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The first antenatal appointment: An exploratory study of the experiences of women with a diagnosis of mental illness

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ABSTRACT

Objective: to explore and gain insight into the expectations and experiences of women with a pre-existing diagnosis of mental illness, of their first booking appointment; to make recommendations for practice development and collaborative partnership working between healthcare professionals.
Design: a qualitative design using semi structured interviews and thematic analysis of the data. QSR NVivo 10 software is used to organise the data into themes.
Setting: the interviews took place either at the women's homes, or within the antenatal service with the consent of the woman and relevant practitioners.
Participants: twelve participants were selected from one antenatal clinic and one perinatal mental health service.
Findings: the themes identified within the data included the lack of information prior to the initial midwife booking appointment; the perception of too much information at the initial booking appointment and women not being clear about their mental health needs at this time; a general positivity about disclosing mental illness diagnoses; overall positive thoughts about midwives although some midwives appeared less knowledgeable about bipolar disorder, and perceptions about a lack of joined up working between antenatal and perinatal mental health services.
Key conclusions and implications for practice: it is recommended that GPs receive adequate training in order to equip them with the skills needed to discuss sensitive issues around perinatal mental illness and the impact on pregnancy and childbirth. Women require more information about their booking appointment, and it would be beneficial for their emotional and physical health needs to be assessed at each follow-up antenatal appointment. Midwives need to be facilitated to receive up-to-date knowledge of antenatal and postnatal mental illness and treatments, and the referral process to perinatal mental health services.

Introduction

Perinatal mental illness is a leading cause of maternal death (Lewis, 2007; CMACE Centre for Maternal and Child Enquiries, 2011). The perinatal period begins from pregnancy through to the first twelve postpartum months. Research reports that women are at increased risk of depression and anxiety during this period, due to the social, psychological and physical changes associated with pregnancy, childbirth and motherhood (Brown and Lumley, 2000; Ross and McLean, 2006; Lee et al., 2007). For some women, mental illness may occur for the first time during the perinatal period, whereas other women will have a pre-existing diagnosis of mental illness. Research has shown that 50% of women with a pre-existing severe mental illness including enduring depression, bipolar disorder and psychosis, relapse during the perinatal period (Cohen et al., 2006). This risk of relapse is higher for those who discontinue their medication (Viguera et al., 2000). Women with severe and enduring mental illness are also more likely to experience obstetric complications, and their babies are at risk of low birth weight, premature birth, still birth and intrauterine growth restriction which further increases the risk of neurodevelopment, long-term cognitive problems and infant mortality (Howard et al., 2003; Jablensky et al., 2005; Holditch-Davis et al., 2007; Talge et al., 2007). Research on the

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causes of these risk factors has suggested genetic susceptibility, along with a delayed access to antenatal care, socio-economic factors, and lifestyle factors including smoking and substance misuse (Howard, 2005; Pacagnella et al., 2014).

In 2007, the National Institute of Clinical Excellence (NICE) introduced a guideline which made recommendations for midwives and other primary health-care clinicians to ask women in pregnancy about any experiences of past or present mental illness (referred to as the Whooley questions). Rothera and Oates (2011) have focused on the implementation of these recommendations in order to improve the detection and management of maternal perinatal mental health to reduce maternal, fetal and neonatal risks. In a survey conducted by Ross-Davie et al. (2006) on midwives preparedness to undertake their public health role in detecting perinatal mental illness, they found that 90% of practitioners identified psychological care to be a core part of the midwife's role. The majority (68%) of the midwives felt ill-equipped in their ability to fulfil this role due to limited time, skills and knowledge. Additionally, research has found that midwives report feeling unconfident in assessing the needs of women with severe mental illness and referring them to relevant specialist services. Attributable causes have been identified such as lack of pre and post-registration training around perinatal mental illness, poor continuity of care, and lack of available specialist services (Stewart and Henshaw, 2002; McCauley et al., 2011). The reluctance of women to disclose their mental health issues was identified by the Boots Family Trust (2013) who conducted a survey of 1500 women who had experienced perinatal mental illness. They found that around 20% of the respondents disclosed that they had not been completely truthful about their mental illness experiences, with a further 30% reporting that they had never told a health professional that they felt unwell. Fear about services and the potential removal of their child were identified as the main contributable factors for non-disclosure of mental illness during pregnancy and the postnatal period.

Women's perceptions of antenatal care have been the focus of several studies. Using a piloted questionnaire to collect a combination of quantitative and qualitative data, Soltani and Dickinson (2005) explored 700 women's perceptions of the pattern of antenatal care. For 58% of women, their first health professional contact in pregnancy was with a GP, whereas more than half of women would have preferred to see a midwife. Women were found to be satisfied with their antenatal care, although a number of areas were identified where women's preferences differed from that which they routinely receive, including first contact with health professionals. The executive summary, 'Delivered with care: a national survey of women's experience of maternity care' (National Perinatal Epidemiology Unit, 2010) examined the process of antenatal care. For example, 95% of women had contact with a health professional by the twelfth week of pregnancy. The booking appointment had taken place for nearly two-thirds of women by ten weeks.

The Francis Report (Francis, 2013), emphasised the importance and need for service user's views and involvement in healthcare design and monitoring of clinical effectiveness, recognising that patient safety and quality of care improves when services work in partnership with patients to provide appropriate healthcare delivery. This exploratory research study asks what are the feelings, perceptions, and expectations that influence how women with pre-existing diagnoses of mental illness experience their first antenatal (booking) appointment. The study used semi structured interviews with twelve participants. This study will make recommendations for practice development and collaborative partnership working between healthcare professionals and the pregnant woman in their care.

Methods

The researchers considered the use of qualitative methodology within a framework of the phenomenology, namely the phenomenological approach of Alfred Schutz (1899–1959) as most appropriate in exploring the expectations and experiences of women with pre-existing mental illness of their booking appointment. Influenced in particular by the philosophers Edmund Husserl and Henri Bergson, and the interpretative sociology of Max Weber, Schutz proposed that perceptions of the world result from past experience. The continuous accumulation of experience and knowledge will enable a person to recognise a situation or object, and will determine how they will act. In *The Phenomenology of the Social World* first published in 1932, Schutz distinguishes between 'action' and 'act.' He uses the term 'action' to refer to tasks initiated by preconceived constructions of the world and the term 'act' as referring to the physical or mental steps taken to enact the task. Tasks undertaken can be considered as repeated but inconclusive ideas that will be tested by the actual acts, which can succeed or fail in achieving a purpose. The desired outcome is to transform an initial perception into a final state, and, in each action, experience and knowledge are increased and developed. What was thought to be clearly understood is, by the process of gaining experience, continuously, as Schutz states, 'supplanted by a coming to be and passing away' (1967:47).

The use of qualitative methodology also enables the essence of lived experience to be explored, and according to Cutcliffe, can be used to interpret key insights into individual experiences and 'lived moments and thus produce a description' (Cutcliffe et al., 2005 p. 57). The qualitative method of semi structured interviews enables the understanding of the experiences, feelings, values, and perceptions that influence behaviour, and bring about giving voice to those whose views are rarely heard (Sofaer, 1999).

The method of using semi-structured interviews was considered by the researchers as having the most potential for achieving the active involvement of the participants. The interview questions (in Appendix B) for the study were developed on the basis of the literature review conducted, and with the advice of a variety of relevant maternity professions for clarity and applicability. The questions were developed in order to find out the women's history of mental health care; their expectations of their booking appointment; their experiences of this appointment particularly in relation to their disclosure of mental illness and what influenced their decisions to disclose including the response of the midwife, and lastly, their thoughts about the birth of their babies and beyond. In the development of the interview questions, the researchers acknowledged that the questions were influenced by a very specific agenda about the women's decisions to disclosure their mental illness diagnoses, which may have influenced the participant's ability to speak from their own perspective. This issue is explored further in the *Reflexivity* section below.

Participants

The inclusion criteria for the research were women who had a pre-existing diagnosis of mental illness and received regular support and care by mental health services. These women had received diagnoses including schizoaffective disorder, bipolar disorder, anxiety and panic disorders, depression, and personality disorders. Some of the women had frequent episodes of mental illness, and required regular support. Many of the women were well for the majority of the time, but could be vulnerable to relapse. The inclusion criteria for this research study included women who wished to take part in the proposed research and were considered well enough to do so by the Lead Practitioner responsible for their care. The study population excluded women