



ORIGINAL ARTICLE

Dread and solace: Talking about perinatal mental health

Susan Law,¹  Ilja Ormel,¹ Stephanie Babinski,^{2,3} Donna Plett,⁴ Emilie Dionne,⁵ Hannah Schwartz⁶ and Linda Rozmovits⁷

¹St. Mary's Research Centre and Department of Family Medicine, McGill University, Montreal, Quebec, ²Faculty of Community Services, Ryerson University, Toronto, Ontario, ³Department of Supportive Care, Princess Margaret Cancer Centre, University Health Network, Toronto, Ontario, ⁴Institute of Health Policy, Management and Evaluation, University of Toronto, Toronto, Ontario, ⁵VITAM - Centre de recherche en santé durable and Université Laval, Quebec City, Quebec, ⁶Psychiatry Department, St. Mary's Hospital Center, McGill University, Montreal, Quebec, and ⁷Linda Rozmovits – Qualitative Health Research Consultant, Montreal, Quebec, Canada

ABSTRACT: Perinatal mental health issues are a global public health challenge. Worldwide, it is estimated that 10% of pregnant women, and 13% of women who have just given birth, experience a mental disorder. Yet, for many reasons – including stigma, limited access to services, patients' lack of awareness about symptoms, and inadequate professional intervention – actual rates of clinical and subclinical perinatal mental health issues are likely higher. Studies have explored experiences such as postpartum depression, but few involve a wider-ranging exploration of a variety of self-reported perinatal mental health issues through personal narrative. We conducted 21 narrative interviews with women, in two Canadian provinces, about their experiences of perinatal mental health issues. Our aim was to deepen understanding of how individual and cultural narratives of motherhood and perinatal mental health can be sources of shame, guilt, and suffering, but also spaces for healing and recovery. We identified four predominant themes in women's narrative: feeling like a failed mother; societal silencing of negative experiences of motherhood; coming to terms with a new sense of self; and finding solace in shared experiences. These findings are consistent with other studies that highlight the personal challenges associated with perinatal mental health issues, particularly the dread of facing societal norms of the 'good mother'. We also highlight the positive potential for healing and self-care through sharing experiences, and the power of narratives to help shape feelings of self-worth and a new identity. This study adheres to the expectations for conducting and reporting qualitative research.

KEY WORDS: mental health, parenting, postpartum depression, pregnancy, qualitative research.

Correspondence: Susan Law, Trillium Health Partners – Institute for Better Health, 100 Queensway West, Mississauga Ontario, L5B 1B8, Canada. Email: susan.law@utoronto.ca

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Susan Law, PhD.

Ilja Ormel, MPH, PhD student.

Stephanie Babinski, MPH, MA, Midwifery Student.

Donna Plett, MSc, PhD student.

Emilie Dionne, PhD.

Hannah Schwartz, MD FRCPC.

Linda Rozmovits, DPhil.

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INTRODUCTION

Worldwide, approximately 10% of pregnant women, and 13% of women who have just given birth, experience a mental disorder (World Health Organization 2020). Despite this relatively high incidence of mental illness during the perinatal period (defined here, as from conception up to one-year postpartum), women are often reluctant to disclose symptoms and access treatment, and only about one third actually receive professional care (Coates *et al.* 2004).

There have been recent calls to action at both national and international levels (National Collaborating Centre for Mental Health 2018, American Public Health Association 2019), to improve access to services and support for women with perinatal mental health problems. However, uptake has been poor and research suggests that this may be due, in part, to the stigmatization of women whose experiences of pregnancy and motherhood do not align with idealized societal norms. For example, scholarship on postpartum depression suggests that women are discouraged from disclosing symptoms and seeking help for fear of being judged as bad mothers (Anderson 2013; Beck 2002). Other research demonstrates how the discourse of the 'good mother' as a 'happy mother' contributes to antenatal anxiety and depression (Staneva & Wigginton 2018), and how social expectations of pregnancy engender and exacerbate antenatal distress (Staneva *et al.* 2017).

Feminist scholars have thus critiqued the discourse of the 'good mother' for the ways in which it obscures women's suffering (Lupton 2000). For instance, they point out that medical discourse about postpartum depression often emphasizes the risk of the mother's mental illness *to the child*, while minimizing the woman's experience and engendering fear of judgement or punishment for her perceived failures as a mother (Godderis 2010). They also show how the 'good mother' ideal influences antenatal experience by instructing pregnant women to minimize stress in order to protect their unborn child (Lupton 2012). Central to the 'good mother' discourse, then, is an exercise of control over women's emotions throughout the perinatal period to protect the child from harm (Lupton 2000).

Existing studies on perinatal mental illness typically focus on a single diagnosis, such as postpartum depression (Beck 2002; Holopainen & Hakulinen 2019; Maxwell *et al.* 2019), postpartum psychosis (Forde *et al.* 2020; Glover *et al.* 2014), or antenatal anxiety (Rowe & Fisher 2015). Several studies also examine experiences that evade clinical categorization, such as perinatal or antenatal distress (Coates *et al.* 2015; Delaney *et al.* 2015; Staneva *et al.* 2015). While these studies provide insight into specific experiences of perinatal distress and mental illness, we extend this by analysing diverse mental health issues that occur throughout the perinatal period. By studying multiple perinatal mental health issues collectively, we aim to shed light, more broadly, on women's experiences throughout the time of pregnancy and birth. We believe that identifying recurring

patterns *across* a range of experiences will contribute to a more holistic understanding of both diagnosed and undiagnosed perinatal mental health issues.

A second area where we aim to contribute to the scholarship on perinatal mental health is in relation to the range of narratives under consideration. Current literature on the discourse of the 'good mother' and perinatal mental health tends to emphasize the harmful effects of common socio-cultural narratives about pregnancy and motherhood. While we, too, explore cultural stereotypes and discourses of 'good' or 'failed' mothers, we also consider the therapeutic possibilities in sharing personal narratives. This article thus explores how individual and cultural narratives of motherhood and mental health can be sources of shame, guilt, and suffering, but also spaces for healing and recovery.

Finally, there are compelling reasons to consider narrative accounts of illness and healthcare such as those presented here. People facing health issues seek information not only about the 'facts and figures' related to their illness, but also about the lived experiences of others; there is a need for reliable, accessible, and evidence-based narrative information (Shaffer *et al.* 2018; Shaw *et al.* 2006; Ziebland & Wyke 2012), and a dearth of accessible resources for women with perinatal mental health issues (Schwartz *et al.* 2021).

METHODS

This study used a qualitative, descriptive design (Sandelowski 2000) to understand the lived experiences of women with perinatal mental health issues. Our approach included: a rigorous participant selection and recruitment process to achieve a maximum variation sample; in-depth data collection through individual narrative interviews using audio and/or video recording; and inductive, thematic data analysis and interpretation (Braun & Clarke 2006; Patton 2002); and preparation of a short film for our www.healthexperiences.ca website.

The study was reviewed and approved by the St. Mary's Hospital Research Ethics Board, and adheres to the COREQ standards for reporting qualitative research (Tong *et al.* 2007).

Recruitment was via email invitations to established mental health programmes and support groups in Ontario and Quebec to invite patients and users of these programmes to consider participation. We also sent recruitment notices to professional and personal networks who shared information about the study with women in their circles of care. Interested participants

completed a short reply form providing their contact information and a brief description of their emotional or mental health issues in their own words. One of the qualitative researchers then contacted potential participants to answer any questions, ascertain eligibility (self-reported mental health issues at any time from conception to one-year postpartum and the ability to speak English or French for the interview) and arrange an interview time. In keeping with best practice in experiential qualitative and narrative research (Sandelowski, 1991), this study relied on the stories and self-described experiences of mental health problems, and not a formal clinical diagnosis, to determine eligibility, in contrast with effectiveness or epidemiological studies where the diagnosis is pertinent in resolving questions about outcomes and attribution.

Consent was obtained in two steps: first to participate in the interview, with audio and/or video recording; second, following their review and approval of the transcript, to use their interview material to produce the short film or in future research or teaching. Participants wishing to remain anonymous could choose an alias for any presentation of their material in print or online. All participants were offered the opportunity to view the film and provide feedback or request changes prior to the launch of the film on the website.

Individual interviews were conducted, between June 2016 and October 2017, by senior qualitative researchers, with 21 women who experienced perinatal mental health issues during the perinatal period. Participants were aged 25–46 years (average age 35) and self-reported a wide range of symptoms including anxiety, mood-related problems, psychosis, personality-related issues, and developmental problems. The most common treatments mentioned were anti-depressants. Most had one additional child at home and the majority indicated English or French as their first language. It was difficult to ascertain diversity of ethnic or cultural background as many did not answer this question (reasons for not answering were not clear). Table 1 presents self-described participant attributes.

A two-part interview guide was used, beginning with the open-ended question, 'Tell me about your experiences from when you first noticed a change', followed by a semi-structured set of questions about their experiences with healthcare professionals, with their family and friends, and about where they looked for and found support, as well as their advice for others. Interviews took place in participants' homes or a preferred location (seven were conducted in workplace or research settings) and ranged from 44 to 107 min. (Interview guide

is available as Supporting information). Audio recordings were professionally transcribed and then checked for accuracy and anonymized by the qualitative researchers. Five participants chose to use an alias. We included women with a range of issues including those related to depression, anxiety, and substance use.

We undertook thematic analysis of the final transcripts, using the constant comparative method, and the application of hybrid inductive-deductive coding strategy, working from the original text of the transcript, the emerging themes, and the questions posed in the interview guide (Miles & Huberman 1994; Strauss & Corbin 1990). Three qualitative researchers from the study team participated in the development of the initial coding framework, analysis, and identification of key themes. (Green & Thorogood 2018).

RESULTS

Our analysis of the data yielded four predominant themes as described below.

Feeling like a failed mother

Many women described themselves as feeling like a failed mother. Some associated past events with their current feelings about their capacity to parent. For example, one participant, who had previously lost twins in the first trimester, recalled how she felt immediately after the birth of a subsequent baby:

I slept there in the, the paed's ward with, you know, all these other moms . . . my baby was a few days old and I'm feeling really I have no confidence in myself as a mom. Because, you know, I still in the back of my mind had this 'Well I killed my first two babies, I can't be trusted with a baby now'. (PMH03)

Such feelings of inadequacy, stemming from a perceived inability to live up to a high standard of mothering, were widely shared.

As participants explained, self-doubt often emerged in comparisons with past or aspirational selves, with other women, or with unattainable, gendered ideals. Many participants saw other mothers or pregnant women as happy and connected to their babies, while they felt different from these 'normal' moms. Participants also described feeling pressured to appear happy when they were around other pregnant women and mothers, or judged for their choices such as using formula instead of breast feeding or taking antidepressant medication while pregnant:

TABLE 1 Self-reported characteristics of 21 participants

| Age (mean = 34.8 yrs) | n | % | Occupation | n | % |
|--|----------|----------|--|----------|----------|
| 25–29 | 3 | 14 | Artist/creative | 1 | 3 |
| 30–34 | 6 | 28 | Caregiver | 1 | 3 |
| 35–39 | 8 | 38 | Communications | 1 | 3 |
| 40–44 | 2 | 10 | Government/policy/administration | 3 | 10 |
| 45+ | 1 | 5 | Lawyer/legal advisor | 2 | 6 |
| DNA* | 1 | 5 | Recreation/social services | 2 | 6 |
| Employment status | n | % | Retail/business/finance | 4 | 13 |
| Working at time of interview | 13 | 62 | Teacher/librarian | 4 | 13 |
| Not working at time of interview | 7 | 33 | DNA | 3 | 10 |
| DNA | 1 | 5 | Marital status | n | % |
| Age at onset (of first diagnosis) | n | % | Married | 10 | 48 |
| 15–19 | 3 | 14 | Common law | 10 | 48 |
| 20–24 | 2 | 10 | DNA | 1 | 5 |
| 25–29 | 4 | 19 | Number of other children | n | % |
| 30–34 | 9 | 43 | 1 | 14 | 67 |
| 35–39 | 1 | 5 | 2 | 6 | 28 |
| DNA* | 2 | 10 | 3 | 0 | 0 |
| Self-reported symptoms** | n | % | 4 | 1 | 5 |
| <i>Anxiety symptoms</i> | 17 | 45 | Treatment(s) & medication(s) used** | n | % |
| Agoraphobia | 1 | | Cognitive behavioural therapy | 1 | 3 |
| Anguish | 2 | | Anti-depressants (SSRIs and SNRIs) | 20 | 65 |
| Anxiety | 10 | | Anti-psychotics | 4 | 13 |
| Social phobia | 1 | | Mood stabilizers | 2 | 6 |
| Post-traumatic stress disorder | 3 | | Benzodiazapines | 1 | 3 |
| <i>Mood symptoms</i> | 13 | 34 | None | 3 | 10 |
| Depression | 6 | | Mother tongue | n | % |
| Postpartum depression | 6 | | English | 10 | 48 |
| Bipolar | 1 | | French | 7 | 33 |
| <i>Psychotic symptoms</i> | 2 | 5 | Bulgarian | 1 | 5 |
| Paranoia | 1 | | Armenian | 1 | 5 |
| Psychosis | 1 | | DNA | 2 | 10 |
| <i>Personality symptoms</i> | 1 | 3 | Country of birth | n | % |
| Borderline personality | 1 | | Canada | 17 | 81 |
| <i>Developmental problems</i> | 1 | 3 | Bulgaria | 1 | 5 |
| Attention deficit/hyperactivity disorder | 1 | | Saudi Arabia | 1 | 5 |
| DNA | 4 | 11 | DNA* | 2 | 10 |
| Ethnic background | n | % | | | |
| Caucasian | 5 | 24 | | | |
| Armenian | 1 | 5 | | | |
| Canadian | 1 | 5 | | | |
| White | 1 | 5 | | | |
| North American | 1 | 5 | | | |
| DNA | 12 | 57 | | | |

*DNA = did not answer.

**Participants may have reported more than 1 symptom, treatment and/or medication. NB - total % in the columns is not always equal to exactly 100% given rounding errors.

When you're feeling this way and you meet up with other sort of normal moms, it feels very isolated, because, you know, they feel happy, they look like they've got things together, and you're just like feeling, 'Well, what's wrong with me?...Why am I sad and I don't want to get up in bed in the morning when I have this wonderful baby?... I was formula feeding

my baby, and my baby had delays... And I didn't want people asking questions or pointing it out... Mommy groups can be great and they can be terrible, because you do experience what I call 'sancti-mommies', you know... everything is organic and their babies are breastfed and they co-sleep and they do all this and they do all that. (PMH14)

Silencing negative experiences of motherhood

Having experiences that deviated from social expectations of pregnancy and the postpartum period as happy phases of life, impacted women's sense of safety around sharing their negative or challenging experiences. Sharing one's story was often marked with fear, shame, and feelings of isolation as participants compared their own experiences to the apparent experiences of others. As one participant put it, 'If it hadn't have been pushed at me how happy you should be I wouldn't have felt so crappy about the fact that I wasn't there' (PMH19).

Women described themselves as keeping it inside, developing a mask, putting on a happy face, or putting up a front rather than sharing their negative experiences, because they feared the potential consequences and judgement of others. Some worried that they would alienate family and friends or even that their child might be taken into protective custody:

I decided not to share my deepest thoughts with others because I was very embarrassed, but more than embarrassed, then, I was afraid ... that my daughter would be taken away ... I was worried because of potential repercussions on myself and my husband professionally. If my daughter ended up needing to be in child services or just having people know what's going on in our family base, we're pretty private and just knowing that this situation requires outside help, how is that going to look and how is that going to have repercussions on us as individuals and as a family? (PMH 13)

Several participants described a highly competitive culture of new motherhood and said they felt vulnerable to judgement about the kind of parent they were.

The moms are nuts. Like other moms are horrible to each other... And I'm like 'Okay you have no idea what anyone's going through'... And I was like very adamant ... I'm not getting into play groups ..I did not want to be part of this mom-eat-mom world where, you know, women can't even be nice to each other but they're going through the same thing. (PMH19)

Coming to terms with a new sense of self

Many of the women we interviewed talked about the ways in which perinatal mental health issues and motherhood had changed them. As one woman commented, 'Although it's wonderful bringing a new life and having a new love, it also is a loss of your former self' (PMH15).

While this may be true of motherhood in general, perinatal mental health issues involved a loss of particular personality traits which had previously been central to some women's sense of self. For example, one woman felt she had lost her vitality and sociability:

That's never happened to me, so it was very new. Like this feeling of dread, no, that had never happened to me. I'm somebody who's full of life even if I have anxiety, even if I've had terrible things happen to me. I get through them. This was like everything shut down. Everything. (PMH16)

Another participant felt that, on account of her experience, she had fundamentally changed:

I don't know how I feel about the question of feeling like myself again because I, I mean I'm always me but I'm profoundly changed by both experiences, by having a son and being a mother and by having had such severe depression where I had no desire to even get out of bed. Those have profoundly affected me as a person and changed the way I look at things. (PMH15)

A third felt that she, too, had undergone profound change but, ultimately, came to see this as an experience of personal growth:

I feel pretty good. I feel much, much better than I did. Um I feel uh really very peaceful with everything I've gone through. Um as difficult as it was it's made me who I am and I like who I am. [laughs] I like me as a person. [laugh]... I mean would I trade this for anything? Yes, probably I wish I hadn't gone through it. I wish everything had been smooth sailing. But I also feel I wouldn't be the person I am had I not gone through it. (PMH03)

Finding solace in shared experience

While many of the women felt stigmatized, and feared the consequences of disclosing their perinatal mental health problems, some were able to share their experiences with select family members or friends and, on occasion, health care professionals. This sometimes resulted in receiving direct support or helpful referrals to groups or resources:

I was very lucky to fall on compassionate doctors, medical professionals who helped me, who listened to me, who understood me, who didn't pathologize, over-diagnose me, and over-medicate me. Who got the full story assessed, were there to support and most importantly to give me accurate, reliable, recent research information. That was a godsend. (PMH16)

Dedicated support groups allowed women with perinatal mental health problems to talk to others living through similar challenges. The opportunity to exchange stories with peers helped women feel less alone and was described, by some, as lifesaving.

I also went to a postpartum depression support group and that group helped so much. I was there during the thick of the postpartum depression. There were six of us and we all had babies around the same age and we were all going through very similar things. Even though we had different lifestyles and different backgrounds we were all feeling the same emotions ... I think those girls really saved my life many times ... knowing that there was no judgement there because when you're going through this you feel like everybody is judging you. (PMH18)

I saw this poster... for the 'Not What I Expected Support Group'... One week we talked about how we deal with distressed situations, you know, when things get really bad and you feel like you're at the edge ... That ... was a very raw vulnerable kind of day for all of us because that was the day that we all really opened up to each other and told our stories. We talked about ... our darkest moments and what we did during those darkest moments and how would we overcome them in the future... It was a day of healing though I think for all of us really because I think for most of us we hadn't told anybody else about all those times. We'd kept them to ourselves and finally being able to open up about them in a room where you weren't judged, it was good. (PMH20)

Several participants had initiated, or become involved in, online support groups or were inspired to take on peer support roles as a result of their experience:

I feel a very interesting accountability to other women to share my experience ... This very tragic thing that can happen to you can bond you with some of the most inspiring strong women that you'll probably meet in your life ... my role in that group is more so as, like, a peer support for other women that are coming because I've already been through, you know, the dark times, and I've learned the skills that I need. I've been able to act more as sort of like a mentor... I just don't want them to feel alone like I did, or not safe. (PMH13)

It sounds cliché, but if I can help one woman understand that what she is going through is maybe not normal by mental health standards, but it's normal in the sense that so many people experience it ... If this could help women feel less alone ... I just want to raise awareness and I just want to lessen the stigma. And it's become a real passion of mine. (PMH18)

DISCUSSION

Our results show the different roles that personal and societal narratives play in shaping experiences and ideas of self in relation to perinatal mental health issues. Across a variety of perinatal mental health problems, unrealistic and idealized cultural narratives about pregnancy and motherhood shape experiences and help-seeking behaviours. As previous literature has shown, stigma and fear of being perceived as a 'bad' or 'failed' mother discouraged women from disclosing mental health problems and from seeking help (Baldisserotto *et al.* 2020; Forde *et al.* 2020; Moore *et al.* 2016). Similarly, women's accounts of hiding their negative thoughts or emotions for fear of judgement, or of negative ramifications, show how women internalize the myth that an unhappy mother is a bad mother (Johnston 2003). Staneva and Wigginton (2018) have termed this the 'happiness imperative' for new mothers.

The interviews we conducted revealed that mental health issues contributed to the changes in, and losses of, their sense of identity that women experienced through the transition to motherhood. Previous work similarly shows that transitions to motherhood and experiences of postpartum depression entail multiple forms of loss – of freedom and autonomy, of one's former self, and of certain relationships (Stone & Kokanovic 2016; Vik & Hafting 2012; Yu & Bowers 2020). Moreover, our findings are consistent with other research that suggests that the process of recovery involves re-defining one's identity and reconciling it with one's experience of mental health problems.

Additionally, our study echoes literature that shows how pressures to fit the mould of the 'good mother' can result in self-silencing and in a denial of one's own needs (Lafrance & Stoppard 2006), while cultural narratives of the 'good mother' and personal narratives about one's inadequacies as a parent, act, in concert, to silence women who suffer from perinatal mental health problems. In her work on postpartum depression, Mauthner (1998) explains that 'active and conscious silencing of their voices and social withdrawal was a central feature of the women's depression and was critical to understanding it' (pp.345). She argues that postpartum depression results from experiencing sadness, loss, and grief but being unable to express it within supportive social relationships (Mauthner 1999). Like the women who suffered from postpartum depression in Mauthner's

studies, the women in our study experienced loss and suffering but were wary of sharing their struggles because of a perceived lack of support, both from other parents as well as from healthcare professionals.

The relational perspective, brought forward in Mauthner's (1998, 1999) work, further highlights how finding other women with whom one's own experience resonates, contributes to recovery. In our study, narrative could also play a therapeutic role. Specifically, exchanging stories with other mothers helped women feel less isolated and more validated. By speaking openly about pregnancy, birth, and postpartum experiences that deviate from socially prescribed norms, women were able to question, and sometimes resist, unattainable ideals of motherhood.

Our work thus suggests a need for resources and support that encourage disclosing negative experiences throughout the perinatal period and challenging the myth of the 'good mother'. Normalizing a wide range of perinatal experiences and identities, in both clinical and community settings, may reduce stigma around perinatal mental health issues while also providing opportunities for diagnosis and treatment. Previous work has emphasized the value of peer support groups in helping with feelings of social isolation and addressing the silent burden of living with postpartum depression (Montgomery *et al.* 2012). Scharp and Thomas (2017) refer to the normalization of birth experiences and the processes of seeking validation for one's experiences and reactions to motherhood, supportive communication, and birth storytelling as *motherwisdom*. *Motherwisdom* involves reclaiming the importance of story and narrative in medicine and views sharing stories as therapeutic (Scharp & Thomas 2017). Research on depression also suggests that recovery may involve 'breaking free' from a former self and actively resisting a 'good woman' identity (Lafrance & Stoppard 2006). Women suffering from perinatal mental health problems may similarly require tools and support in order to resist norms of the 'good mother'. Our work stresses this need in relation to illnesses that occur at any time from conception to one-year postpartum. A qualitative meta-synthesis of experiences of using online forums for maternal mental illness also shows that forums provide spaces where mothers can reconcile their mental illness experiences with their identities as 'good mothers'. Posted experiences and anecdotes challenge dominant narratives of ideal parenthood and show how good parenting and mental illness are reconcilable (Moore *et al.* 2016, 2019).

Limitations

Our study has several limitations. First, existing research shows that factors such as income, race, and education create additional structural barriers to performing ideal motherhood (Keefe *et al.* 2018). Our study was only able to consider the social determinants that contribute to perinatal mental health problems within a single sample. Second, while our recruitment process aimed for maximum variation, it was carried out in only two provinces and achieved a limited degree of diversity in relation to socio-cultural background, sexual orientation, and gender identity.

Conclusions

In this study we considered the ways in which women describe their perinatal mental health challenges, how they coped, what worked for them, and how narratives (both in the sharing of their personal experience *and* in the receiving of others' narratives) shape identity, feelings of self-worth, and the capacity for self-care. We identified four predominant themes in women's narratives of perinatal mental health issues: feeling like a failed mother; societal silencing of negative experiences of motherhood; coming to terms with a new sense of self; and finding solace in shared experiences. These findings are consistent with other studies that highlight the personal challenges associated with perinatal mental health issues, particularly the dread of associated with social expectations of the 'good mother'. We also highlight the positive potential for healing and self-care through shared experiences, and the power of narratives to help shape feelings of self-worth and a new identity. The personal journey that these women have been on is indicative of both their resilience and the need for improvements in awareness about, acceptance of, and care for, women with perinatal mental health issues.

RELEVANCE TO CLINICAL PRACTICE

This study provides further evidence of the need to raise awareness and enhance communication skills amongst healthcare professionals involved in perinatal care, including hospital maternity/obstetrical teams, public health and primary care teams, midwives and other generalist and specialist personnel. Knowing when and how to provide timely information is critical to support women experiencing perinatal mental health problems. The provision of information about mental

health issues and effective therapies should be routinely adopted throughout the perinatal period to reduce stigma and create a safe space for women to talk about their experiences. Those directly involved in leading prenatal classes, for instance, could consistently raise the topic of perinatal mental health with a view to normalizing experiences that are relatively common, yet remain hidden. In addition to normalizing a range of experiences, enabling women to, more readily, recognize behaviours, and symptoms that may represent an underlying psychiatric disorder and feel comfortable seeking help, would be desirable.

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AUTHORSHIP STATEMENT

All authors listed meet the authorship criteria according to the latest guidelines of the International

Committee of Medical Journal Editors, and all authors are in agreement with the manuscript.

ETHICS APPROVAL

Ethics approval for this study was obtained from the St. Mary's Hospital Research Ethics Committee, SMRC-REC #11-22E. Written consent was obtained from all study participants by the study team to conduct qualitative interviews about their experiences of mental health and pregnancy, and for future use of this data, including the production of online material and future secondary analysis.

PATIENT CONSENT FOR PUBLICATION

Written consent was obtained from all participants in this study as described above and in the text of the manuscript. We used a two-step consent process. Participants first provided consent to the original interview. They then provided a second consent (after review of their transcript) to permit use of the interview materials for future research (including secondary analysis), in publications, for teaching purposes and for online materials with video/audio excerpts at www.healthexperiences.ca.

After their interview and prior to giving secondary consent, participants were sent the transcript for review with a request to remove any material they did not wish the research team to use. They were given the option of using an alias or their real name in this work. Prior to release of the short film online, all participants were provided an opportunity to review their excerpts and the film and to provide feedback or request the removal of their material. Following the launch of the online material, participants could request the removal of their information at any time. This is the standard approach adopted for the international network of research teams known as DIPEX International of which our Canadian team is a part. See: www.dipexinternational.org.

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SUPPORTING INFORMATION

Additional Supporting Information may be found in the online version of this article at the publisher’s website:

Appendix S1. Mental health and pregnancy: Women’s experiences in Canada.