenerational transference of maternal caregiving experiences that can occur in the perinatal period (Zdolska-Wawrzkiewicz et al., 2020). It is poignant that the language used within findings of being a

'monster' in the context of concern about bonding, and underpinned by transgenerational maternal caregiver relationship, mirrors language in similar research within attachment theory (Burman, 1996; Frost, 2011). Research has demonstrated a significant relationship between new mother's attachment styles with their own mothers, and maternal representations of both self and mother (Zdolska-Wawrzkiewicz et al., 2020). Recent research highlights the mediating role of shame in maternal attachment and infant bonding, which may further contextualise findings from this study (Yazdanimehr et al., 2023). Access to parent-infant therapists can support this relational need for both mother and infant as demonstrated in research highlighting impact on outcomes and recently progressed in exemplar perinatal services within the UK (Cantwell, 2023; Zeanah, 2019).

Existing research identifies previous mental health difficulties as a risk factor for PMHD (Blount et al., 2021; Wenzel, 2016; Yang et al., 2022), and while this was reflective of participants' experience in this study, the nature and presentation of these difficulties differed. Where participants had previous experience of anxiety, this became overwhelming or shifted from generalised anxiety to fear of harm to the baby. Interestingly, it was often the conflictual emotional experiences that led to most psychological distress for participants. These experiences reflect society and culture where maternity is idealized, and healthy ambivalence becomes 'forbidden' feelings (Schmied et al., 2018). To cope with this conflict, coping mechanisms develop to polarize aspects of this new demanding reality, and maintain a sense of self (Raphael-Leff, 2020). The coping mechanisms explored within the findings of this study offer insight into participants' experience and reality of the baby's existence. Understanding these mechanisms within an attachment informed lens can offer insight into variability within seeking support and interpersonal interactions with HCPs (Bright et al., 2019; Fraiberg et al., 1975).

The findings also prompt reflection on the concept of emotional coping, which is aimed at reducing distress associated with stressful experiences (the perinatal period) and is more likely to be used if the person views the stressor as uncontrollable (Guardino & Schetter, 2014). The experience of fragmented care described within the findings may have perpetuated this sense of 'uncontrollable'. Some women may have sought support directly or indirectly as an attempt to cope, and other women may have avoided seeking support due to an avoidant coping style, by attempting to escape from distress associated with PMHD and the system they felt powerless in (Guardino & Schetter, 2014). Consideration of these findings in an Irish context, and similar healthcare care pathways, is most relevant given this relationship between coping and support seeking (Button et al., 2017).

A disconnected coping mechanism may impact on their ability to accept their difficulties, and seek support, until it reaches a point of overwhelming distress. Other participants may have projected their own internal feelings of overwhelm and out of control, eliciting a response from HCPs to reinforce this internal belief, such as HCPs viewing them as 'helpless'. This may offer understanding of participants' experiences of dismissal when they had eventually connected with their reality, or where they felt their overwhelm and out of control feelings, and were met with lack of collaborative decision making, or over-medicalization by HCPs. In an attempt to exert control, HCPs and organisations may respond in a hierarchal manner, reducing collaborative decision making (Huschke, 2022). The responses from HCP's may be reflective of research with midwives conducted in an Irish context, highlighting only 17.8% of midwives sampled (n=157) felt confident in caring for women with PMHD (Noonan et al., 2018). It is of upmost importance to address this type of HCP care, as it can result in women feeling powerless and can result in traumatic birth experiences and negative perinatal mental health outcomes (Arnold et al., 2025; Creedy et al.,

2000). When women are not empowered in the perinatal period the care becomes less woman-centred and increasingly interventionist and standardised (Huschke, 2022).

Findings reflected the importance of the relationship with the HCP in supporting participants overcome internal barriers such as mistrust, stigma and shame, to seek support (Ayers et al., 2019; Ayres et al., 2019; Ford et al., 2019). When participants did have positive HCP interactions, these were characterised by positive experiences of non-judgemental and compassionate care which supported participants to feel emotional safety and validated (Ford et al., 2019; Megnin-Viggars et al., 2015). In these instances the findings were reflective of healthcare relationships desired by women (Megnin-Viggars et al., 2015).

However, while some HCPs provided this relational care, this was often undermined by systemic barriers including fragmented services, limited referral options and poor continuity of care, of all which negatively impacted on the ability of HCPs to action access to appropriate mental health supports (Coates & Foureur, 2019; Dadi et al., 2020; Sambrook Smith et al., 2019).

Participants frequently received compassionate care from non-mental health clinicians such as public health nurses and midwives. While participants were supported by this care and articulated their appreciation of HCPs, it did not always lead to the appropriate referral pathway or access to specialist support. As a result participants experienced barriers in accessing the support they required, echoing perspectives of HCPs in previous research (Noonan et al., 2017; Noonan et al., 2018a; Noonan et al., 2018b; Noonan et al., 2018c ; Pope et al., 2023). This reoccurring shared experience of conflict between relational care and systemic barriers from both service user and service provider prompts reflection on the impact on service users. During the perinatal period, a time of heightened vulnerability, not only are women coping with their own difficulties, but also appear to be contending with systemic barriers which may create additional distress. The empathetic resonance which

filters through organisations, through relationships between HCPs and service users has been demonstrated within maternity care and may contextualise the heighted stress participants experienced when witnessing these systemic barriers (Berg et al., 2012; Crowther et al., 2014).

An important reoccurring experience for participants, was the role of clinical decision making as a barrier to support. This included HCPs gatekeeping, ambiguity and reluctance to prescribing medication in pregnancy, and a lack of formal screening or assessment prior to decision. The barriers such as HCP uncertainty about psychotropic medication advice have been previously highlighted by service users in an Irish context (Health Service Executive, 2017). While the SPMHS Model of Care instructs the management of PMHD, such as mild-moderate depression, at primary care level with access to advice on the use of psychotropic medication in pregnancy and breastfeeding, the experience of participants in this study highlights a discrepancy between model of care and service user experience. This discrepancy may be related to HCP anxiety or knowledge, which can result in conflicting advice, and highlights the importance of information to facilitate discussion and informed decision making (NHS, 2022). While the consensus regarding use of psychotropic medication in pregnancy and breastfeeding remains a challenge worldwide, barriers to HCP clinical decision making and service user information can be overcome with training, consultation and implementation of pathways (Fabiano et al., 2025; Health Service Executive, 2017; NICE, 2020).

Holistic care, that is flexible to the needs of the perinatal woman, her child and partner is a key recommendation based on participants' experiences. The inclusion of partners in perinatal mental health support as necessary is recommended, and previous research has demonstrated the important role of the partner in PMHD (Antoniou et al., 2021; Moran et al., 2023; Noonan et al., 2021; Powell et al., 2022). Recent conceptualisations of

proximal and distal risk factors in perinatal mental health can support an integrated understanding of how perinatal women, and their experiences are embedded within these communities, organisations and societal narratives (Schmied et al., 2018). This integrated approach may support a shift from current approaches of mental health services to 'manage' mental health conditions to supporting the wider perinatal needs including partners, the mother-infant relationship and infant mental health (Cantwell, 2023).

Participants reflected their desire for holistic care that consisted of a safe space to explore and support their understanding of perinatal mental health experiences. Indeed, the majority of participants accessed this therapeutic space via private healthcare, creating a two-tiered system (Huschke, 2022). This ability to access care through private financial means, highlights the absence of socioeconomic disadvantage (a commonly identified PMHD risk factor) and additionally illustrates means to overcome the public system shortcomings (Wilson et al., 2024). This access to private healthcare due to public system shortcomings raises additional concern regarding the progress of mental health reform towards a universal healthcare system in Ireland (Mental Health Commission, 2021; Schulmann et al., 2024). While financial means can create access to private services, it also raises consideration of how this may impact on challenges in continuity of care, communication between services, clinical oversight and regulation of practitioners (Cantwell, 2023; Sambrook Smith et al., 2019). These challenges are of unique importance to perinatal women who experience multiple healthcare appointments in pregnancy and may therefore particularly feel the negative outcomes of having their feet planted in many services (Department of Health, 2016).

It is promising that person centered perinatal mental health care can be achieved through interpersonal and organisational factors, which are modifiable (Webb et al., 2023). Low-intensity mental health interventions which normalise perinatal mental health and infant

bonding experiences could form preventative strategies (WHO, 2022). Reconceptualising the perinatal narrative to promote maternal wellbeing and the diversity of experience can be achieved through simple actions such as health messaging in healthcare environments (Schmied et al., 2018). Psychological interventions, such as CFT, target the constructs of shame and self-criticism and have accrued evidence for low and high intensity perinatal intervention (Cree, 2010; Gammer et al., 2020; Kelman et al., 2018; Lawrence et al., 2024; Lennard et al., 2021; Millard & Wittkowski, 2023; Mitchell et al., 2018; Thirkettle et al., 2024). Similarly, a recent scoping review has demonstrated preliminary support for Dialectical Behavioural Therapy in treating a range of perinatal mental health symptoms and promoting emotion regulation & positive parenting behaviours (Hellberg et al., 2024).

Addressing interpersonal and organisational factors will require significant, meaningful investment and enactment of existing guidelines and policies, particularly those which promote a person centred approach that listens to women's experiences (Huschke, 2022; Huschke et al., 2020; National Women's Council, 2024). The findings offered within this study from participants accounts of PMHD and help-seeking from HCPs, within an Irish context, form a valuable contribution to this listening process.

Limitations

Participants who participated were self-selected and may differ in their experiences of PMHD to those who chose not to participate. It is notable that seventeen individuals expressed interest in participation; had the study been able to accommodate additional participants, a broader and potential more diverse range of experiences may have emerged. Despite adopting an inclusive recruitment strategy, sample participants did not include ethnic minorities and was relatively homogenous in terms of socioeconomic status. Participants were employed, highly educated with access to financial resources. This composition likely shaped the narratives shared and potentially demonstrated perspectives reflective of

individuals with socioeconomic stability and access to wider support systems. As such, researchers and practitioners should exercise caution and clinical judgement in applying these findings to different socioeconomic and cultural contexts, as experiences of this research topic may be experienced different across diverse populations.

Another limitation of this study relates to the semi-structured interview, which may contain bias due to the researcher-developed questions at the early stages of the research project (Galletta & Cross, 2013). While many questions were prompts for exploration, questions to specifically discuss participants' experiences with HCPs may have led to discussion of areas such as being asked about their mental health. However, several steps were taken to mitigate this potential bias such as role play of the semi-structured interview format. Additionally, input from the PPI contributor supported a sensitive, flexible delivery of the questions. This was of importance to the lead researcher who is not a member of the perinatal community, and sought PPI input to conduct the interviews in a sensitive and meaningful way (Ennis & Wykes, 2013; Smith et al., 2022).

Practitioner Points

The following points highlight key clinical implications for clinical psychologists and healthcare professionals (HCPs) based on the study's findings:

1. Personal and societal narratives about the perinatal period can shape women's perinatal experience, namely their mental health and support seeking. Psychoeducation that normalises the perinatal period as a biologically, psychologically and socially complex time can help foster more validating and psychologically flexible narratives.
2. Beyond antenatal screening of PMHD, recognising understanding the individual and temporal variability of PMHD, can aid earlier identification and tailored intervention across the entire perinatal period.

3. All HCPs have an important role in recognising and responding to PMHD. Clinical psychologists are well-placed to support HCPs through systemic consultation, training and supervision of non-specialist professionals.

Conclusion

To the authors' knowledge, this study is the first to explore the experiences of women seeking perinatal mental health support from HCPs in Ireland. This research has highlighted the significant internal, interpersonal and systemic barriers participants faced in seeking support for perinatal mental health needs. Furthermore, participants conveyed the significant adjustment to the perinatal period in the context of mental health difficulties. Participants highlighted the biopsychosocial factors which influenced and impacted on their mental health, encouraging a more holistic understanding and response to these difficulties. Participants used their experiences to advocate for themselves, their infants and partners, while also finding the strength to advocate for other women.

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Chapter Four

Discussion and Conclusion

Introduction

This chapter provides a summary of the overall purpose of this thesis, alongside a synthesis of findings from both studies. The unique contributions of each study are discussed, with an exploration of overarching themes relating to perinatal narratives and relational care. Implications for practice, education, policy and research are discussed, with researcher reflections concluding this chapter.

Summary of Findings

This thesis aimed to explore the experiences of perinatal women seeking and receiving healthcare intervention by conducting two studies.

Study One

The first study, a systematic review and thematic synthesis, analysed existing qualitative research on the experiences of perinatal women and their families' engaging in psychosocial interventions for perinatal mental health. Thirty-one studies were included, with a wide range of intervention across a broad geographical context. A limited amount of studies focused on specific minority groups or cultures, an important consideration in the application of findings across socioeconomical and geographical locations. Thematic synthesis identified six core themes (Navigating matrescence, A tapestry of relationships, The influence of a therapeutic facilitator, Invisible walls faced by participants, What works for perinatal women? and "Left hanging") and 21 subthemes, highlighting key engagement factors and barriers such as family inclusion, role of the therapeutic facilitators and outstanding needs.

Overall, psychosocial interventions were positively received by perinatal women and their families.

Study Two

The second empirical study explored the experiences of perinatal women seeking mental health support from HCPs, using semi-structured interviews and IPA analysis. PPI was a key element of the study design. Three GETs and seven subthemes were identified: (1) Navigating matrescence and perinatal mental health (*Ghosts on the journey; The 'Do-It-All Mother'; Stigma and shame*), (2) A fragmented system (*Barriers, barriers everywhere!; Healthcare professionals*), and (3) Transforming perinatal mental health ("*She sat in the bed, and she just listened to me."; Seeking justice and change*). Findings illustrated PMHD experienced by participants and their experiences in seeking support from HCPs. Findings identified the internal and external barriers faced by participants. While situated in Ireland, findings in relation to healthcare can be applied to similar healthcare contexts, such as the U.K, with potential broader application of study concepts which transcend geographical and cultural contexts such as perinatal narratives and relational care.

Perinatal Narratives

One theme which threads throughout this thesis is the role of perinatal narratives, and how complex, often conflicting narratives can shape women's perinatal experience, their mental health, and access to support (Fenech & Thomson, 2014; Ussher et al., 2019; Wenzel, 2016,). The findings of both studies align with previous research, demonstrating that unrealistic and idealized cultural narratives shape women's experiences and help-seeking behaviours (Goodwin & Huppatz, 2010; Law et al., 2021; Michaels & Kokanović, 2018;

Reddish et al., 2024). Societal narratives of the ‘good mother’ idealise the perinatal period, contributing to anxiety and depression, creating stigma and fear which deter help-seeking (Law et al., 2021).

The findings echo feminist theories highlighting how dominant discourses obscure the reality of the perinatal period; a time of tension and contradiction, self-fulfilment and a strain on self-actualization (Henriksson et al., 2023; Lupton, 2012). Understandably women with PMHD require support and tools to resist the norms of the ‘good mother’ (Lafrance & Stoppard, 2006). By illustrating how narratives impact PMHD, and help-seeking, this thesis adds a unique perspective.

As outlined in the introductory chapter of this thesis, the BPSM offers an understanding of the complexity of PMHD (Engel, 1977). It’s application has been critiqued for vagueness and lack of clinical application (Bolton & Gillett, 2019; Ghaemi, 2009). This research demonstrates how personal, interpersonal, and institutional factors interact, suggesting potential for integrating BPSM with woman-centered care models (Bolton, 2023; Nolte, 2017). Other more recent conceptual frameworks such as a matrix framework of the barriers and facilitators to perinatal mental healthcare may support the BPSM (Webb et al., 2023). Unlike the BPSM, the complex interplay of individual and system-level factors that influence women and services are explicitly stated within the framework, which may provide clarity and clinical utility (Webb et al., 2023). The explicit identification of barriers, as highlighted in this thesis, is particularly important for healthcare systems in Ireland and the U.K., which rely on perinatal women to recognise and seek support for PMHD. In light of findings from this thesis, embedding the discourse of motherhood within these frameworks may also support further understanding of PMHD (Schmied et al., 2018).

Unlike diagnosis-specific studies, this thesis captured diverse PMHD experiences, highlighting women's resilience in overcoming societal narratives and seeking support

despite stigma (Button et al., 2017; Hajure et al., 2024; Thomson, 2017). These experiences differ from research findings that demonstrate reluctance to disclose and access treatment (Coates et al., 2004). This highlights the ability of some women to overcome the challenging societal narratives they experienced, and risk being perceived as the 'bad mother' (Law et al., 2021; Miller et al., 2017; Schmied et al., 2018). Participants in this study may possess characteristics such as psychological resilience, mental health literacy, and self-efficacy, along with access to protective psychosocial resources (Button et al., 2017; Daehn et al., 2022; Hajure et al., 2024; Thomson, 2017). However, findings caution against framing resilience without acknowledging the need for systemic support (Fontein-Kuipers et al., 2015; Thomson, 2017).

When healthcare systems failed to validate women's experiences, societal narratives remained unchallenged. In contrast, shared interventions, particularly group settings, facilitated normalisation and redefined motherhood experiences through 'motherwisdom', the reclaiming of narrative importance in medicine (Loy & Kowalsky, 2024; Scharp & Thomas, 2017). Peer support interventions are desired by women with PMHD and demonstrated as particularly beneficial across diverse perinatal groups (Thomson, 2017; Looney et al., 2024; Bellhouse et al., 2022). Findings highlight the potential role of *motherwisdom* within group interventions, which can create a shared experience, and reduce feelings of social isolation, stigma and shame in mental health difficulties (Bellhouse et al., 2022; Matvienko-Sikar et al., 2023; Wadephul et al., 2016). These findings reiterate that PMHD is not a personal failure, but rather a failure of healthcare systems to effectively assess and respond with adequate support (Huschke, 2022; Kirkbride et al., 2024).

The Essentialness of Relational Care in Supporting Perinatal Mental Health

The second area of findings which shaped this thesis is relational care, reinforcing the centrality of compassionate, sustained relationships within perinatal healthcare (Cibralic et al., 2023; Cummins et al., 2025; Hadfield & Wittkowski, 2017; Thomson, 2017).

Systemic barriers frequently undermined the delivery of relational care, highlighting the challenges between a holistic model and the structured, certainty of a medicalised system (Crowther et al., 2021; Huschke, 2022). Sustainable relational healthcare not only relies on the individual psychosocial resilience of HCPs, but a sustainable system (Crowther et al., 2016; Thomson, 2017). These findings bring the relational, reciprocal nature of healthcare to the fore, reflective of recent research on the reciprocity between individuals, HCPs and the environment (Hannon et al., 2023).

Collaborative, woman-centred models can enhance care pathways and equalise power imbalances (Breman et al., 2024; Psaila et al., 2014; Tuohy et al., 2025; WHO, 2010). When absent, women can experience lack of self-esteem, self-trust and control and a sense of powerlessness, worsening perinatal experiences and PMHD (Garcia & Yim, 2017; Huschke, 2022).

Provision of a relational, woman-centred model of healthcare fosters collaborative, shared decision-making approaches (Brady et al., 2019; Dove et al., 2017; Huschke, 2022; Mackenzie & Stoljar, 2000). To build and sustain psychosocial resilience in the perinatal workforce, the power of relationships must be promoted (Thomson, 2017). Findings within this thesis, notably in study 1, support the application of these relational findings not only in Ireland, but across socioeconomic, cultural and geographical locations. However, wide variation and tokenism in applying woman-centered care principles remain a concern (Brady et al., 2019; Carolan & Hodnett, 2007; Crepinsek et al., 2023; Hunter et al., 2017; Leinweber et al., 2023; McEvoy et al., 2024).

By prioritising participant perspectives and lived experience through PPI contribution, this thesis offers a distinct contribution to the literature and reinforces the need for genuine patient involvement in woman-centered research and practice (Sturgiss et al., 2022).

Practice Implications

The findings from this study highlight the need for compassionate, relational and inclusive care approaches. Supporting perinatal women with mental health literacy to understand and normalise their distress, may support the narratives of motherhood (Henriksson et al., 2023). Clinical psychologists are uniquely placed to deliver flexible psychosocial interventions that validate women's experiences and promote social connectedness (Austin et al., 2017; British Psychological Society, 2016, 2022, 2023; O'Brien et al., 2023). Clinical psychologists are also uniquely placed to provide training and supervision to colleagues through evidence based psychological and psychosocial interventions including the mother-infant dyad and partners (Austin et al., 2017; NHS, 2021; NICE, 2020; O'Brien et al., 2023). This training and supervision of other HCP colleagues, is pertinent to findings within this thesis given the potential role of non-specialist HCPs in the identification of PMHD and delivery of psychosocial interventions.

Education

Perinatal mental health care provision depends on HCPs in contact with the perinatal population (Wilson et al., 2024). Training to address the complexity of PMHD with reflective practices is required to support HCPs in their work with perinatal women (Cummins et al., 2025; O'Leary et al., 2022; Thomson, 2017). However, systematic barriers must be acknowledged and addressed to avoid idealising approaches, such as compassionate HCP care, without organisational support (Dashtipour et al., 2021).

Policy

Large scale system reform is a complex process (Wilson et al., 2024). The findings of this thesis reiterate the need for existing policies to move beyond rhetoric and action woman-centred, trauma informed approaches in perinatal healthcare (National Women's Council, 2024; Schulmann et al., 2024). Universal healthcare access is critical in supporting perinatal women, as evidenced by the two-tiered healthcare system highlighted within this thesis. Further clinical guidance is needed on holistic family system approaches, inclusive of partners in an Irish context (Cantwell, 2023; Duffy et al., 2023; O'Brien et al., 2023). Co-design approaches to ensure the voices of women are the core of services are necessary within an Irish context currently establishing SPMHS (Dubreucq et al., 2023; Mongan et al., 2023; Wrigley & O'Riordan, 2023).

Research

This thesis contributes valuable participant and PPI experiences to a qualitative literature base that remains sparse (Huschke et al., 2020). Future research that includes marginalised groups and promotes participatory methodologies to enhance participant recruitment are necessary for inclusive research (Ennis & Wykes, 2013; Kukura, 2022).

Researcher Reflections

This section is written in the first person as it reflects upon my personal experience of this research. To support my reflexivity I used supervision, reflective journals and publications related to researcher identity, feminism and maternal status (Franks, 2011; Frost & Holt, 2014; Frost & Rodriguez, 2015; Smith et al., 2022). These publications clarified the experiences I had as a psychologist in clinical training, navigating research alongside personal and professional identity.

Early Research Journey

I began this research after initially beginning a different research project from an existing list of projects. This research came from an opportunity to explore and choose a research topic myself. This process taught me the importance of choosing a research project where I could flourish and develop as a psychologist in clinical training.

During this period, I found myself reflecting on experiences with positivist approaches emphasising objectivity and neutrality (Franks, 2011). I struggled at times during clinical training with the idea of neutrality, believing that the personal is political, and that clinical psychology does not exist in a vacuum. I questioned whether there was space for a feminist clinical psychologist. This qualitative research project has taught me a more pragmatic approach, integrating positionality through reflective practice.

From the beginning, this research was shaped by my own identity, personal experiences, and those of my family and friends. In the early stages, my interest in the topic related to women's healthcare and mental health. I chose this research following conversations with friends, particularly one conversation centered on matrescence, perinatal trauma and the strength of self-advocacy within a medicalised perinatal system.

I was drawn to the topic due to my own experiences and interest in women's health, and I was struck by the lack of formal input I had received on the perinatal period during two years of clinical training and previous employment as an Assistant Psychologist.

Considering the knowledge held as a discipline regarding early life experiences, formulation and mental health, I felt deprived of this knowledge and wanted to know more.

Identity and Access to Participants

As a white, middle-class, cisgender woman, my identity likely shaped access to participants from marginalised groups early in the research process. As I did not have access to participants from marginalised backgrounds through personal networks, I used formal methods of recruitment, such as agencies, to reach these potential participants. However,

having completed the studies, I learned more about the barriers that marginalised groups face in accessing services, and I now question whether these methods of recruitment were sufficient. It feels uncomfortable to continue a rhetoric of "methodological difficulties" in recruiting from marginalised populations, without acknowledging how my own identity influenced recruitment.

This experience shifted my perspective on the importance of recognising personal and professional identity in research and clinical training. A more diverse clinical psychology workforce may have better success in researching and representing diverse identities. This learning will influence my future research and clinical role where I will explore options to work with PPI contributors from marginalised backgrounds and increase this visibility in study materials.

Researcher Role and Maternal Status

Just as my identity shaped the early stages of the research, it continued to interact with other parts of the project, particularly through PPI contribution and my role as a HCP, non-mother, feminist researching mothers.

Before becoming a HCP myself, I grew up with a mother, a HCP, who tirelessly advocated for the psychological and emotional wellbeing of patients who were victims of abuse within a healthcare system. For me, inclusion of service users or individuals with lived experiences is not tokenistic; it is a core part of using the privilege I hold to centre lived experience within research. It also ensures that my clinical work as a HCP remains connected to service users' voices.

I am acutely aware of the mistrust that service users can feel following negative healthcare experiences, and PPI contribution was a way to communicate my genuine interest in potential participants' experiences and to treat their accounts with sensitivity.

The PPI process also helped me to manage my dual identity as both a HCP and researcher, especially when interviewing participants who shared difficult experiences with healthcare systems. This became more apparent as I analysed interviews while working in a SPMHS. I felt conflicted at times, and relied on core IPA text to stay close to participants experiences while witnessing similar interactions in my role as a HCP.

Conducting Interviews

Prior to interviews, reflections from conversations with the PPI contributor about perinatal mental health supported my understanding of this subject. During interviews I found this helpful to communicate a sense of empathy and understanding with participants. It also supported me in managing the discomfort I experienced as a non-mother. I noticed my tendency to introduce myself in terms of my professional role, research interests, and PPI collaboration. This may have been an effort to legitimise my role and reduce the space for self-disclosure. This choice may have reduced the emotional labour required to discuss my non-mother identity. It was also guided by participants' needs, reflecting my clinical role, to create a space focused on them rather than on myself. I have always been cautious about self-disclosure in clinical work and research, believing it can sometimes disrupt rather than enhance connection, depending on the individual client or participant.

However, findings from this thesis, particularly the emphasis on relational care among HCPs, have prompted me to reconsider my perspective and acknowledge my non-mother status in certain contexts. Findings from this thesis have also led me to wonder if my views of keeping personal and professional separate reflect narratives of "good mothers" or "good feminists". My perspective on self-disclosure may have related to the narrative of a woman who can juggle multiple roles and selves, ensuring each are contained and regulated.

In early interviews, I worried that participants would ask about my maternal status and that a rupture in connection might occur if they knew I was not a mother. I found that my

clinical skills, particularly my capacity for empathy, compassion and validation, supported me in navigating these fears. Although I lacked lived experience of the perinatal period, I could offer a level of relational understanding that was "good enough" to support participants.

Nonetheless, the interviews evoked personal feelings of being "less than" as a woman and a sense of loss without perinatal experiences. This discomfort was challenging to reconcile with my feminist values supporting choice and equality within reproduction, and I noticed myself leaning on my professional role and knowledge to navigate this absence of lived experience. I wonder if this dynamic influenced my choice of analytical method, IPA, with its emphasis on participants' experiences, which felt particularly important given my outsider position.

My lack of personal perinatal experience was also evident when interpreting findings. I was shocked to learn about the impact of dominant perinatal narratives on mental health, and I can only imagine how difficult it must have been for participants to experience and learn about these narratives simultaneously. This realisation deepened my admiration for participants' resilience and the value of centring participant experience throughout the research process.

Finally, I have personal experience of navigating systems and requiring support from HCPs while feeling vulnerable. I believe these experiences enhanced my openness to participants' accounts and added to the depth of the findings within the thesis.

Conclusion

Through exploration of perinatal women seeking and receiving mental health support, this thesis offers unique insights into barriers, facilitators and the transformative power of relational care and compassionate perinatal narratives. These findings demonstrate important

implications for clinical psychology and perinatal mental healthcare in the areas of clinical practice, education, policy and research.

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Appendix A

BPSM of Wellness

Table A1

BPSM of Wellness

Tenets	Risk Factors	Components
Biological		
	Physical	Body changes, hormonal changes, medication concerns, epigenetic changes
	Nutritional	Poor nutrition, vitamin deficiencies, lack of access to quality food
	Neurobiological	Neurological changes (e.g., brain structure changes), genetic predisposition to illness/health
	Adverse Childhood Events (ACEs)	Negative/traumatic experiences of childhood
Psychological		
	Peri-Partum	Anxiety, fatigue/exhaustion, baby blues, mood changes (in last month of gestation or first few months after delivery)
	Post-Partum	Baby blues, post-partum depression (PPD), depression, self-esteem issues, anxiety, stress, lack of support (in post-gestation)
	Stressors	Caused by biological components (e.g., physical changes, nutritional demands, neurobiological changes, traumatic events), mental wellness concerns, anxiety, lack of support, weathering phenomenon
	Transgenerational Trauma	Past traumatic experiences influencing offspring
Sociological		
	Income/Poverty	Lower SES associated with negative maternal and neonatal outcomes
	Discrimination	Unjust treatment, negative impacts on maternal and neonatal outcomes
	Race	Racial disparities in birth outcomes, most common form is verbal-based discrimination, WOC experience worse maternal and neonatal pregnancy lifecycle outcomes
	Relational Aspects	Love, friendship, social support, intimate partner violence (IPV)
	Access to Insurance/Quality Healthcare	Insurance plans, family planning access/reproductive care

Note. Adapted from "Biopsychosocial Factors During the Perinatal Period: Risks, Preventative Factors, and Implications for Healthcare Professionals" by A. B. Blount, 2021, *International Journal of Environmental Research and Public Health,* 18(15), Article 8206 (https://doi.org/10.3390/ijerph18158206). Copyright 2021 by the authors.

Appendix B

Journal Submission Guidelines

Women's Health

Your article must be within the scope of the journal and be of sufficient quality. If not, it will not be reviewed. Please read the journal's Aims and Scope to see if your article is appropriate. The manuscript must be your original work, you must have the rights to the work, and you must have obtained and be able to supply all necessary permissions for the reproduction of any copyright works not owned by you, including figures, illustrations, tables, lengthy quotations, or other material previously published elsewhere.

Article types

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Please visit the Sage Journal Author Gateway for guidance on producing visual and/or video abstracts.

Original Articles. The Editors will consider clinical interventional and observational studies with clearly stated aims, well-reported methodology (including main outcome measures) results, and a discussion of the results in the context of the published literature.

Abstract: Maximum 300 words. Should be structured to include: Background; Objectives; Design; Methods; Results; Conclusion; Registration (if applicable)

Plain language summary: optional

Word count: up to 6000 words (excluding tables, figure legends and references) is recommended (this can be flexible)

Figures/Tables: no limit

References: no limit

Reporting guidelines: Please ensure you follow the appropriate reporting guidelines when preparing your manuscript and submit the completed checklist as supplementary material.

Please state in the methods which guidelines were consulted when preparing the manuscript. More information on reporting guidelines can be found on the EQUATOR website APC: Standard APC, found in the Publishing Fees and Open Access section of these guidelines

Systematic Reviews – these should answer a specific research question and involve a comprehensive search strategy aimed at identifying, assessing and summarising all the current evidence on a specific topic.

Abstract: Structured, maximum 300 words. Should be structured to include: Background; Objectives; Design; Data Sources and Methods; Results; Conclusion; Registration (if applicable)

Plain language summary: optional

Word count: around 4000 – 6000 words (excluding tables, figure legends and references) is recommended. This can be flexible

Figures/Tables: no limit

References: no limit

Reporting guidelines: Please ensure you follow the PRISMA guidelines when preparing your manuscript and submit the completed checklist as supplementary material. More information on reporting guidelines can be found on the EQUATOR website

APC: Standard APC, found in the Publishing Fees and Open Access section of these guidelines

Title

Your manuscript's title should be concise, descriptive, unambiguous, accurate, and reflect the precise contents of the manuscript. A descriptive title that includes the topic of the manuscript makes an article more findable in the major indexing services.

Abstract

Please include a structured or unstructured abstract, as outlined for each article type above, between the title and main body of your manuscript that concisely states the purpose of the research, major findings, and conclusions. If your research includes clinical trials, the trial registry name and URL, and registration number must be included at the end of the abstract. Submissions that do not meet this requirement will not be considered. For clinical trials, the trial registry name and URL, and registration number must be included at the end of the abstract. This journal includes Video abstracts, Infographics, Plain language Summaries. For more information on how to prepare a plain language summary, please see this page.

Plain language summaries

A plain language summary (PLS) is an optional addition that can be submitted for any article type that requires an abstract. The plain language title (approx. 50 words) and plain language summary (approx. 300 words) should describe the article using non-technical language, making it accessible to a wider network of readers. More information and guidance on how to write a PLS can be found on our Author Gateway. PLS are published directly below the scientific abstract and are open access making it available online for anyone to read. Peer review of the PLS will be conducted following our PLS reviewer guidelines. When submitting, authors should enter their plain language title and plain language summary into the box provided in the submission system when prompted. The PLS does not need to be provided in the manuscript text or as a separate file. If you are not submitting a PLS with your submission, please enter "N/A" in each box. If you need professional help writing your Plain Language Summary, please visit our Author Services portal.

Keywords

Please include a minimum of 2 keywords, listed after the abstract. Keywords should be as specific as possible to the research topic. Artwork, figures, and other graphics

For guidance on the preparation of illustrations, pictures, and graphs in electronic format, please read Sage's artwork guidelines. Figures supplied in color will appear in color online.

Appendix C

Example of SR Review Disagreements

Table C1

Example of SR Review Disagreements

ID	TITLE	Reviewer decision FL	Reviewer decision MD	Reviewer note ÁNG	temp outcome	final decision
90677769	Postpartum Mental Health Promotion: Perspectives from Mothers and Home Visitors	include		originally excluded as findings mixed but they could be accessible due to presentation	include	include
90677745	Non-specialist-delivered psychosocial intervention for prenatal anxiety in a tertiary care setting in Pakist	include		findings are mixed from participants	exclude	exclude
90677831	Mothers' and birthing parents' experiences with 1-day cognitive behavioural therapy-based workshops for post	include		orginally noted wrong population as thought wasn't specific to PPD but reviewed PS (with an infant (<12 months), living in the province of Ontario in Canada with an Edinburgh Postnatal Depression Scale (EPDS) score ≥10)	include	include
90677881	Mothers' experiences	include		wrong outcome	exclude	exclude

Appendix D

Checklists: AACODS and JBI

Table D1

AACODS checklist

Paper	Item	Explanation	Criteria met?
Parry et al. 2016 Communities for Children: Final Report: Final report: The Western Perinatal Support Group (WPSG) program in Western Adelaide	Authority	Identifying who is responsible for the intellectual content. **Individual author**: Associated with a reputable organisation? Professional qualifications or considerable experience? Produced/published other work (grey/black) in the field? Recognised expert, identified in other sources? Cited by others? (use Google Scholar as a quick check) Higher degree student under 'expert' supervision? **Organisation or group:** Is the organisation reputable? (e.g. W.H.O) Is the organisation an authority in the field? **In all cases:** Does the item have a detailed reference list or bibliography?	Yes

Accuracy	Does the item have a clearly stated aim or brief? Is so, is this met? Does it have a stated methodology? If so, is it adhered to? Has it been peer-reviewed? Has it been edited by a reputable authority? Supported by authoritative, documented references or credible sources? Is it representative of work in the field? If No, is it a valid counterbalance? Is any data collection explicit and appropriate for the research? If item is secondary material (e.g. a policy brief of a technical report) refer to the original. Is it an accurate, unbiased interpretation or analysis?	Yes
Coverage	All items have parameters which define their content coverage. These limits might mean that a work refers to a particular population group, or that it excluded certain types of publication. A report could be designed to answer a particular question or be based on statistics from a particular survey. Are any limits clearly stated?	Yes
Objectivity	It is important to identify bias, particularly if it is unstated or unacknowledged. Opinion, expert or otherwise, is still opinion: is the author's standpoint clear? Does the work seem to be balanced in presentation?	Yes

Date	For the item to inform your research, it needs to have a date that confirms relevance Does the item have a clearly stated date related to content? Or easily discernible date is a strong concern. If no date is given, but can be closely ascertained, is there a valid reason for its absence? Check the bibliography: have key contemporary material been included?	Yes
Significance	This is a value judgment of the item, in the context of the relevant research area Is the item meaningful? (this incorporates feasibility, utility and relevance) Does it add context? Does it enrich or add something unique to the research? Does it strengthen or refute a current position? Would the research area be lesser without it? Is it integral, representative, typical? Does it have impact? (in the sense of influencing the work or behaviour of others)	Yes

Table D2

JBI critical appraisal checklist

Paper number	Author	1. Is there congruity between the stated philosophical perspective and the research methodology?	2. Is there congruity between the research methodology and the research question or objectives?	3. Is there congruity between the research methodology and the methods used to collect data?	4. Is there congruity between the research methodology and the representation and analysis of data?	5. Is there congruity between the research methodology and the interpretation of results?	6. Is there a statement locating the researcher culturally or theoretically?	7. Is the influence of the researcher on the research, and vice-versa, addressed?	8. Are participants, and their voices, adequately represented?	9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?
1	Anolak et al. (2023)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
2	Baylis et al. (2020)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
3	Broberg et al. (2020)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
4	Buultjens M et al. (2008)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
5	Carter et al. (2020)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
6	Chakkalackal et al. (2021)	✓	✓	✓	✓	✓	X	X	✓	X	✓
7	Chartier et al. (2015)	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
8	Corey et al. (2019)	✓	✓	✓	✓	✓	X	X	✓	✓	✓

9	Forsyth et al. (2017)	X	✓	✓	✓	✓	X	X	✓	✓	✓
10	Goodman et al. (2014)	✓	✓	✓	✓	✓	X	X	✓	X	✓
11	Hall et al. (2021)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
12	Howard et al. (2023)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
13	Ingram et al. (2021)	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
14	Jallo et al. (2015)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
15	Kinser et al. (2021)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
16	Le at al. (2021)	✓	✓	✓	✓	✓	X	X	✓	X	✓
17	Lönnberg et al. (2018)	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
18	Masood et al. (2015)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
19	Mendelson et al. (2018)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
20	Ockhuijsen et al. (2015)	✓	✓	✓	✓	✓	X	X	✓	X	✓
21	Perkins et al. (2018)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
22	Platt et al. (2024)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
23	Pritchett et al. (2020)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
24	Pulliainen et al. (2019)	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
25	Rubio et al. (2021)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
26	Russell et al. (2020)	✓	✓	✓	✓	✓	X	✓	✓	X	✓
27	Seshu et al. (2021)	✓	✓	✓	✓	✓	X	X	✓	✓	✓
28	Shakespeare et al. (2006)	X	✓	✓	✓	✓	X	✓	✓	✓	✓
29	Turner at al. (2010)	✓	✓	✓	✓	✓	X	X	✓	✓	✓

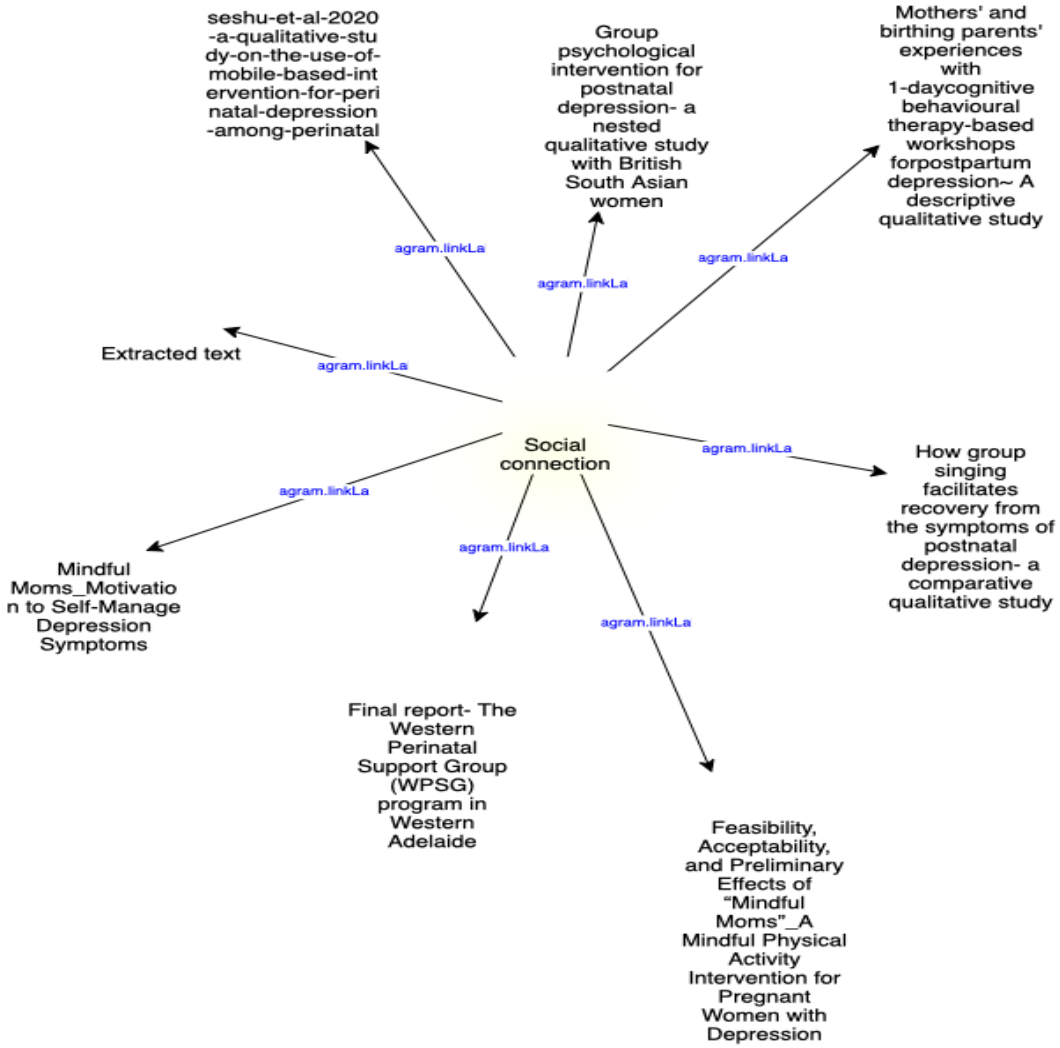
30	Varambally et al. (2024)	✓	✓	✓	✓	✓	X	X	✓	✓	✓

Appendix E

Example Of SR Coding and Related Studies

Figure E1

Example of 'social connection' code



Appendix F

PPI Terms of Reference

Purpose: The purpose of this study is to understand the experience of women seeking perinatal mental health support from Health Care Professionals. Public Patient Involvement (PPI) is a core part of this study. PPI is the process of collaboration between people with lived experiences, researchers, and research institutions. This involvement is invaluable as it endeavours to produce an ethical, sensitive and dignified study to all involved. The research team wish to meet with the PPI collaborator on a maximum of four occasions via in person or online meeting (1 hour maximum).

The four key areas the PPI collaborators will be responsible for are;

Feedback on the proposed interview schedule

Feedback on summary analysis of the data

Communication of the findings to ensure research impact in non-academic communities

Reflection and learning from the project following completion

A timeline will be agreed with the PPI members and research team following ethical approval of the study. PPI collaborators will be required to sign a confidentiality agreement in relation to the study. PPI collaborators will be offered support from the research team and signposting to relevant supports should any need arise (https://assets.hse.ie/media/documents/employee-assistance-programme-leaflet-pdf.pdf). The contribution of PPI collaborators will be acknowledged in all dissemination activities of this study.

Appendix G

Ethical Approval

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Coláiste na nEalaíon, an Léinn Cheiltigh agus na nEolaíochtaí Sóisialta
College of Arts, Celtic Studies and Social Sciences

Scoil an Síceolaíochta Feidhmí
School of Applied Psychology

University College Cork,
Cork, Ireland.

T +353 (0)21 490 4551 / 4552
E infoapsych@ucc.ie
http://www.ucc.ie/en/apsych/

8th July 2024

Dear Áine,

Clinical Psychology Research and Ethics Panel

The experience of women seeking perinatal mental health support from Health Care Professionals

Thank you for submitting the above research proposal to the Research and Ethics panel.

This has been approved in full.

Yours sincerely,

Dr Samantha Dockray
Chair Clinical Psychology Research and Ethics Panel

Dr Chris McCusker
Head of School of Applied Psychology

Coláiste na hOllscolie Corcaigh
University College Cork

Appendix H

Study Advertisement

University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Experiences of women seeking perinatal mental health support from Health Care Professionals.



🌟 **Your voice matters!** 🌟

Are you a woman who has experienced changes in your mental health and wellbeing during pregnancy or the first year after giving birth? These changes may have been anxiety, depression, and/or other mental health difficulties.

Did you seek support for your mental health during your pregnancy or the first year after giving birth?

If you gave birth in 2022 or 2023 and are now between 12-24 months after having your baby with the above experience, then we would value hearing from you!

🌿 **Your story is valuable and important.** 🌿

Join our research study to share your experience of seeking support for your mental health with Health Care Professionals such as midwives, nurses or GPs, during the perinatal period. Your experience could help shape maternal mental health care for future mothers.

Join our study and participate in a 1-hour interview with us. Your input is valuable in advancing research in this crucial area.

Led by Ms. Áine Ní Ghráda, Psychologist in clinical training at UCC, under the supervision of Dr. Maria Dempsey, Senior Lecturer and Dr. Fionnuala Larkin, Senior Lecturer and Clinical Psychologist, at the School of Applied Psychology, UCC, this study aims to understand and support women's mental health during pregnancy and early parenthood.

Contact us to participate in the study and let your voice be heard.

Scan the QR code

OR Text this number: 087-1819246 (I will arrange to phone you).

OR email: ainenighrada@umail.ucc.ie

Appendix I

Participant Information Sheet



This study is funded by University College Cork (UCC) and Cork Kerry HSE Adult Mental Health Services.

Title of the study : The Experience of Women Seeking Perinatal Mental Health Support from Health Care Professionals.

Purpose of the study

Being pregnant and early motherhood is a time of transition. In particular, the perinatal period can be a vulnerable time for women. The perinatal period is from the start of pregnancy up to 1 year post birth. For many women, this transition can result in changes in their mental health and wellbeing. Women may seek or receive support from Health Care Professionals for these changes, such as Nurses/Midwives, Medical Doctors, Psychologists, Social Workers, Counsellors.

Women may or may not be asked about their mental health during this time. Some women look for support for their mental health and receive this, and some do not.

This study aims to understand the experience of women who

Experienced changes in their mental health and wellbeing during the perinatal period, for example feelings of anxiety/ depression.

Looked for support for their mental health and wellbeing with Health Care Professionals during the perinatal period.

We want to listen to your experience looking for support for your mental health and wellbeing while you were pregnant or in the first year after giving birth (the perinatal period).

You will now 12 to 24 months after having your baby. By listening to and understanding your experiences, we aim to further the research in this area and influence maternal mental health care. We believe that research in this area is very important, as for many women the perinatal period is one of significant change and this can be a challenge to their mental health. We hope this research can support women in the perinatal period in the future. Any experience you have of this subject is very welcome.

The research team

Ms. Áine Ní Ghráda, Psychologist in clinical training at UCC is conducting this research under the supervision of Dr. Maria Dempsey and Dr. Fionnuala Larkin, Senior Lecturers at School of Applied Psychology, UCC. This project will have a public patient involvement (PPI) representative. This representative will be a woman who has used perinatal mental health services, as this woman will have experience of receiving mental health support during the perinatal period. This experience will help ground our research in lived experience. We will consult with this woman to hear their views and opinions on the research.

Who can take part?

Participants who can take part are now 12-24 months after having their baby. This means you will have given birth to a live baby in 2022 or 2023. You have experienced changes in your mental health during the perinatal period and looked for support from a Health Care Professional for this. Whether you choose to participate or not, your engagement with your maternity and/or health care service will not be affected in any way.

Is there any reason I should not take part in this study?

While we will do everything possible to ensure you feel safe and comfortable in taking part in this study, you may experience some upset by discussing this topic. We will support you with this.

Researching the experience of women who have a moderate-severe mental health diagnosis is very important, however for the purpose of this study we are only recruiting women who experienced mild-moderate mental health difficulties in the perinatal period, and who are not currently attending a specialist perinatal mental health service, or HSE adult mental health services.

Can I change my mind?

You can think about taking part and if you have any questions about the study, you can contact the research team. We will support you with any questions you may have. If you consent to take part, and then decide before the interview that you no longer wish to take part you can withdraw. If you decide after the interview that you wish to withdraw, you can let us know up to two weeks after interview and we will then remove your contribution from the research.

What will I have to do?

If you take part in our study, we will ask you attend an interview with Áine Ní Ghráda at a time and place that suits you. The interview will take approximately 1 hour to complete. This interview can be in person or online depending on location. The lead researcher will try her best to facilitate what is most convenient for you. The audio of the interview will be recorded with a Dictaphone. The researcher will then type out what was said, and the audio recording will be deleted. Typing out the interview helps the researcher to analyse the interview.

What kind of questions will I be asked?

Examples of questions you might be asked are:

Can you tell me about your experience of becoming pregnant; what was that time like for you?

Can you tell me about any changes to your emotional wellbeing and mental health throughout your pregnancy?

I am wondering about your supports from Health Care professionals during pregnancy. Can you tell me about a time that you tried to get support regarding your mental health during pregnancy/ and in the months after?

What happens to the information I share at the interview?

The information you share during the interview will be kept confidential to this study. If at any stage I am concerned for your wellbeing and safety, or the safety of a child or vulnerable adult I will need to act on this information. In the unlikely event that this happens, I will support you through this process.

When the interview has been typed up, the lead researcher will remove any information about you that could identify you such as your name or name of the hospital you attended. Your privacy is important, so the researcher will give you a code to protect your identity for example 'Participant 1'.

When this is done the findings will be reviewed by the research supervisors, Dr Maria Dempsey and Dr Fionnuala Larkin.

This project will have a Public patient involvement (PPI) representative, who has lived experience in the subject matter. When the lead researcher has analysed the interview data, and removed any information that could identify you, will invite the PPI representative to review a small part of the findings and give feedback. This is to help the lead researcher consider other views of the findings.

This data may also be used in future research by the research team in exploring the same subject. For example, they may want to look at the findings again and analyse them in a different way. There will be no identifying information about you in this data.

Will other people know I am taking part?

Your participation will be kept confidential. Any forms you give to us with your details on them will be password protected and kept on the MS Teams research team folder, only

accessible by the lead researcher and two supervisors, Dr. Maria Dempsey and Dr. Fionnuala Larkin, to comply with UCC data protection policy. Audio files from the interview will be stored on the Dictaphone of the primary researcher or MS teams recording where the interview is online. The audio recording will then be transferred to the same MS teams folder. The audio file will be transcribed, with any identifying information deleted. The audio file will then be deleted from the MS teams folder. The transcripts will be stored on the MS teams folder. These documents will also be password encrypted. Data will be stored for at least 10 years in line with UCC policy. The data will then be destroyed.

This study has obtained ethical approval from the Clinical Psychology Research Ethics Committee (CPREC).

Who can I talk to about this research?

I would love to hear from you. If you have any queries about this research, you can contact me;

Áine Ní Ghráda, Psychologist in clinical training

Email: ainenighrada@umail.ucc.ie

Phone: 0871819246 (Please text and I will arrange to phone you)

I want to participate, what do I do now?

Thank you. If you agree to take part in the study, please fill out the consent form online (via the QR code) or you can email Áine Ní Ghráda to do this via email. If you would like a hard copy, you can request this too (ainenighrada@umail.ucc.ie)

Data protection statement

If you have a concern about how we have handled your personal data, you are entitled to this raise this with the Data Protection Commission. The Data Protection Officer (DPO) in UCC is: Catriona O' Sullivan

Information Compliance Manager

Office of Corporate & Legal Affairs

University College Cork

Email: gdpr@ucc.ie

Telephone: +353 (0)21 4903949 or 4901862

Should you become aware of a breach of the personal data of participant(s), you must report this to the data controller.

“A personal data breach occurs when the data is accessed, disclosed, altered, lost or destroyed in contravention of an organisation’s obligation to keep personal data in its possession safe and secure”

https://www.dataprotection.ie/

Appendix J

Participant Consent Form

I ……..(name) consent to participate in the study "The experience of women seeking perinatal mental health support from Health Care Professionals".

The purpose and nature of the study has been explained to me in the information sheet and I have had an opportunity to ask any questions prior to consenting.

I understand that my participation will be kept confidential to the research team all identifying information will be deleted, because personal data is collected only to record consent and is stored separately to data collected from interview, with no attempt made to link them. My data will have an anonymous identifier e.g. participant 1.

I understand that I can withdraw from the study, without any explanation needed, up to two weeks after the interview has been completed, without repercussions. To do this I know I will need to……. Send an email to Ms. Áine Ní Ghráda to let her know I am withdrawing from the study (ainenighrada@umail.ucc.ie).

I understand that the data and any personal details collected are for research within the scope of the study "The experience of women seeking perinatal mental health support from Health Care Professionals". I understand that this data may also be used as secondary data by the research team to inform future research on this subject and will be done so in line with Psychological Society of Ireland code of ethics. Please mark the relevant box to indicate your choice;

☐ I consent to my data being used as secondary data for the purposes outlined above

☐ I do not consent to my data being used as secondary data for the purposes outlined above

My personal details will be processed and handled in accordance with European legislation including the General Data Protection Regulation (EU) 2016/679. I have the right to access these data, rectify them, limit, or oppose their processing and to request deletion of my personal data.

☐ I understand that disguised extracts (e.g. quotes) that do not reveal my identify may be quoted in presentations and subsequent publications (journal article, book chapter, doctoral thesis which this study forms, journal article, conferences, etc.), if I give permission below (please tick):

I consent to participating in this study (please mark the box)

Signature: _____ Date: _____

Name (Capital letters): _____

Contact email or telephone: _____

Appendix K

Semi-Structured Interview Schedule

Table K1

Semi-Structured Interview Schedule

Anchor point	Prompt questions
1.Mental health during the perinatal period	When you became pregnant, what was it like for you emotionally?
2. Support during your pregnancy	I am wondering about your supports from Health Care professionals during pregnancy. At any point in your pregnancy did a HCP enquire about how you were coping emotionally or ask about your prior mental health experience?
3. Conversations regarding mental health	I would love to hear about any conversations you had with a Health Care Professional regarding your mental health.

Appendix L

Participant Demographic Information Sheet

Name :

Age :

Nationality:

Education:

Working outside of the home:

Relationship status:

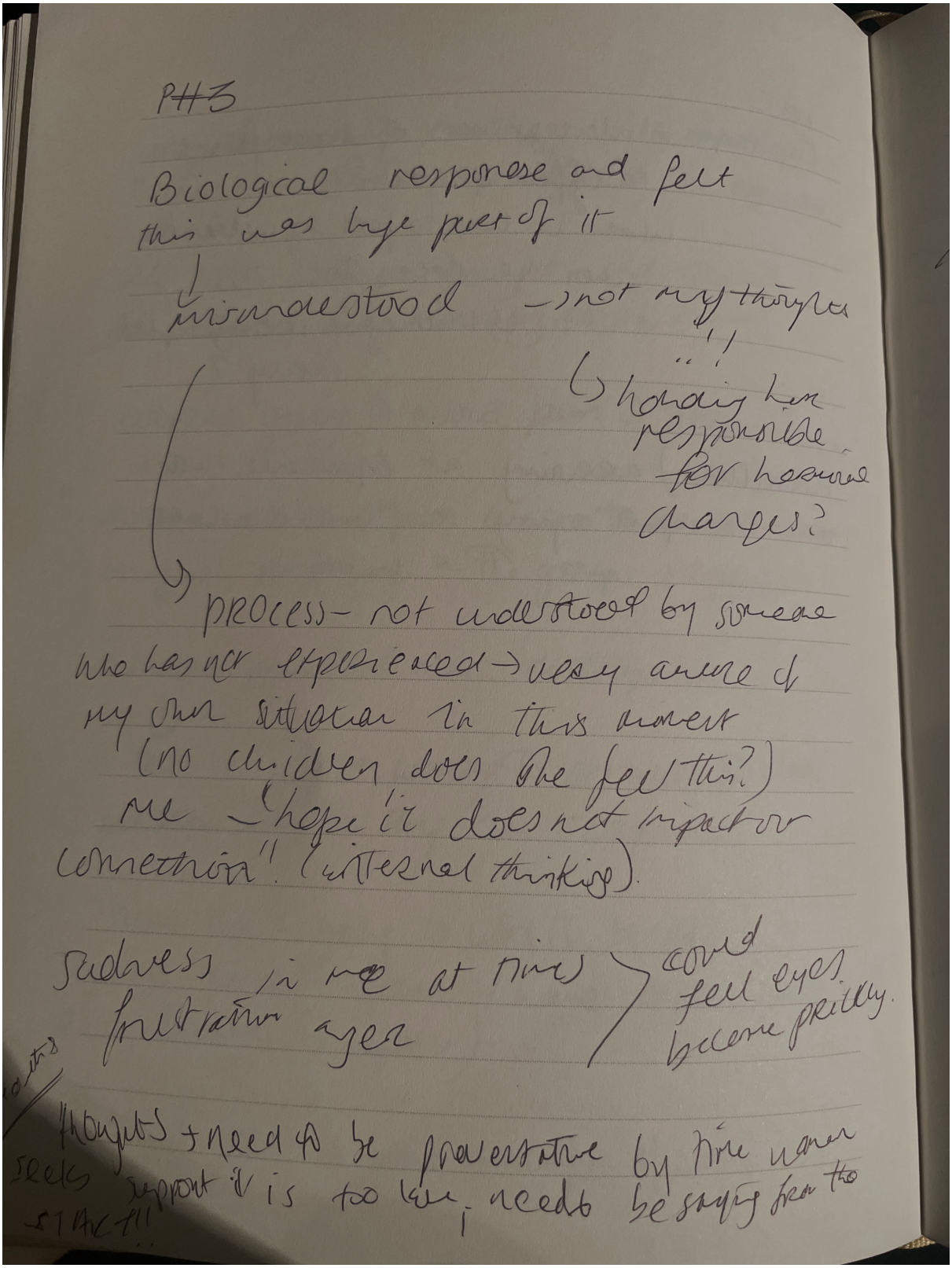
How long since giving birth?

Previously pregnant prior to this recent pregnancy:

Other children:

Appendix M

Reflective Journal Entry



Appendix N

Example of Exploratory Noting

	Her mental health very clearly changed in the postnatal period.
P: Post Natal. I: OK, yeah. So when do you want to tell me a little bit about when that happened or when you first kind of noticed that? P: Yeah, like, I suppose she was a really easy baby and stuff when she came and I had a planned section because I've had previous back surgery and do you know, it was all like, I didn't have a traumatic, traumatic birth or anything like that.	Baby was a really easy temperment and the planned c section and birth went as planned. She highlights that she did not have a traumatic birth.
I think it was like the two main factors for me was one, like all my mom's stuff kind of just reared its ugly head, you know, and that, sorry, thinking back, that did actually crop up around the 18 to 22 week mark when I was pregnant.	She is clear on the two main factors that impacted her postnatal mental health. Her mother's mental health reared **its ugly head. Indicates her anger/disgust towards this?**
And I forgot about that, sorry, because I think I'd gone like two or three weeks without speaking to my mom.	Upon reflection, in her pregnancy she had a period of time without speaking to her mum. Fractous relationship?
	during the difficulties with her mother she was also feeling baby kick, buggy shopping, having a scan. Managing difficult relationship with her own mother while also developing her own role as a mother?
And in those couple of weeks, I'd felt the baby kick. We'd gone buggy shopping. We'd had our anomaly scan and I was like, she doesn't know any of this.	
And I got upset and like, I didn't have any preference for boy or girl. But at that stage, I kind of deep down had a preference then for a girl because I was like, maybe I could rewrite, you know, and just have a different relationship with my daughter and stuff.	She became upset at the point of discovering the gender of baby. Becoming a reality? Having a baby girl could give the opportunity to rewrite history, and have a different relationship with her daughter.
And now that's not to say I'm like, I am close to my mother. We've had great times as well, but it's just very complex relationship through the goods and the bads.	But is she not as close to her mother as she wants?
So yeah, around the 18/22 weeks, I was like, will we find out sex?	Complex relationship with her mother due to mental health needs of mother.

It was all kind of in my own head.	
And then so I just convinced myself I was having a boy so that I wouldn't be disappointed because I was like, I don't want that poor boy to feel like I don't want him or don't love him. Now it ended up being a girl, but I wouldn't even watch like I got signed off in 27 weeks and I wouldn't even watch Gilmore Girls because it's all about because everyone's like, you should watch Gilmore Girls if you've never watched it.	Convinced herself she was having a boy to avoid any dissapointment. Surpressing her own desires of baby? guilt or shame to supress? Signed off work at 27 weeks and avoided watching gilmore girls due to mother & daughter relationship.
I couldn't watch it because I was like, no, because it'll make me want a girl. And I don't want to do that to the boy because I was convinced I was having a boy. So yeah, that was sorry.	Can't watch programme because it will trigger my needs? Avoidance of uncomfortable feelings related to her mother and unborn?
I totally forgot about that.	totally forgot about the experience of some of these difficult emotions in pregnancy
So then when I did have the baby, just yeah, just reared up so much like anger, upset, empathy, understanding, like, you know, I was like because I breastfed as well.	The difficult experiences with her mother reared up anger, upset, empathy, understanding. This is quite an array of emotions when baby was born.
And I just remember being like 3 O clock in the morning being like, despite all the bad things, my mum still did this part. She still could fed me.	She recalls breastfeeding her baby, at 3am, thinking despite all the bad things my mother did, she still did this part. her mum still fed her. Sitting in the still of the night alone, and how much this takes as a new mum maybe gave her empathy and appreciation for her own mums circumstances?
She still did the night feeds, you know, but then also anger at all the other stuff she did and how come she didn't protect me and how god like ...so overwhelming.	empathy for what her mother did and anger and what she did not do - protecting her. It was very overwhelming for her to have all these feelings.
Just all of the, it all just came to and like, I've dealt with that in counselling before, but it was just the becoming a mum really just absolutely knocked me for six.	She had processed her own relationship with her mother in counselling before,but becoming a mother knocked her for six.

Appendix O

Creating PETs from Statements

PET 3: Paper thin walls

Consultant responds by suggesting she doesn't seem depressed and advises talking therapy rather than medication.

Participant hears HCP discuss her case next door. A shameful experience.

- Participant hears the conflicting HCP discussion regarding her suitability for support.

- Left feeling under pressure and scared

where the consultant then tries to speak on her behalf, suggesting her difficulties are not related to the birth trauma.

Subtheme: Shutters come down

- Disbelief and disappointment in the response to her seeking help, left to gather herself, and the shutters come down again.

- Poker face on to cope with the shame, self-protection, rejection.
- Felt dehumanized to be treated this way, particularly as an HCP herself.

Subtheme: HCP's gatekeeping resources

- Services/HCPs push responsibility to the woman when they feel they don't have the resources or skills.
- An unknown HCP enters and directly asks, "Is it because of the birth trauma?" because if so, she cannot be seen.
- Shuts down due to the pressure and fear of HCP approach, and the HCP dismisses her further, telling her to refer herself to birth reflections as she had decided it was birth trauma-related.

Appendix P

Example of Initial Creation of GETs

Unique journey into the perinatal period	Interplay of identity and mental health	Barriers in accessing support	Lasting connections
Miscarriage as the crux of later perinatal experience.	Navigating a new self Subtheme: A mental health professional with mental health needs	: Mistrust, systemic, healthcare Subtheme: Systemic barriers	External Validation subtheme: Positive relationships with skilled HCPS
Initial Expectations of pregnancy & Seeking Support	My Mother and becoming Mom	Barriers	
Anxiety in the context of fertility struggles	Mental health shifting throughout the pregnancy	Lack of Support from HCPs	PHN ready to hold at home