Received: 25 March 2022 | Accepted: 3 April 2024

DOI: 10.1111/papt.12527

RESEARCH ARTICLE

"It is not all glowing and kale smoothies": An exploration of mental health difficulties during pregnancy through women's voices

Alison Reddish[1,2] | **Lisa Golds**[2] | **Angus MacBeth**[1,2]

[1]NHS Grampian, Aberdeen, UK

[2]Clinical Psychology, School of Health in Social Science, University of Edinburgh, Edinburgh, Scotland, UK

Correspondence
Angus MacBeth, Clinical Psychology, The School of Health in Social Science, University of Edinburgh, Edinburgh, Scotland, UK.
Email: angus.macbeth@ed.ac.uk

Abstract

Objectives: This study aimed to explore the experiences of women with moderate-to-severe mental health difficulties during pregnancy, with a focus on establishing their psychological needs. Psychological distress caused by mental health difficulties during pregnancy is common and can significantly impact women and their babies. However, women's subjective experiences of difficulties with their mental health throughout pregnancy, alongside their experiences of staff, services and treatments are less well understood.

Design: In this qualitative study, an Interpretive Phenomenological Analysis (IPA) approach was used.

Methods: Semi-structured interviews were conducted with participants recruited via a regional Perinatal Mental Health Service. Interviews were transcribed and analysed following the IPA methodology.

Results: Five superordinate themes were identified which represented the lived experiences of the 11 participants on their journey through pregnancy whilst living with mental health difficulties and subsequent psychological distress: (i) Feeling the 'wrong' feelings, (ii) Societal pressures and a desire for greater acceptance, (iii) Searching for answers despite a lack of resources, (iv) What made a difference and (v) Experiences and expectations of service provision. Within these themes, 13 subordinate themes were also identified.

Conclusions: These themes highlight the need for greater awareness and acceptance of mental health difficulties during pregnancy as well as postnatally. While perinatal mental health services are evolving, there is still an urgent

requirement for services to continue to develop to meet women's needs, as well as to develop the role of clinicians as facilitators of engagement with needs-matched care.

KEYWORDS
lived experience, mental health, perinatal, postnatal, pregnancy, qualitative

INTRODUCTION

Mental Health Difficulties during Pregnancy (MHDP) in pregnant women are common and often lead to moderate-to-severe psychological distress such as depression, anxiety or stress (Staneva et al., 2015). Prevalence rates for depression are estimated to be between 7% and 20% in pregnant women (Biaggi et al., 2016), while prevalence rates for anxiety are estimated at around 15% (Rubertsson et al., 2014). Additionally, 9% of pregnant women will receive a clinical diagnosis of co-morbid depression and anxiety disorders (Falah-Hassani et al., 2017). Increased distress associated with pre-existing mental health conditions, such as obsessive compulsive disorder (OCD) and eating disorders, is also prevalent (Howard & Khalifeh, 2020). Distress caused by MHDP is associated with a range of suboptimal outcomes for mother and infant, including birth complications (Gentile, 2017), low birth weight (Grote et al., 2010), attachment difficulties (Carter et al., 2001; Erickson et al., 2019) and childhood behavioural issues (Glover, 2014). Associations between under-treated psychological distress in women during the perinatal period and suicide remains a public health concern (Xiao et al., 2022).

In recent years, UK perinatal mental health (PMH) services have undergone significant transformation. In England, specific developments in service provision for perinatal mental health, particularly for women with moderate-to-severe perinatal mental health difficulties, emerged from the NHS Long Term Plan (NHS, 2019), including specialist community care, improved access to evidence-based psychological therapies (NHS Talking Therapies for Anxiety and Depression; formally IAPT) and mental health support for partners of women accessing PMH services. In Scotland, establishment of a Government Perinatal and Infant Mental Health Board (Scottish Government, 2019) initiated investment in increased access to Mother and Baby units, developing specialist community PMH services, supporting partners and families of women experiencing perinatal distress and investing in third-sector organisations providing peer support and counselling. The roll-out of these services continues, having been stalled during the COVID-19 pandemic, although notably perinatal distress increased during this period (26% for depression and 31% for anxiety; Tomfohr-Madsen et al., 2021).

Despite these clinical practice developments, there remains gaps in the understanding of the lived experiences of pregnant women engaging with PMH services, in contrast to the increased emphasis on quantitative outcomes, treatment data and the identification of barriers relating to PMH care (Smith et al., 2019). It has been suggested that PMH-related stigma is widespread, with women reporting resulting feelings of isolation, changes in relationships and delays in accessing treatment (Hadfield & Wittkowski, 2017; Oh et al., 2020), both ante- and postnatally (Brown, 2009). Women also report feeling judged by professionals, with worries that disclosing symptoms results in negative views of their ability to parent (Lever Taylor et al., 2021; McCauley et al., 2011). These issues are further nested within adversity and social determinants of mental health (Ban et al., 2012). Focusing solely on service and treatment outcomes, therefore, obscure consideration of other underlying needs. Research on women's lived experiences has also often focused on the postnatal period and has been parsed by diagnosis (e.g. Postnatal Depression [PND], post-partum psychosis and Post Traumatic Stress Disorder) rather than gaining a holistic, sensitive and needs-matched understanding of psychological distress and the transition towards greater wellbeing (Czarnocka & Slade, 2000; Glover et al., 2014; Leahy-Warren & McCarthy, 2007; Megnin-Viggars et al., 2015).

Two existing meta-syntheses of MHDP and distress based on common disorders, for example anxiety and depression (Staneva et al., 2015) and anxiety and stress (McCarthy et al., 2021) report overlapping themes. From a review of eight studies (Staneva et al., 2015) highlighted five core themes: (i) recognising that things are not right, (ii) dealing with stigma, (iii) negotiating the transformation, (iv) spiralling down, and (v) regaining control; whilst also highlighting a bias towards bio-medical perspectives within these studies, potentially obscuring women's accounts. Included studies focused on mild–moderate difficulties, fear related to childbirth and impact on maternal-foetal attachment, highlighting a gap in the understanding of the needs of women experiencing moderate-to-severe MHDP. Contrastingly, (McCarthy et al., 2021) identified 13 studies, with participants who were either experiencing distress during pregnancy or up to 1 year post-partum, again highlighting five core themes relating to (i) social support, (ii) women's experiences of health care, (iii) social norms and expectations, (iv) factors that impact on coping and (v) mother and baby's health (including 'women's health' and 'baby's health'). This themes also highlighted that unrealistic expectations of pregnancy and motherhood can lead to high levels of stress and anxiety throughout the perinatal period.

More recently, Oh et al. (2020) thematic analysis of 17 UK women with self-reported anxiety during pregnancy and the postnatal period identified three superordinate themes defined as (i) barriers to disclosing perinatal anxiety, (ii) help-seeking for perinatal anxiety and (iii) establishing and engaging support networks. Much of the discourse highlighted in the study revolved around feelings of stigma and shame. Similarly, (Hore et al., 2019) interpretative phenomenological analysis of the lived experiences of seven pregnant women in the UK identifying as having anxiety highlighted four superordinate themes: (i) adjustment to pregnancy and motherhood and the experiences of anxiety, (ii) unfamiliarity, uncertainty and uncontrollability of pregnancy influences anxiety, (iii) personal and social expectations and pressures of pregnancy and motherhood and (iv) relying on health care systems—the good and the bad. Finally, a thematic analysis of individual narrative interviews with 21 Canadian participants (Law et al., 2021) highlighted the importance of women being able to share their experiences of pregnancy and distress as an act of defining and redefining self-identity within the perinatal period. While these studies demonstrate overlapping themes of importance to women, there is still scope to understand women's experiences in-depth during pregnancy specifically.

Further as many PMH services are still in development or early roll-out, there is a paucity of understanding regarding psychological needs and how this informs provisioning of services in practice, although preliminary findings suggest that these services are well received (Millett et al., 2018). Indeed, NHS Talking Therapies for Anxiety and Depression represents only one approach to psychologically informed treatment provision and is weighted towards mild-to-moderate, rather than moderate-to-severe mental health difficulties (Millett et al., 2018). Setting is also important and there may be additional aspects of access, place, community and isolation that relate to service provision in rural settings, which have hitherto been under-researched (Jackson et al., 2020).

Accordingly, understanding the unique lived experiences of women during pregnancy and identifying psychologically informed needs is vital to the ongoing development of services and needs-matched, sensitive care, ensuring that services are invested in and developed in a way that is appropriate and effective for women's needs. The current study explored the experiences of women with moderate psychological distress caused by mental health difficulties during their pregnancy. Specifically, we asked:

- What were the lived experiences of women with psychological needs and other unmet needs experiencing moderate-to-severe psychological distress during pregnancy?
- What were the expectations of women attending perinatal services of pregnancy and wellbeing during pregnancy?
- Were there barriers to optimal care?

METHOD

Design

This qualitative study used Interpretive Phenomenological Analysis (IPA), an approach focused on exploring life experiences and how people make sense of these, drawing upon phenomenology, hermeneutics and idiography (Smith et al., 2009). IPA requires lived experiences to be explored on their own terms without use of a pre-set hypothesis of what the research will establish, with acknowledgement that both researcher and participants are part of the sense making process (Smith et al., 2009). An IPA approach enables us to explore the lived experiences of women living with distress caused by mental health difficulties during pregnancy, and how they made sense of their own unique experience.

Ethics

The study had ethical approval from the NHS South East Scotland Research Ethics Committee (REC: 17/SS/0030) and had local Research and Development approval.

Participant inclusion and exclusion criteria

Participants were eligible if they were experiencing or had experienced moderate-to-severe distress caused by MHDP (as identified by their lead clinician) during pregnancy, were aged between 18 and 55 years and were able to provide informed consent. Participants were excluded if they had known current child protection concerns, were non-fluent English speakers, were experiencing acute distress as identified by the lead clinician involved in their care or lacked capacity to consent to participating in active research.

Recruitment

Recruitment took place via a local NHS Perinatal Mental Health Service (PMHS) in Northern Scotland, covering both urban and rural settings from August 2017 to March 2018. While only one local service was used to recruit participants, the health board in which it was located served a geographically large and diverse area, including both rural and urban communities. As it was assumed that barriers to access such as stigma would create problems in recruitment (Viveiros & Darling, 2018), convenience sampling was utilised, using purposive sampling methods. As such, staff within the service identified potential participants and informed consent was taken by researcher 1. Although clinicians in the service were provided with a list of possible mental health difficulties to consider, inclusion was not dictated by diagnosis specifically, given the focus on distress. Following a 'real-life' approach to sampling, women were recruited regardless of previous history of mental health difficulties. Similarly, women who were first time mothers or had already given birth to children previously were all eligible for recruitment. In order to recruit an appropriate sample size, we decided a priori to continue recruitment until 14 participants had expressed interest in the study. It was felt that this number would allow for dropouts, whilst still maintaining an appropriate number of participants to uncover depth in the narratives, rather than breadth from a larger sample (Pietkiewicz & Smith, 2014). While all women who were recruited were known to experience distress during pregnancy, a majority of the participants (82%) took part in interviews during the postnatal period. All interviews took place within local NHS facilities.

Data collection

Data was collected via semi-structured interviews, following IPA principles (Smith et al., 2009). Each interview was conducted by the researcher and recorded using digital recorders. Interviews took an average of 82 min (range = 60–110 min). An interview schedule was used as a starting point for interviews, with interview content subsequently guided by participants (see Appendix 1 for topic guide). Participants could choose not to answer any questions and had control over what material they shared during the interview.

Analysis

Data analysis was primarily undertaken by researcher 1, utilising word documents for line by line coding of verbatim transcribed transcripts. They noted descriptive, linguistic and conceptual comments consistent with existing approaches (Smith et al., 2009). From this initial coding further word documents were created to conceptualise patterns and develop themes. These were explored in relation to each originating transcript ensuring a degree of fit with each participant's overall narrative. Subsequently, themes were printed, and the researcher grouped these together to understand patterns across all transcripts. Superordinate and subordinate themes were developed from these patterns, informing the final write up of themes. The third researcher also undertook this process for multiple transcripts independently and the researchers discussed these themes to establish a consensus reading of the scripts. Alongside coding, a reflective log was utilised by the main researcher, to note and identify any possible biases in the reflections of the researcher in order to minimise the influence of these upon interpretations from the coding. At write up stage, written descriptions of each theme were also discussed by the research team to ensure these were consistent with the interviews. A sample size of 8–12 participants was agreed within the research team to be appropriate based on existing guidance (Smith et al., 2009) and resource constraints.

Reflexivity

In keeping with the main principles of IPA, the research approach focused on the phenomenological perspective, ensuring that the experiences of participants and the perception of these experiences were foreground, achieved through a succession of hermeneutic loops. The researcher was guided by a social constructionist stance in keeping with Smith et al. (2009). Reflexivity denotes consideration of the influence of the researcher in the construction of meaning throughout the research process (Nightingale & Cromby, 1999). The primary researcher was a white, female trainee clinical psychologist with experience of working with individuals experiencing psychological distress, although not specifically during pregnancy. Experience of supporting individuals in distress and building empathic relationships with individuals was thought to be a positive quality that could benefit participant engagement. The researcher did not have personal experience of pregnancy, a factor that could impact on the construction of meaning. The primary researcher kept a reflective log that was updated after each interview and then reviewed throughout the analysis process. These notes included reflections on own potential biases. Additionally, throughout the analysis process the potential themes and reflections were discussed within the research team. Researcher 2 was a white, female PhD researcher with research and policy experience of perinatal mental health. Researcher 3 was a white, male clinical psychologist and academic, with extensive research experience in perinatal, maternal and infant mental health, and clinical experience across health service and non-governmental sector in working with adult mental health, including perinatal groups. They were also a parent. The latter 2 researchers were not involved in direct participant interviews.

Trustworthiness and rigour

To ensure all themes were fully grounded in the narrative data, the approach to analysis was reflexive and collaborative. In-depth discussions between researcher 1 and researcher 2 ensured that the interpretation of the themes was consistent and relevant to the participants' narratives rather than being influenced by the researcher's own experiences (Smith et al., 2009). Both levels of themes were discussed in-depth to ensure consistency with the IPA approach. Two interviews were also coded by researcher 3, to fully compare themes and ensure consistency across researchers' interpretations.

RESULTS

Participant characteristics

Fourteen women expressed interest in participating, although three did not reply to subsequent contact. A total of $n = 11$ women who had experienced moderate distress due to MHDP participated—seven women from an urban setting and four from a rural location. Although eligible to participate, no women with severe MHDP (e.g. psychosis) participated in the study. The participants' psychological distress was associated with diagnoses (including comorbidities) of single episode or recurrent moderate depression, persistent anxiety disorders or eating disorders. All participants were recruited via the PMHS and were engaged with services. Most women who participated ($n = 9$) had already given birth prior to the interview and described their experiences retrospectively. Interviews being held postnatally reflected the timing of referral to services as many participants were seen towards the latter stages of pregnancy, and it was felt most appropriate to interview them post birth. Participant ages were given as a range to reduce identifiability risks, with one participant was aged 18–25 years; four were aged between 26 and 34 years and the remaining six participants were aged between 35 and 40 years. Further demographic information is listed in Table 1.

To ensure full anonymity, participants will be referred to as P1–P11, as it was felt that assigning pseudonyms, ad hoc and without consultation with each participant, could influence how the participant

TABLE 1 Participant demographics.[a]

Participant number	Main reasons for referral to PMHS	History of mental health difficulties	First pregnancy?
1	Depression and anxiety	Yes	No
2	Depression and anxiety	Yes	No
3	Depression and anxiety	No	Yes
4	Depression and anxiety	Yes	No
5	Depression, anxiety and eating disorder	Yes	Yes
6	Depression and anxiety	Yes	Yes
7	Anxiety and depression	No	Yes
8	Depression, anxiety and eating disorder	Yes	No
9	Anxiety and depression	No	No
10	Depression and OCD	No	Yes
11	Depression and anxiety	Yes	No

Abbreviation: PMHS, Perinatal Mental Health Services.

[a]Further details were not collected in order to maintain the anonymity of participants.

is perceived, as names are often aligned to specific ethnicities, age groups and socioeconomic status etc. (Allen & Wiles, 2016). It has also been suggested that assigned pseudonyms can make participants feel separated from their own stories, as though the experiences within the narrative do not belong to them anymore (Lahman et al., 2015).

Qualitative findings

Across the interviews multiple themes were identified and from these, five superordinate themes arose comprising: (i) Feeling the 'wrong' feelings, (ii) Societal pressures and a desire for greater acceptance, (iii) Searching for answers despite a lack of resources, (iv) What made a difference and (v) Experiences and expectations of service provision. Figure 1 represents the women's journeys of how they experienced their own distress throughout pregnancy, as well as the relationship between these superordinate themes. Subordinate themes are also represented within Figure 1, suggesting the manner in which these themes have affected the lived experiences of the participants. Each superordinate and subordinate theme is discussed below, with key indicative quotes.

Superordinate theme 1: Feeling the 'wrong' feelings

All participants described intense emotional experiences, with daily impacts on functioning. These experiences were defined as Superordinate Theme 1: 'Feeling the "wrong" feelings'. For many there was a sense that they had to endure these feelings alone and that they had 'survived'. Participants often described conflicted feelings, still experiencing the joy of pregnancy at times, whilst then feeling incredibly low or anxious. Such emotional conflict was often seen as disconcerting. This theme consisted of two subordinate themes.

> It was awful, it was anxiety I had panic attacks… it was like drowning.
>
> P3

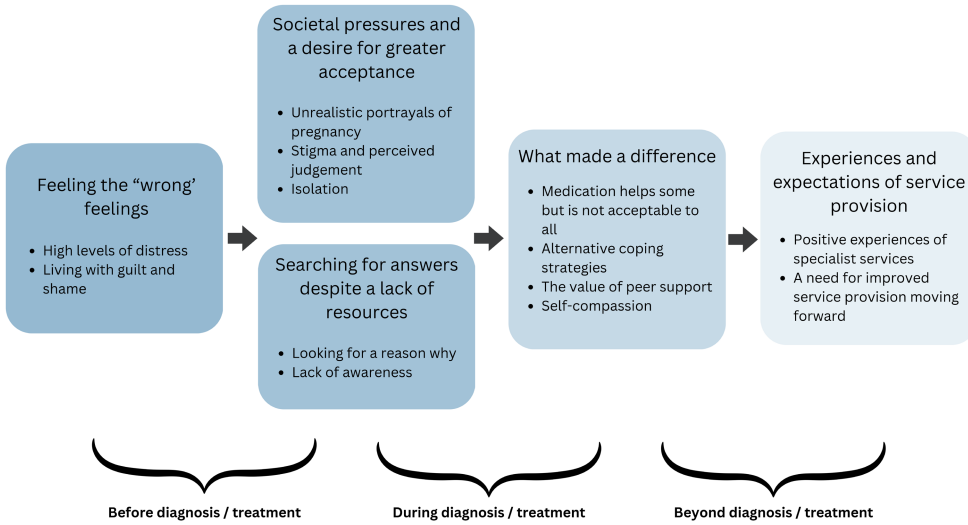

FIGURE 1 Superordinate and subordinate themes.

Subordinate theme 1.1: High levels of distress

Many participants described feeling out of control, due to how extreme their emotions felt or not understanding why they were feeling that way, which exacerbated their distress.

> I felt like the thoughts were out of control a little bit and it wasn't, well now I know they're intrusive thoughts.
>
> P8

Feelings of exhaustion were also commonly expressed, attributed to a combination of the physical impact of pregnancy and poor mental health outcomes.

> I was exhausted anyway for being pregnant, but I was absolutely shattered but I wasn't sleeping. I just you were lucky if I slept two or three hours.
>
> P4

> I just constantly felt like I'd been hit by a bus.
>
> P5

Additionally, many participants felt that these intense feelings would never end and reported that they had expected to only feel worse when trying to cope once their baby was born.

> You just can't see the end of it, you can't see the light at the end of the tunnel, you feel like everything is just going to keep getting more difficult and you're going to bring this baby into the world and it's going to be even more difficult.
>
> P4

Subordinate theme 1.2: Living with guilt and shame

Often participants had felt trapped by their thoughts, and many described feeling ashamed by the thoughts they had. Several participants expressed feeling disconnected from their pregnancy. They noted not feeling the bond or connection that they had expected, which often reinforced their distress. Some remarked that not connecting with the pregnancy may have been a way of coping, a sense of keeping their distance in case something went wrong.

> …just that kind of numbness and just feeling disconnected from yourself and everyone else and, and the pregnancy as well you know from the baby and then that cycle of then that leading to you feeling guilt, because you felt that way about, about the baby.
>
> P11

Guilt and shame were common to all interviews, with participants often describing themselves using self-critical language. Guilt was often expressed for having had ego-dystonic thoughts, having felt different from their peers or related to comments received from others.

> I felt guilty, like pretty much through the whole pregnancy for feeling the way that I did.
>
> P6

Superordinate theme 2: Societal pressures and a desire for greater acceptance

The influence of society was powerfully reflected throughout the interviews, as reflected in Superordinate Theme 2. All participants felt as though they had not lived up to the expectations of what it means to be pregnant. In turn, this experience of perceived failure reinforced feelings of stigma and perceived judgement from society in general, leading to participants feeling as though they had become isolated at a time when they most needed support. This theme consisted of three subordinate themes.

> I feel like everyone who was ever pregnant and spoke to me lied to me (laughter) that's what I feel like and people say things now like oh we never wanted to say to you what it was like, you don't want to scare someone and you're like you could have given me a heads up.
>
> P6

Subordinate theme 2.1: Unrealistic portrayals of pregnancy

Perceived expectations from others impacted on participant's expectations about pregnancy, with reinforced feelings of guilt and shame when the participant's experience did not correspond to what was expected. Many participants highlighted the portrayal of pregnancy as an idyllic time without difficulty and referred to a lack of discourse around the harder elements of pregnancy and being pregnant. Most described the impact of pregnancy on their physical and mental health as contrasting with this 'glowing' portrayal. There was a strong sense that this discourse needs to change as the difference between expectations and reality increased levels of distress and shame. There was a need for a realistic portrayal of pregnancy, that highlighted its individual nature and difficulties, as well as the positive elements.

> I suppose until I got pregnant myself, I would have bought into it, but then you suddenly realise no you feel sick, you've got heartburn, you ache, you're heavy, you can't do anything it's not all joyous.
>
> P6

Additionally, many described an expectation from society about how one *should* feel during pregnancy with a repeated suggestion that one should feel happy and excited without experiencing negative emotions. Again, feeling different from how one expected to feel compounded perceptions of shame and alienation during pregnancy and acted as a barrier to disclosing these 'wrong' feelings to others.

> You're just meant to feel happy when you're pregnant. People expect you to be um happy and glowing.
>
> P1

Subordinate theme 2.2: Stigma and perceived judgement

Each participant described ways in which they felt they had to hide how they had been feeling and how they had experienced a perceived judgement from others.

> There's such stigma still associated probably with, well mental health in general but to have mental health problems in pregnancy it's still something that, it's not discussed.
>
> P8

Many participants conveyed their need for acceptance within society as well as by themselves. The experience of feeling judged by others was commonplace, as were experiences of stigma. Participants reported either experiencing open negative comments or perceiving others as silently judging them.

> …when I asked for help, but you feel like you can't, because what are they going to think of me if I can't do this.
>
> P6

> …mentally thinking oh I'm such a dreadful mother, um, you know there's all these risks with taking drugs during pregnancy all these perfect mothers online go on about how they drink kale smoothies and here I am taking horrible chemicals.
>
> P9

Subordinate theme 2.3: Isolation

These feelings of perceived judgement became a barrier to many women disclosing their true feelings and in turn resulted in participants feeling intensely isolated.

> I was very good at putting a mask on things and pretending everything was ok and I think maybe part of that, that ends up feeling quite alone.
>
> P11

Many participants attributed the development of, or exacerbation of, difficulties to hiding their feelings and feeling judged by others. This sense of isolation contrasted with a perception that feeling accepted, or hearing about other women's difficulties, would, conversely, have positively impacted on their experiences.

> …definitely felt quite alone and isolating in that way as well, because um I didn't know of anyone else who had certainly ever said that they'd had um any issues in pregnancy.
>
> P11

> I say that kind of isolation I guess isn't quite so bad if there's other people that are kind of going through the same thing.
>
> P5

Superordinate theme 3: Searching for answers despite a lack of resources

In this Superordinate Theme, participants reported trying to make sense of why they experienced psychological distress and reflecting on possible influences. The need for greater awareness of mental health difficulties during pregnancy was highlighted in all interviews, and many participants emphasised this need as a key message. This theme consisted of two subordinate themes.

Subordinate theme 3.1: Looking for a reason why

Focusing on a biological or medical explanation for mental distress was commonplace. There was a sense that this explanation was often provided by services with no alternative offered. However, in some cases, receiving such an explanation was perceived as disempowering for participants and left them feeling that there was nothing they could have done and that their difficulties were inevitable.

> I can't fix my head there's nothing I can do about my head it's, your hormones are so my hormones were a mess.
>
> P1

Despite these feelings of disempowerment, there was often a sense that participants had been searching for further understanding of why they had difficult experiences. As part of this search for an explanation, participants often reflected on their past experiences of mental health.

> I was depressed and sometimes I think there's two types of depression. I think there's the depression where it's completely chemical in your head and you can't do anything and there's situational depression where there's something that you need to change.
>
> P1

Subordinate theme 3.2: Lack of awareness

There was a strong sense from the participants of being unaware of perinatal mental health distress until they experienced it personally, precipitating difficulties identifying from whom to seek support.

> Nobody had heard of it before. Everybody's heard of postnatal depression.
>
> P1

A lack of awareness from those around them also impacted on their wellbeing and accessing of appropriate support services. There was a recognition that individually and societally there is an awareness of postnatal depression (PND), with it often highlighted by services without additional difficulties in pregnancy even being considered, which some participants expressed as having led to feelings of alienation and frustration.

> I was shocked to find out how common it was and I was like I can't believe that nothing is done to make people aware.
>
> P1

The need for more information and additional resources was discussed in most interviews. Many participants tried to find information for themselves, commenting that little was available, and it was difficult to find.

> I think there's definitely less information out there about it during pregnancy.
>
> P11

> I just feel like there's no information on it.
>
> P1

Superordinate theme 4: What made a difference

The first three themes reflect the sense from most of the interviews that women experienced very little which they felt helped them to feel less distressed during their pregnancy. However, and despite having experienced little alleviation to their own distress, when reflecting on their experiences, many of the women had a sense of what could have helped, often focusing their narrative on a feeling of what could have been. This theme was defined as Superordinate Theme 4: 'What made a difference' and consisted of four subordinate themes.

Subordinate theme 4.1: Medication helps some but is not acceptable to all

All participants described feeling concerned about the possible harmful impacts of medication on their unborn baby. For some, this concern stopped them from taking medication until postnatally.

> If I had the opportunity to take medication I wouldn't during pregnancy. There is no way, knowing myself that I would have. I would be begging for some consultation, some doctor with a specialist, like a psychologist, a psychiatrist a mental, a person that is specialist in mental health.
>
> P3

Other participants felt the benefit to their mental health outweighed the potential risks. Overall, there was a desire for clearer information about medication.

> …talked about it (medication) with the GP and at that stage I wasn't very keen…but by the time I saw specialist midwife I was still struggling, and I was getting tired and I knew I wasn't right so she suggested it and I said yes, now is the time.
>
> P9

Subordinate theme 4.2: Alternative coping strategies

The participants often reflected on looking for alternative ways of coping. There was a sense that pregnancy-related changes (both physical and lifestyle) often acted as a barrier to accessing prior coping methods.

> There's probably things like keeping busy helps, but I haven't got the energy, so that's very difficult um walking, you know just gentle exercise, but again I can't even just to go down into town.
>
> P9

Despite the sense of hopelessness and lack of relief there was also a perception that short-term relief was possible for some, often obtained by seeking reassurance from health professionals. A small number of participants made use of coping strategies during their pregnancy including mindfulness or focusing on their children to motivate them.

> I started doing mindfulness during pregnancy and I did find that really beneficial.
>
> P11

Those who found mindfulness beneficial had previously engaged with mindfulness prior to pregnancy. Several women in the sample also stated they had no previous experience of such techniques or other psychological strategies to improve mental health during pregnancy.

Subordinate theme 4.3: The value of peer support

Additionally, a number of participants highlighted the role of peer support in accepting and combatting the feelings associated with negative experiences. Being able to share with, and gain support, from others who had lived through the same experiences was crucial for some participants.

> …just to see that other people have gone through this and have seen the end of it.
>
> P2

Talking to others, whether it had been through informal support networks, peers or professionals was repeatedly highlighted as an invaluable way of coping, although many women did not experience this support during their pregnancy. Participants described the benefits of having a non-judgemental space in which to talk, having another's perspective, and not being left alone with their feelings.

> It was very, very helpful talking with them because I didn't have to hide, I didn't have to pretend that I'm happy.
>
> P3

Subordinate theme 4.4: Self-compassion

A clear sense of the need for self-compassion arose across the narratives, often articulated as a message to others who may be going through similar experiences. This message contrasted with the self-criticism and blame which often surfaced when participants described their own experiences. Many of the participants did not appear to be compassionate towards themselves during pregnancy and while reflecting on their experiences often spoke in a self-critical manner and yet conveyed the need for others to be kinder to themselves.

> …but in actual fact you haven't had a minute to sit down and actually really think about everything that's happened or changed.
>
> P4

By communicating their thoughts about what could have helped, the participants also appeared to be making a suggestion of what could help others in the future. From many of the participants there was a sense that taking more time and space to think and reflect on the life changes they had experienced during pregnancy would have helped, a sense that there was a need for adjustment. A few participants experienced improvements in their mood whilst taking a break from work, whereby reducing environmental stressors also provided them with more time to reflect and adapt. Others wondered if such a break could have made a difference to their experience when they started to struggle.

> I think looking at the tiny little achievements throughout the day the fact that you got your shower, the fact that you went to your bed on time, the fact that you didn't eat that cake, or you ate that cake and you don't feel guilty about it you know silly things like that the anxiety will go away, well it might not all go away altogether because I know mine won't ever all go away altogether but it does get easier to cope with.
>
> P4

> Hang on in there, it will get better.
>
> P1

Superordinate theme 5: Experiences and expectations of service provision

This theme reflects that most participants commented on their experiences of engaging with mental health services. While many participants were happy with the level of service that they received on an individual level, the women's narratives spoke of the need for systemic changes to take place to

ensure that mental health services were accessible and effective for all. This theme consisted of two subordinate themes.

Subordinate theme 5.1: Positive experiences of specialist services

Many reflected positively on their experience with specialist perinatal mental health services, emphasising the value of non-judgemental listening in having facilitated the disclosure of their thoughts and feelings, and the benefit of talking with staff who had worked with other women going through similar experiences.

> It has been really helpful to talk to specialist midwife to hear that it's normal, other people go through these things and just to talk it all out really, just to say this is what's going on in my head, to verbalise what I'm feeling.
>
> P10

Despite positive experiences of specialist services, it was felt there was a need for earlier referrals. Participants were often not referred until postnatally, receiving no input during pregnancy. Many felt support was not available when they most needed it either due to delays in referrals, waiting times or felt it was difficult to open up to professionals in the initial stages of referral.

> I thought well that's like a long time [inaudible word] excuse my language, how's that going to help now? What's the point? It's what I was saying before like you need the help when you need the help not like months and months later when you've had to endure it on your own.
>
> P1

Subordinate theme 5.2: A need for improved service provision moving forward

Due to these delays in referral which many of the women experienced, there was a recognition of the need for increased knowledge and promotion of perinatal mental health within wider health services. Many participants described difficult experiences in routine health care, with some perceiving non-mental health staff to be lacking knowledge and, therefore, at times, having been insensitive in their responses. The need for services to create more open discussion about mental health during pregnancy was highlighted whether within maternity services prior to birth, antenatal education classes or at general health appointments.

> …pregnancy it's still something that, it's not discussed or even, like even in the antenatal clinic it's not advertised about mental health during pregnancy there's nothing on the walls or, or even like I think there maybe was one poster in one room about a support group, but other than that there's no leaflets or um nothing to promote um positive mental health like I think, there's nothing advertising it.
>
> P8

A lack of communication between services caused difficulties for many participants, and at times, participants felt torn between conflicting advice that they received between the services that they were attending.

> I think had there been a better link between my GP, the psychiatrist and my psychotherapist it probably would have been a lot smoother for me instead of having to go and tell the story three times, basically every time.
>
> P6

The importance of continuity of care was highlighted throughout, and a lack of continuity was highlighted as a key barrier to disclosing distress symptoms. Participants reflected that time was required to build up relationships with professionals and that this particular feature of service provision was often a facilitating factor in feeling they could talk about their mental health. Many participants valued supportive relationships with professionals during their pregnancy including with community midwives and therapists. A number of participants noted that consultant led antenatal care often resulted in seeing multiple doctors, and receiving less time with midwives, creating a barrier to opening up about their feelings and their needs.

> You see a different registrar every time, but that's it is that continuity of care, um and you know I can't fault anything that's been said or done, but I haven't got that same level of comfort that I had last time.
>
> P8

DISCUSSION

This study provides an insight into the lived experiences of women with moderate MHDP-related distress, and the needs they may have. A strength of the study is that participants were recruited from a mixed urban/rural area and, therefore, reflect a hitherto under-researched group (Jackson et al., 2020). While there is an existing body of literature focussing on the unique needs of pregnant women in the perinatal period, the findings provide novel evidence of the alignment between the narratives of women and recent, ongoing developments in service provision, specifically in the UK and in nation countries such as Scotland.

Consistent with findings from recent studies (Jackson et al., 2020; Lever Taylor et al., 2021), our participants emphasised a wider understanding of PMH as a public health and societal priority, evidenced in the key themes of 'societal pressures and a desire for greater acceptance' and 'searching for answers despite a lack of resources'. Balanced against this was a sense from many participants that there is little awareness of MHDP within certain areas of public health services, reflecting the corrosive role of barriers to care for this group (Smith et al., 2019). The 'societal pressures and a desire for greater acceptance' could also be interpreted through the lens of stigma, with an underlying sense that participants felt isolated and needed to hide how they felt. Furthermore, the theme of 'feeling the wrong feelings' reflected how intense and distressing MHDP can be, with women clearly communicating, in a powerful manner, how difficult the lived experiences of MHDP are. These findings are similar to existing work from a mainly postnatal sample relating to the experience of PMH in rural communities (Jackson et al., 2020).

We also identified a theme denoting 'searching for answers despite a lack of resources': a sense that participants tried to understand why they were experiencing such difficulties even though there was a lack of awareness surrounding these issues. This search for meaning, alongside the theme of 'what made a difference' and 'experiences and expectations of service provision', highlights the need for the development of a more holistic approach to health care provision for women experiencing distress caused by MHDP. These highlighted themes also resonate with a consistent theme in the literature around a bias towards biomedically derived explanations of MHDP, at least in the context of routine practice. Finally, the theme of 'societal pressures and a desire for greater acceptance' highlighted the role society plays in understanding and acceptance of MHDP, a theme found in prior research focused postnatally (Dolman et al., 2013) and again highlighting public health priorities (Maternal Mental Health Alliance, 2022).

One interpretation of our findings points to a tension between self- and other-related elements of participant's lived experiences. Self-related concepts identified within the narratives relate to themes of 'feeling the wrong feelings', 'searching for answers despite a lack of resources', and 'what made a difference'. In contrast, themes of 'societal pressures and a desire for greater acceptance' and 'experiences and expectations of service provision' related more to how participants reflected on their experiences of others' perceptions of mental health during pregnancy. A thread throughout the interviews was the importance of awareness and open discourse—including being open to talk to others about 'wrong' feelings,

discourse to normalise and increase acceptance, as well as the need for services, health professionals and society to share more information and resources about mental health difficulties during pregnancy. This suggestion may have implications for public health services vis a vis how options for care of MHDP are communicated to women and could be important in improving experiences during pregnancy.

The themes also resonate with concepts of basic psychological needs such as relatedness (Deci & Ryan, 2000) and belongingness (Baumeister & Leary, 1995). These parallels highlight the overlap between the needs identified in the study and universal psychological needs, suggesting commonality in the experience of MHDP-related distress. However, there may be key experiences during pregnancy that drive the 'desire for greater acceptance', including the impact of feeling different from peers, experiences of stigma and the value of peer support. The challenge of coping with highly intense emotional states during pregnancy, which occurs alongside the many physiological changes/difficulties (such as changes to body image, hormonal changes, physical pain and fatigue) across the perinatal period may differentiate pregnancy from other potentially stressful life events. Furthermore, the permanent changes to women's lives, relationships and, potentially, to their identities, that take place following pregnancy, as they adjust to motherhood, may separate pregnancy from other stressful life events that could have more of a temporary impact on people's lives.

Implications for clinical practice

Due to recent developments in perinatal mental health service provision across the UK, it is important to consider how the narratives of women with lived experiences match up to the services with which they are currently being provided. The co-occurrence of distress which is often caused by high levels of emotional intensity alongside, for some, positive moments in pregnancy presents a unique need. Services could partly address these feelings of dissonance by normalising the range of emotions experienced during pregnancy.

There are also implications around expectations of services and barriers to accessing help. The women's narratives suggest that the impact of a lack of awareness resulted in women not realising that help was available or appropriate, often women did not perceive what they were experiencing as being mental health difficulties, which was a clear barrier to accessing help. Lack of acceptance often resulted in women not disclosing how they were truly feeling causing an additional barrier to necessary help. This hesitance to talk about negative experiences reflects contemporary findings that suggest stigma leads to delays in accessing treatment and to isolation for women in distress (Hadfield & Wittkowski, 2017). Women's expectations of wellbeing were highlighted in the societal influence theme, although too often, expectations were different from the reality of their experience which furthered distress and feelings of alienation, also resulting in a barrier to help-seeking. Stigma has been highlighted across health policy as an area of mental health provision which needs to be addressed more fully. For example, the Scottish Government Perinatal and Infant Mental Health Programme Board have included removal of stigma within their equalities impact assessments (Scottish Government, 2021) as well as working closely with third-sector organisations to create toolkits to tackle stigma around PMH (See Me Scotland, N.D.). Importantly, this implication suggests that the needs of women are taken into account when designing mental health services, although it is likely that much more can be done to remove stigma from mental health issues within the perinatal period (Law et al., 2021; Moore et al., 2020). The themes relating to societal pressures and the impact of unrealistic expectations of pregnancy were also consistent with previous research, highlighting the gap between expectations and reality (Dolman et al., 2013; Staneva & Wittkowski, 2013). This theme relates to previously identified 'myths of motherhood' and expecting to be able to meet unrealistic expectations of society, often described as the 'superwoman' ideal that new mothers must conform to (Oakley, 2018). For our participants, the gap between this ideal and the reality of their experience negatively impacted on their wellbeing and prevented them from sharing their feelings and seeking

help. This dissonance also relates to stigma (Staneva et al., 2015), highlighting the idea of the 'perfect pregnancy' and 'what is proper for a pregnant woman to do, eat and feel', with perceived failure to conform reinforcing shame, inadequacy and self-stigma (Staneva et al., 2015). Knowledge of these experiences would create direct clinical implications for clinicians involved in antenatal care who could take a preventative approach, encouraging discussions about pregnancy expectations and promoting a 'sensible image of motherhood' (Staneva & Wittkowski, 2013).

When discussing 'societal pressures and a desire for greater acceptance', all of the participants' narratives were consistent with results of other studies, highlighting the importance of compassionate understanding both ante- and postnatally (Dolman et al., 2013; Megnin-Viggars et al., 2015; Staneva et al., 2015). In addition, the value that each woman placed on the access to peer support echoes observations of peer support as a safety net (Staneva et al., 2015). The normalising and validating power of peer support appeared to be a key part of acceptance, suggesting there is a need for more opportunities for pregnant women to access peer support. Access to peer support has also been written into the Scottish Government's action plan for developing PMH services (Scottish Government, 2021), once again suggesting that women's voices are being heard as part of service development. However, our participants often felt as though this support was provided too late in their pregnancy journey, so it is important for clinical services to provide such assistance early and efficiently, by removing stigma from the need for external support.

The need for wider treatment options and the promotion of wider coping strategies than purely medical treatment options was repeatedly raised. Therefore, there remains a need for services to have wider treatment options available including those recommended in clinical guidelines, such as psychological therapies (National Institute for Clinical Excellence, 2018). Further, if services cannot provide such options directly, there should be clear treatment pathways to access these and clinicians in specialist services should consider referring to such treatments and making individuals aware of a broader choice of treatment options including medication, psychological therapies and online support.

Limitations

We acknowledge a number of limitations. Firstly, there was risk of sampling bias due to the recruitment method—with the possibility of potential participants identified based on clinicians' subjective judgements of suitability. However, the researcher regularly met with clinicians to discuss recruitment and emphasised inclusion/exclusion criteria. Second, recruitment centred on one specialist service, biasing towards those already actively engaged with services. Although recruitment was focused on moderate–severe difficulties, rather than specific diagnoses, most participants experienced depression and anxiety disorders, and no participants opted in who experienced psychosis. These sample characteristics may have been a function of exclusion due to acute distress, clinicians' conservatism regarding referral, or individuals choosing not to opt in. Third, we note that narratives were mostly collected retrospectively, after treatment was complete. Therefore, recall bias may have been a factor in the narratives that the participants gave. This particular bias could be addressed in future studies by using prospective data collection alongside PMH treatment. Additionally, there were limits to the collection of demographic data and related contextual information. For instance, we did not collect the length of period since birth (for postnatal interviewees), or whether pregnancies were either IVF/ART related or medically high risk. The justification for collecting limited demographic data was to maintain participants' anonymity as much as possible; however, we acknowledge that without this contextual information the transferability of the study findings to other contexts is limited. Finally, we recognise that recruitment took place prior to the onset of the Covid-19 pandemic and our findings are, therefore, silent on the impact. However, in the context of work on mental health in general, societal change and social determinants of health during Covid-19, we tentatively conclude that our findings, particularly around isolation, stigma and support (Iyengar et al., 2021) still have resonance.

Considerations for future research

In terms of future research, it would be beneficial to determine the extent to which the themes constructed in this study resonate with other groups of women at risk of distress caused by MHDP, including ethnic minorities (Smith et al., 2019), migrant groups (Markey et al., 2022), LQBTQI+ families (Darwin & Greenfield, 2019), non-birthing partners (Lever Taylor et al., 2018) and other 'hard to reach' groups in pregnancy such as women using substances (Smith et al., 2019). Also, given adaptations in services as a result of increased provision of PMH services and the proliferation of different models of access to care that have emerged as a function of Covid-19 adaptations (such as self-directed and digital pathways to care) it would be of interest to conduct similar interviews with women utilising such sources of service provision. Other groups for targeted intervention could also include such as those accessing support from third-sector organisations as well as those not currently engaged with any support services.

CONCLUSION

The current study adds to the understanding of the lived experiences of women with MHDP, and the experiences of accessing services and interventions, informing a psychological understanding of these experiences. Our identified themes highlight an ongoing need to increase awareness of and normalise distress caused by MHDP, with potential links to the wider promotion of mental health outcomes within maternity services and a broader range of treatment options acceptable to women.

AUTHOR CONTRIBUTIONS

Alison Reddish: Conceptualization; data curation; formal analysis; investigation; methodology; project administration; writing – original draft. **Lisa Golds:** Formal analysis; writing – review and editing. **Angus MacBeth:** Conceptualization; data curation; methodology; supervision; writing – review and editing.

CONFLICT OF INTEREST STATEMENT

Dr MacBeth is a member of the NHS Scotland Perinatal Managed Care Network Steering group.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy and ethical restrictions.

ORCID

Angus MacBeth https://orcid.org/0000-0002-0618-044X

REFERENCES

Allen, R. E. S., & Wiles, J. L. (2016). A rose by any other name: Participants choosing research pseudonyms. *Qualitative Research in Psychology*, *13*(2), 149–165.

Ban, L., Gibson, J. E., West, J., Fiaschi, L., Oates, M. R., & Tata, L. J. (2012). Impact of socioeconomic deprivation on maternal perinatal mental illnesses presenting to UK general practice. *British Journal of General Practice*, *62*(603), e671–e678.

Baumeister, R. F., & Leary, M. R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*, *117*(3), 497–529. https://doi.org/10.1037/0033-2909.117.3.497

Biaggi, A., Conroy, S., Pawlby, S., & Pariante, C. M. (2016). Identifying the women at risk of antenatal anxiety and depression: A systematic review. *Journal of Affective Disorders*, *191*, 62–77.

Brown, M. (2009). Perinatal mental health services. *Primary Health Care*, *19*(8), 36–39.

Carter, A. S., Garrity-Rokous, F. E., Chazan-Cohen, R., Little, C., & Briggs-Gowan, M. J. (2001). Maternal depression and comorbidity: Predicting early parenting, attachment security, and toddler social-emotional problems and competencies. *Journal of the American Academy of Child & Adolescent Psychiatry*, *40*(1), 18–26.

Czarnocka, J., & Slade, P. (2000). Prevalence and predictors of post-traumatic stress symptoms following childbirth. *British Journal of Clinical Psychology*, *39*(1), 35–51.

Darwin, Z., & Greenfield, M. (2019). *Mothers and others: The invisibility of LGBTQ people in reproductive and infant psychology*, Vol. 37 (pp. 341–343). Taylor & Francis.

Deci, E. L., & Ryan, R. M. (2000). The "what" and "why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, *11*(4), 227–268.

Dolman, C., Jones, I., & Howard, L. M. (2013). Pre-conception to parenting: A systematic review and meta-synthesis of the qualitative literature on motherhood for women with severe mental illness. *Archives of Women's Mental Health*, *16*(3), 173–196.

Erickson, N., Julian, M., & Muzik, M. (2019). Perinatal depression, PTSD, and trauma: Impact on mother–infant attachment and interventions to mitigate the transmission of risk. *International Review of Psychiatry*, *31*(3), 245–263.

Falah-Hassani, K., Shiri, R., & Dennis, C.-L. (2017). The prevalence of antenatal and postnatal co-morbid anxiety and depression: A meta-analysis. *Psychological Medicine*, *47*(12), 2041–2053.

Gentile, S. (2017). Untreated depression during pregnancy: Short-and long-term effects in offspring. A systematic review. *Neuroscience*, *342*, 154–166.

Glover, L., Jomeen, J., Urquhart, T., & Martin, C. R. (2014). Puerperal psychosis–a qualitative study of women's experiences. *Journal of Reproductive and Infant Psychology*, *32*(3), 254–269.

Glover, V. (2014). Maternal depression, anxiety and stress during pregnancy and child outcome; what needs to be done. *Best Practice & Research. Clinical Obstetrics & Gynaecology*, *28*(1), 25–35.

Grote, N. K., Bridge, J. A., Gavin, A. R., Melville, J. L., Iyengar, S., & Katon, W. J. (2010). A meta-analysis of depression during pregnancy and the risk of preterm birth, low birth weight, and intrauterine growth restriction. *Archives of General Psychiatry*, *67*(10), 1012–1024.

Hadfield, H., & Wittkowski, A. (2017). Women's experiences of seeking and receiving psychological and psychosocial interventions for postpartum depression: A systematic review and thematic synthesis of the qualitative literature. *Journal of Midwifery & Women's Health*, *62*(6), 723–736.

Hore, B., Smith, D. M., & Wittkowski, A. (2019). Women's experiences of anxiety during pregnancy: An interpretative phenomenological analysis. *Journal of Psychiatry and Behavioral Sciences*, *14*, 15.

Howard, L. M., & Khalifeh, H. (2020). Perinatal mental health: A review of progress and challenges. *World Psychiatry*, *19*(3), 313–327.

Iyengar, U., Jaiprakash, B., Haitsuka, H., & Kim, S. (2021). One year into the pandemic: A systematic review of perinatal mental health outcomes during COVID-19. *Frontiers in Psychiatry*, *12*, 674194.

Jackson, K., Smart, D., Henderson, E. J., Newham, J. J., McGovern, R., Kaner, E., & Lingam, R. (2020). Exploring care from extended family through rural women's accounts of perinatal mental illness–a qualitative study with implications for policy and practice. *Health & Place*, *66*, 102427.

Lahman, M. K., Rodriguez, K. L., Moses, L., Griffin, K. M., Mendoza, B. M., & Yacoub, W. (2015). A rose by any other name is still a rose? Problematizing pseudonyms in research. *Qualitative Inquiry*, *21*(5), 445–453.

Law, S., Ormel, I., Babinski, S., Plett, D., Dionne, E., Schwartz, H., & Rozmovits, L. (2021). Dread and solace: Talking about perinatal mental health. *International Journal of Mental Health Nursing*, *30*, 1376–1385.

Leahy-Warren, P., & McCarthy, G. (2007). Postnatal depression: Prevalence, mothers' perspectives, and treatments. *Archives of Psychiatric Nursing*, *21*(2), 91–100.

Lever Taylor, B., Billings, J., Morant, N., & Johnson, S. (2018). How do women's partners view perinatal mental health services? A qualitative meta-synthesis. *Clinical Psychology & Psychotherapy*, *25*(1), 112–129.

Lever Taylor, B., Kandiah, A., Johnson, S., Howard, L. M., & Morant, N. (2021). A qualitative investigation of models of community mental health care for women with perinatal mental health problems. *Journal of Mental Health*, *30*(5), 594–600.

Markey, K., Noonan, M., Doody, O., Tuohy, T., Daly, T., Regan, C., & O'Donnell, C. (2022). Fostering collective approaches in supporting perinatal mental healthcare access for migrant women: A participatory Health Research study. *International Journal of Environmental Research and Public Health*, *19*(3), 1124.

Maternal Mental Health Alliance. (2022). https://maternalmentalhealthalliance.org/campaign/act-now/community/

McCarthy, M., Houghton, C., & Matvienko-Sikar, K. (2021). Women's experiences and perceptions of anxiety and stress during the perinatal period: A systematic review and qualitative evidence synthesis. *BMC Pregnancy and Childbirth*, *21*(1), 1–12.

McCauley, K., Elsom, S., Muir-Cochrane, E., & Lyneham, J. (2011). Midwives and assessment of perinatal mental health. *Journal of Psychiatric and Mental Health Nursing*, *18*(9), 786–795.

Megnin-Viggars, O., Symington, I., Howard, L. M., & Pilling, S. (2015). Experience of care for mental health problems in the antenatal or postnatal period for women in the UK: A systematic review and meta-synthesis of qualitative research. *Archives of Women's Mental Health*, *18*(6), 745–759.

Millett, L., Taylor, B. L., Howard, L. M., Bick, D., Stanley, N., & Johnson, S. (2018). Experiences of improving access to psychological therapy services for perinatal mental health difficulties: A qualitative study of women's and therapists' views. *Behavioural and Cognitive Psychotherapy*, *46*(4), 421–436.

Moore, D., Drey, N., & Ayers, S. (2020). A meta-synthesis of women's experiences of online forums for maternal mental illness and stigma. *Archives of Women's Mental Health*, *23*, 507–515.

National Institute for Clinical Excellence. (2018). Antenatal and postnatal mental health: clinical management and service guidance [NICE Guideline No. 192]. https://www.nice.org.uk/guidance/cg192
NHS. (2019). The NHS long term plan. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/
Nightingale, D., & Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice*. McGraw-Hill Education (UK).
Oakley, A. (2018). *From here to maternity (reissue): Becoming a mother*. Policy Press.
Oh, S., Chew-Graham, C. A., Silverwood, V., Shaheen, S. A., Walsh-House, J., Sumathipala, A., & Kingstone, T. (2020). Exploring women's experiences of identifying, negotiating and managing perinatal anxiety: A qualitative study. *BMJ Open*, *10*(12), e040731.
Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, *20*(1), 7–14.
Rubertsson, C., Hellström, J., Cross, M., & Sydsjö, G. (2014). Anxiety in early pregnancy: Prevalence and contributing factors. *Archives of Women's Mental Health*, *17*, 221–228.
Scottish Government. (2019). Delivering effective services: Needs assessment and service recommendations for specialist and universal perinatal mental health services. https://www.pmhn.scot.nhs.uk/delivering-effective-services/delivering-effective-services-report/
Scottish Government. (2021). Perinatal and infant mental health: Equalities impact assessment. https://www.gov.scot/publications/perinatal-infant-mental-health-eqia/pages/2/
See Me Scotland. (N.D.). Perinatal and infant mental health stigma. https://www.seemescotland.org/health-social-care/perinatal-and-infant-mental-health-stigma
Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. SAGE.
Smith, M. S., Lawrence, V., Sadler, E., & Easter, A. (2019). Barriers to accessing mental health services for women with perinatal mental illness: Systematic review and meta-synthesis of qualitative studies in the UK. *BMJ Open*, *9*(1), e024803.
Staneva, A., & Wittkowski, A. (2013). Exploring beliefs and expectations about motherhood in Bulgarian mothers: A qualitative study. *Midwifery*, *29*(3), 260–267.
Staneva, A. A., Bogossian, F., & Wittkowski, A. (2015). The experience of psychological distress, depression, and anxiety during pregnancy: A meta-synthesis of qualitative research. *Midwifery*, *31*(6), 563–573.
Tomfohr-Madsen, L. M., Racine, N., Giesbrecht, G. F., Lebel, C., & Madigan, S. (2021). Depression and anxiety in pregnancy during COVID-19: A rapid review and meta-analysis. *Psychiatry Research*, *300*, 113912.
Viveiros, C. J., & Darling, E. K. (2018). Barriers and facilitators of accessing perinatal mental health services: The perspectives of women receiving continuity of care midwifery. *Midwifery*, *65*, 8–15.
Xiao, M., Hu, Y., Huang, S., Wang, G., Zhao, J., & Lei, J. (2022). Prevalence of suicidal ideation in pregnancy and the postpartum: A systematic review and meta-analysis. *Journal of Affective Disorders*, *296*, 322–336.

How to cite this article: Reddish, A., Golds, L., & MacBeth, A. (2024). "It is not all glowing and kale smoothies": An exploration of mental health difficulties during pregnancy through women's voices. *Psychology and Psychotherapy: Theory, Research and Practice*, *00*, 1–21. https://doi.org/10.1111/papt.12527

APPENDIX 1

Topic guide and sample starter questions

Narrative around pregnancy

Suggested opening question: 'Tell me your story ….?'

Mental health and pregnancy

Suggested questions

'Can you tell me about what pregnancy has been like?'

'How has pregnancy impacted on your mental health?'

Reflection on experience

'Tell me about your experience since you've been pregnant, what's it been like for you?'

'What has been different since you've been pregnant?'
'What has been helpful'?
'What hasn't been helpful?'

Social supports
Do you talk to others about this? Who?

Reflection on involvement with mental health services
'Perinatal service? How did you become involved with the service?'
'What advice would you give to someone feeling a similar way?'
'Is there anything else you would like to talk about or tell me about?'