BARRIERS TO ACCESSING PSYCHOLOGICAL SUPPORT FOLLOWING EARLY MISCARRIAGE. PERSPECTIVES OF THE IAPT PERINATAL CHAMPION.

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ABSTRACT

Early miscarriage has been linked to a wide variety of subsequent psychological difficulties. Despite this, challenges in accessing appropriate psychological support following early miscarriage are emphasised throughout the literature. Few studies have explored barriers to accessing support following early miscarriage from the perspective of healthcare professionals providing support, and none of these have focused solely on NHS primary mental healthcare settings. This study therefore sought to address the gap in the literature through a qualitative exploration of the perspectives of Increasing Access to Psychological Therapies (IAPT) perinatal champions, deemed to be in a position most likely to be providing support for people following early miscarriage. The aim of this study was to elicit a fuller, critical understanding of the potential barriers to accessing psychological support following early miscarriage, with the hope of eliciting suggestions for how to improve it.

12 participants, who had all at some point held the role of IAPT perinatal champion, took part in semi-structured interviews exploring their experiences of providing psychological support for people following early miscarriage. Thematic analysis of the interview transcripts yielded four key themes: unclear guidance, service-centred care, journey to role, and societal stigma.

The findings revealed a variety of potential barriers to accessing support following early miscarriage. Unclear guidance was thought to influence referrals and create uncertainty regarding perinatal labelling and the remit of IAPT in providing post-miscarriage support. Services were reported to be built around prioritising commissioning and financial objectives over client need, resulting in structural constraints and a diagnosis-focused system that was not set-up for providing the individualised support required following early miscarriage. Participants described their journeys to the role of perinatal champions as often lacking the autonomy, training, support and resources required. The role of services in perpetuating societal stigma around early miscarriage, including shame, blame, silence and invalidation was also highlighted. This study has implications in terms of informing service structure, roles and training within IAPT to improve pathways to support, following early miscarriage.

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LIST OF ABBREVIATIONS

BPS- British Psychological Society
CBT- Cognitive Behavioural Therapy
CINAHL- Cumulative Index of Nursing and Allied Health Literature
DNA- Did Not Attend
DoS- Director of Studies
EBSCO- Elton B. Stephens Company
EPU- Early Pregnancy Unit
GDPR- General Data Protection Regulation
GP- General Practitioner
HCPC- Health and Care Professions Council
IAPT- Increasing Access to Psychological Therapies
NHS- National Health Service
NICE- National Institute for Health and Clinical Excellence
PWP- Psychological Wellbeing Practitioner
UEL-University of East London
UK- United Kingdom
USA- United States of America

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CHAPTER ONE: INTRODUCTION

1.1. Introduction to Subject

Despite the frequent misconception that miscarriage is rare (Chichester & Harding, 2021), it has been highlighted as one of the most commonly experienced pregnancy-related complications (Hammerslough, 1992) and the foremost in requiring hospital admission (Nybo Andersen et al., 2000). In the UK, around 250,000 miscarriages are estimated to occur each year (Miscarriage Association, 2022), with 25 percent or one in four women experiencing at least one miscarriage in their lifetime (Tommy's, 2022; Petals, 2023). The majority of these are classed as 'early miscarriages'; defined as losing a pregnancy within the first 12 weeks (Larsen et al., 2013). These are thought to happen in around 15% of pregnancies (Quenby et al., 2021), although these figures are speculated to be higher (Williams et al., 2020). This is partly due to recent advances in the sensitivity of home pregnancy tests revealing pregnancies resulting in early miscarriage, that never go on to be medically confirmed (Bottomley & Bourne, 2009). Other influences may include the fact that not everyone seeks support after a miscarriage (Hemminki, 1998) and not all pregnancies are detected (Hardy & Kukla, 2015).

1.1.1. Key Definitions and Terminology Choices

Based on the perspectives of those with lived experience of miscarriage expressed throughout the literature, it is felt important to avoid medical terminology in this research, which can come across as pathologizing and lacking empathy. This includes terminology found in earlier literature, referring to miscarriage as 'spontaneous abortion', which may be experienced as problematic due to its associations with the decision to terminate a pregnancy (Hutchon & Cooper, 1998). Aside from the literature search terms, the term "early miscarriage" will therefore be used to refer to pregnancies that end within the first 12 weeks. This is the preferred term, deemed to express empathy and sensitivity (Chichester & Harding, 2021) but it is acknowledged that this term may also feel jarring to some, through conveying the unborn baby has been somehow carried incorrectly (Zucker, 2021). There are also terminological challenges in naming those that have been pregnant and have subsequently experienced early miscarriage. For example, Browne (2018) explains that referring to ‘pregnant women’ can be considered as discriminating against males or those who are gender non-binary and pregnant. Terms such as ‘pregnant people or child/non-childbearing partners’ are increasingly favoured, although such language has been criticised for clouding feminist debate around pregnancy and its association with womanhood and femaleness (Browne, 2018). Holding this in mind, this study will use gendered terminology like ‘pregnant women’ when discussing research which specifically reports on gendered discourses, whilst ‘pregnant people or child/non-childbearing partners’ will be used otherwise.

1.1.2. Societal Response

Difficulties in talking about early miscarriage is a recurrent theme in the literature (Visa & Briones-Vozmediano, 2020), with many factors likely contributing to this. For example, misunderstandings about the causes and impact are commonplace (San Lazaro Campillo et al., 2018; Cesare et al., 2020) and despite miscarriage being recognised as the foremost pregnancy and gynaecological complication requiring hospitalisation (Nybo Andersen et al., 2000), research indicates that people frequently underestimate its occurrence (San Lazaro Campillo et al., 2018).

Conversely, the large number of early miscarriages means that in many cultures it is framed as a negative but trivial and routine event which is straightforward to medically manage (Claringbold et al., 2021; Murphy & Philpin, 2010). This ‘scientisation of death’, particularly in relation to early miscarriage, is thought to contribute to the uncertainty and isolation experienced by so many (Frost et al., 2007). For instance, medicalised language referring to early miscarriages as ‘chemical pregnancies’ (Kevin, 2017) or ‘heavy periods’ (Frost et al., 2007) positions them as purely biological events. Ignoring the meaning of this felt loss for the individual or couple can have damaging consequences. Despite the improving quality of medical provision and cultural shifts resulting in parents having increased expectations for positive pregnancy outcomes (Bansen & Stevens, 1992), such narratives may be informed by a history that did not class miscarriage as a loss, but a fleeting and inconsequential event (Lee & Slade, 1996). This has led to early miscarriage becoming an intangible loss with no formal mechanism to mark it in Western societies, such as a funeral through which to express the emotions experienced, or a clear cultural script to rely on (Murphy, 1998). Experiences like this, which are not publicly recognised and minimised by society, have been described as provoking ‘disenfranchised grief’ (Doka, 1999), leaving those going through them in a struggle to navigate and make sense of their experience, whilst potentially trying to conceal the loss and its consequences (Quenby et al., 2021). The silence experienced around early miscarriage is repeated throughout the literature. Whereas discussion around pregnancy is often public and encouraged, there is a Westernised expectation for people not to disclose the news of their pregnancy until after the first trimester, claiming to ‘save’ them from having to reveal a later loss (Reiheld, 2015). This instead fuels the silence, lack of knowledge and view that early miscarriage is shameful or unimportant (Markin, 2016). A cultural propensity to concentrate on a pregnant person’s body rather than their internal experience, as well as the links between miscarriage and other potentially sensitive areas such as death, sex and failure, add further taboo in breaking this silence (Markin, 2016; Murphy & Merrell, 2009). Suggestions have been made that the strong societal pull to isolate those going through early miscarriage serves to protect others through keeping up the mythical belief that ‘this kind of thing can never happen to me’ (Markin, 2016). An alternative perspective is that the silence around early miscarriage is not an act of resistance, but a representation of society’s incapability of accepting the emotional aspects of miscarriage, resulting in subsequent difficulties in knowing what to say, with people therefore opting to say nothing (Radford & Hughes, 2015).

Many people report feelings of blame following an early miscarriage (Keep, 2021). This may be directly related to the perceived silence they experience, which is open to interpretation and might be inferred to suggest that fault lies with them (Hiefner, 2020), making it harder to seek or access support and obscuring inequities in this experience. Medical professionals ascribing losses using language such as ‘blighted ovum’, ‘hostile mucus’ and ‘incompetent cervix’, further emphasise these connotations of blame (Jonas-Simpson & McMahon, 2005). The role of psychology in reinforcing this blame must also be considered. For example, historically early losses in particular were often framed in psychodynamic terms as an unconscious rejection of pregnancy (Sorrel, 1967), resulting in victim blaming narratives which pathologized the quite reasonable desire to protect oneself from the distress associated with early miscarriage. This links to wider discussion around women's rights, societal positioning and perceived responsibility for reproductive success (Reiheld, 2015). It has also been hypothesised that the increasing accessibility of information concerning the influence people can have on their own wellbeing, such as debates around the 'safe' level of alcohol consumption during pregnancy (McCallum & Holland, 2018), is leading people to feel more responsible when something does go wrong with a pregnancy (Bansen & Stevens, 1992). This suggests that society creates a division from people who miscarry, through isolation, uncertainty and blame; disabling them from accessing relevant support, information or reassurance.

Some more recent shifts in Westernised social norms relating to early miscarriage have been noted, with participants in studies from the 1990s e.g., Bansen & Stevens (1992) reportedly not feeling able to share their experiences, whilst a decade later most reported wanting the opportunity to talk (Maker & Ogden, 2003). In response to these societal shifts, research has begun to increasingly explore the significance of early miscarriage, recognising it as an event with potentially long-lasting effects. Furthermore, it has begun to highlight that just because a miscarriage happens in the earlier stages of pregnancy, the potential impact of this must not be ignored or underestimated (Radford & Hughes, 2015).

1.1.3. Psychological Sequelae

Whilst everyone's reaction to early miscarriage is individual and unique; with responses varying from those that are transient to prolonged and feelings ranging from relief and ambivalence to devastation, the evidence base highlights a wide variety of psychological difficulties commonly experienced following early miscarriage. These can have a lasting impact and even influence future experiences of pregnancy and parenting (Gergett & Gillen, 2014; Murphy & Merrell, 2009). Research, including that published by Petals Baby Loss Counselling Charity (2023), highlights psychological distress as being frequently experienced following early miscarriage, more than half of women reporting difficulties including low mood, anxiety and trauma (Séjourné et al., 2009). Many report feelings of grief (Wong et al., 2003), loss (Chichester & Harding, 2021), shame (Lind & Deveau, 2017), guilt, sadness, self-blame, anger and isolation (Claringbold et al., 2021). The impact is recognised as substantial and important (Adolfsson et al., 2006), with emotional recovery frequently reported as extending way beyond the physical recovery of the loss (Stratton & Lloyd, 2008). Early miscarriage has been linked to a subsequent increased risk of suicide (Quenby et al., 2021) and a theme of 'the loss of possibility' has been noted (Frost et al., 2007), recognising that early miscarriage often involves prospective grieving, whereby hopes, fantasies and imagined futures are mourned (Markin, 2016). This may be particularly relevant to the trend in industrialised countries to postpone parenthood to later ages, potentially increasing the risk of complications including miscarriage (Sobotka, 2010), whilst feeling at the mercy of a biological clock (Winkler, 2014). With difficulties in processing and understanding the experience of miscarriage being commonplace, it is unsurprising that research also indicates the potential for it to impact someone's identity and sense of self (Frost et al., 2007).

Research into early miscarriage experiences in the context of a diverse range of relationships is lacking (Markin, 2016) and little research has explored beyond women's experiences or considered the psychological impact on non-childbearing partners (Williams et al., 2020). However, whilst there may be differences in responses (Beutel et al., 1996), similar feelings of grief, trauma and helplessness have also been reported by male members of heterosexual couples following early miscarriage (Abboud & Liamputtong, 2005; Chichester & Harding, 2021). Non-childbearing partners have also described feeling the pressure to ignore their own feelings to support the one going through the physical loss (Puddifoot & Johnson, 1997). This highlights the need for support to be available for both childbearing, and non-childbearing partners following early miscarriage.

1.1.4. Access to Support

With early miscarriage being a common experience that has the potential to impact the mental health of a large proportion of the childbearing population and partners, we might expect compassionate, trauma-informed support to be routinely offered and easily accessible (Chichester & Harding, 2021). However, although some support may be available through charitable services, specialist psychological care related to early miscarriage is not available directly through the NHS (Petals, 2023). Research suggests most women would appreciate the offer of psychological support following early miscarriage (Séjourné et al., 2009), and positive contact with healthcare professionals following early miscarriage is shown to improve later coping in couples and reduce the likelihood of subsequent relationship breakdown (Abboud & Liamputtong, 2003; Petals 2023). However, although there are some positive reports (Baird et al., 2018), problematic experiences in accessing subsequent mental health support is a recurrent theme in the literature. Dissatisfaction is expressed regarding the care received following early miscarriage (Stratton & Lloyd, 2008), with no follow-up care routinely available (Nynas et al., 2015) and little change in the availability of support over the last three decades (Lee et al., 1996). Little research to date has focused on staff perspectives in delivering this type of support and it is stressed by service-users in the literature that healthcare professionals often perpetuate the societal response to early miscarriage, through lacking recognition and understanding of the impact and playing into themes of silence and dismissal (Hiefner, 2020). Although each individual's context and response to early miscarriage will be unique, and psychological support might not be something everyone wants or needs, research findings emphasise the need for increased accessibility, knowledge and awareness to allow this choice (Séjourné et al., 2009).

1.1.5. Future Impact

Lack of timely access to perinatal psychological support is predicted to cost social services and the National Health Service (NHS) £1.2 billion (HM Government, 2021), factoring in longer term implications of parenting alongside mental health difficulties, the risk of which is increased following early miscarriage. For example, early miscarriage has been shown to increase the likelihood of anxiety and depression in future pregnancies (Bergner et al., 2008), with fear of another loss often resulting in chronic hypervigilance (Franche & Mikail, 1999). Reported consequences also include higher rates of future hospital admissions, increased alcohol use and the psychological impact on other children (Petals, 2023). It has been linked to an overall increased sense of vulnerability and loss of security, accompanied with cynicism about the predictability and fairness of life (Bansen & Stevens, 1992). To manage these emotions, some people are noted to turn to 'emotional cushioning' whereby attempts are made to protect themselves from the impact of another miscarriage through devoting less time visualising the baby and themselves in a parental role, consequently leading them to experience the pregnancy as less real (Markin, 2016).

This may create difficulties in bonding with the new baby (O’Mahen & Healy, 2020) and can affect attachment, parenting styles and caregiving practices (Dayton et al., 2010), potentially impacting the development and mental health of those children born after an early miscarriage (Côté-Arsenault et al., 2020). Concerns about initial psychological responses to early miscarriage developing into longer term psychological difficulties (Adolfsson et al., 2006), such as enduring grief responses that could be carried through to future pregnancies have also been raised (Yang et al., 2022), further emphasising the need for more clearly defined and accessible support following early miscarriage.

1.1.6. Factors Influencing Psychological Response

Certain factors have been noted to impact the level of psychological distress and subsequent need for support following early miscarriage. These include whether, and to what degree a pregnancy is ‘planned’ or ‘wanted’, if in vitro fertilisation (IVF) had been used and factors which might increase levels of risk such as problematic drug or alcohol use (Yang et al., 2022). It is also hypothesised that gestational age and obstetric history might affect someone’s emotional response to miscarriage, although research has indicated that a better predictor of subsequent grief is attachment to the unborn baby (Markin, 2016). Feelings of failure have been noted to be more likely when people have had multiple early miscarriages or when a foetal anomaly is found to be the probable cause. Lacking understanding of what causes miscarriage, feeling unprepared and having no living children are all thought to increase the risk of psychological difficulties following early miscarriage (Athey & Spielvogel, 2000; Maker & Ogden, 2003). Past losses of all kinds are also thought to have the potential to influence early miscarriage responses (Markin, 2016). Belief systems (Bansen & Stevens, 1992) and not being able to have a formal ritual or funeral in line with individual beliefs are other factors identified as potentially increasing the likelihood of psychological harm following early miscarriage (Robinson, 2014), as well as lower socioeconomic status, historic mental health difficulties and lacking social support (Iles, 1989). These points highlight the possible cumulative effects of systemic factors and individual intersects (Crenshaw, 2019) in influencing experiences of early miscarriage, subsequent distress and need for support.

1.1.7. Primary Care Context

Identification of early miscarriages often takes place within ultrasound departments or early pregnancy units (EPUs; Knez et al., 2014), either via routine scans or following referrals to EPUs in response to symptoms indicating possible miscarriage such as pain and bleeding. There have been calls for these departments to be better equipped to provide psychological support (Farquharson, 2017), and the National Institute for Health and Clinical Excellence (NICE; 2019) recommends that an option to have a follow-up appointment with a choice of healthcare professionals should be offered to women following early miscarriage. Despite this, there has been criticism of EPUs for not being set-up to accommodate support far beyond the initial identification of early miscarriage. As such, primary care providers have been identified as playing an integral role in providing this support (Baird et al., 2018). However, there is no clear primary care pathway for support following an early miscarriage. This means that general practitioners (GPs) are often relied upon by other health professionals to provide psychological follow-up and continued emotional support to their patients. This may be in part influenced by the view that they are better placed in the community to make onward referrals to alternative services if required (Claringbold et al., 2021). However, GPs are not in a position to be providing ongoing psychological support and are therefore likely to signpost to other NHS or charitable services, with Increasing Access to Psychological Therapies (IAPT) services often highlighted as the most accessible, due to their position within primary care and self-referral routes in (Miscarriage Association, 2021). In response to the Long Term Plan (NHS, 2019), new Maternal Mental Health Services are being established. However, this is not yet consistent across the country, and with their remit being for moderate to severe psychological difficulties, they would not provide support for those presenting with ‘milder’ difficulties following early miscarriage, meaning these people would continue to present within IAPT.

1.1.8. IAPT Context and Perinatal Champions

IAPT services provide psychological support for mental health difficulties, including anxiety, depression and trauma, all highlighted as being regularly experienced following early miscarriage. The IAPT manual (NHS, 2018) recommends prioritising service-users within the ‘peri-natal period’ (HM Government, 2021), from conception to 12 months after birth (O’Mahen & Healy, 2020), with the aim for them to be assessed within 2 weeks and to have started treatment within 4 weeks (HM Government, 2021). To help deliver these perinatal targets many IAPT services have introduced the role of perinatal champion. There is little literature outlining the specific remit of this role, but based on the IAPT Perinatal Competency Framework (O'Mahen & Healy, 2020) and accounts of other services implementing perinatal champions (Baldwin et al., 2018), it is a role based around improving access and support offered to perinatal service-users. It therefore makes sense that support following early miscarriage would fall under the remit of this role, although due to the lack of literature in this area it is unclear whether this is currently happening.

With early miscarriage occurring within the perinatal period, and NICE (2019) guidance recommending tailored psychological support to be offered as a priority following early miscarriage, we might expect these service-users to receive priority assessment and treatment delivered via perinatal champions. However, whether IAPT services are consistently fulfilling this requirement is ill-defined, with reviews and personal accounts indicating variability across services in the application of the perinatal label (Khan, 2015) and no information provided on where support following early miscarriage fits within this.

1.1.9. Summary

What we can see from the information presented is that there appears to be a gap between what support is wanted and needed following early miscarriage and what is available. People want to talk about their early miscarriage experiences (Maker & Ogden, 2003) and being given the opportunity to do so appears to buffer some of the potentially negative psychological implications of going through this (Abboud & Liamputtong, 2003). However, within the current NHS context it is unclear where this support might be best accessed and whether staff feel equipped to be offering it.

Most research in this area has focused on the perspectives of those who have gone through early miscarriage, their subsequent experiences of seeking support and perspectives on potential barriers to it. This has repeatedly identified dissatisfaction with the support available, including issues such as the medicalisation of early miscarriage (Bueno, 2019) and healthcare professionals lacking empathy or recognition of the potential impact (Hutchon & Cooper, 1998). Whilst this draws attention to some key information on possible barriers to accessing post-miscarriage support, few studies have focused specifically on early miscarriage, occurring in the first 12 weeks, or considered the perspectives of the healthcare professionals delivering or guiding this support.

Interactions with healthcare professionals following early miscarriage can influence recovery and the overall experience of accessing psychological support, as well as affecting engagement with care providers in the future (Griffin et al., 2021). This highlights the importance of shedding more light on these relationships and the disconnect between knowledge and actions from a variety of viewpoints. It therefore makes sense to gain a broader perspective through also understanding the barriers from the viewpoint of the healthcare professionals potentially delivering this support. This is likely to bring to light not only individual factors relevant in influencing what support they can offer, but wider service-level and systemic factors and their impact. With the steps to accessing support following early miscarriage within an NHS context being unclear, further exploration of the perspectives of staff members positioned in services accessed by those experiencing early miscarriage, with roles that include the potential provision or guidance to subsequent support, appears imperative.

1.2. Literature Review

1.2.1. Literature Search Strategy

A scoping review of the current literature was carried out to highlight any studies that had investigated professionals' perspectives in providing support to people following early miscarriage. The scoping review protocol was developed and completed with input from a university librarian and the researcher's Director of Studies (DoS). It was also guided by these five steps recommended in the literature; 1) defining the research question 2) finding relevant studies 3) selecting studies 4) recording the data and 5) reporting and summarising the results (Arksey & O'Malley, 2005).

The following six databases were searched, from the start of each database up to June 2022: Academic Search Ultimate (EBSCO), PsycINFO (EBSCO), CINAHL (EBSCO), PubMed, ScienceDirect and Scopus. Search strategies were developed using medical subject headings and keywords identified through pilot searching, and the same approach was used to search each database, with some adjustments made due to the specific database's preferred index terms (see Appendix A). The concept of 'psychological support' and 'early miscarriage' were linked together using the Boolean operator 'AND' (please see Appendix A). Snowball searches were also used through manually examining the article reference lists to find any additional papers that also met the inclusion criteria but were not included in the initial searches.

Whilst this study aimed to focus on experiences of providing support following early miscarriage, defined as losing a pregnancy in the first 12 weeks, it should be noted that there was some variation found in terms of how this is defined across the literature, creating challenges in summarising what is known in this field. Included studies were therefore those that were published in English which specified their focus as being on the support provided for 'early' miscarriage. It was recognised that because of the ambiguity around early miscarriage terminology, some studies may include perspectives relating to miscarriage at over 13 weeks pregnant. Consequently, it was decided that studies would meet the inclusion criteria if some of the perspectives drawn on in the research related to pregnancy loss within the first 12 weeks. Papers that were included drew on perspectives of professionals involved in providing support following early miscarriage. Due to the limited nature of the research available, especially in relation to a UK-based context, we included research drawing on perspectives of professionals outside of just an NHS primary care context. This review also does not solely focus on therapeutic interactions and encompasses literature which takes the perspective of a variety of professionals who may offer support following early miscarriage, including: midwives, nurses, medical specialists, psychiatrists, psychologists, therapists, counsellors and social workers. Exclusion criteria included studies that concentrated on a patient rather than professional perspective, as well as those that focused perinatal loss, stillbirth, abortion, threatened miscarriage and medical treatment of early miscarriage rather than psychological support.

After the searches were complete, titles and abstracts were assessed for suitability. Following exclusion, any papers deemed relevant were read in full to ascertain their appropriateness. 21 papers were included and read in their entirety. Of these, eight were excluded, leaving 13 papers included in the review (Please see Appendix B). As outlined in the table below, nine of the 13 papers included directly reported on research exploring professionals' perspectives of providing support following early miscarriage. The decision was also made to include three practice guidance papers as these were written from the perspectives of relevant healthcare professionals, drawing on their experiences on the provision of support available following early miscarriage and potential barriers to this. Although these referenced literature relevant to the field in general, this did not overlap with the papers already included in the scoping review. There was some overlap with the single review article included, with it referencing three of the empirical papers also included in the scoping review (Murphy & Philpin (2010), Easterwood (2004), Murphy & Merrell (2009). Due to the very limited amount of research in this area the decision was made to still include the review paper in the scoping review as it was written from the perspective of a nurse who was also drawing reflections from their own experience. However to avoid over-emphasising findings included in both the review and empirical papers, care was taken to only draw out information from this article which was not directly reliant on the other included papers.

Table 1

Papers Included in Scoping Review

Paper Number	Authors	Date	Country	Title	Methodology	Participants/Perspectives	Journal
1.	Yang et al.	2022	New Zealand	'Views of health professionals on the impact of early miscarriage on women's mental health and the accessibility of services and support'	Research: Qualitative, semi-structured interviews and semi-inductive thematic analysis.	Nurses GPs Foetal Medicine Specialists Termination of Pregnancy Providers Maternal Mental Health Psychiatrists Clinical Psychologists Termination of Pregnancy Counsellors Maternal Foetal Medicine Midwives Social Workers	New Zealand Medical Journal
2.	Griffin et al.	2021	Australia	'Caring for women through early pregnancy loss; Exploring nurses' experiences of care'	Research: Qualitative, interviews and thematic analysis.	Nurses	Collegian
3.	Chichester and Harding	2021	USA	'Early pregnancy loss: Invisible but real'	Practice Guidance: Nurse's perspective on current support following early miscarriage.	Nurses	Nursing

4.	Claringbold et al.	2020	Australia	‘Early pregnancy assessment services in Australia: What psychosocial support is available? A qualitative study’	Research: Qualitative, semi-structured interviews and thematic analysis	Clinical Managers/Coordinators Nurses/Midwives Obstetrician/Gynaecologist Consultants/Registrars Specialised GPs Pastoral Care Practitioners Sonographers Clinical Psychologists Bereavement Counsellors	Women and Birth
5.	Nash et al.	2018	Ireland	‘Midwives’ experiences of caring for women with early pregnancy loss in an Irish maternity hospital’	Research: Qualitative, semi-structured interviews and thematic analysis	Midwives	British Journal of Midwifery
6.	Markin	2016	USA	‘What clinicians miss about miscarriages: Clinical errors in the treatment of early term perinatal loss’	Practise Guidance: Clinician’s perspective on errors in providing support following early miscarriage	Unspecified ‘Clinicians’	Psychotherapy
7.	Robinson	2014	UK	‘Provision of information and support to women who have suffered an early miscarriage’	Review Article: (also drawing on nurse’s perspective on barriers to support following early miscarriage)	Unspecified ‘Health Professionals’	British Journal of Midwifery

8.	Gergett and Gillen	2014	UK (Northern Ireland)	‘Early pregnancy loss: perceptions of healthcare professionals’	Research: Qualitative, semi-structured interviews and thematic analysis	Unspecified ‘Healthcare professionals from several disciplines’	Evidence Based Midwifery
9.	Zavotsky et al.	2013	USA	‘Early pregnancy loss and bereavement in the emergency department: Staff and patient satisfaction with an early fetal bereavement program’	Research: Quantitative, implementing programme and reviewing via surveys.	Physicians Nurses	Journal of Emergency Nursing
10.	Murphy and Philpin	2010	UK	‘Early miscarriage as ‘matter out of place’: An ethnographic study of nursing practice in a hospital gynaecological unit’	Research: Qualitative, ethnographic study-observation, analysis and interviews.	Nurses Doctors Ultrasonographers	International Journal of Nursing Studies
11.	Murphy and Merrell	2009	UK	‘Negotiating the transition: caring for women through the experience of early miscarriage’	Research: Qualitative, ethnographic study-observation, analysis and interviews.	Nurses Doctors Ultrasonographers	Journal of Clinical Nursing

12.	Easterwood	2004	USA	‘Silent lullabies: Helping parents cope with early pregnancy loss’	Research: Mixed Methods, implementing programme and reviewing via surveys and qualitative feedback	Nurses	AWHONN Lifelines
13.	Iles	1989	France	‘The loss of early pregnancy’	Practice Guidance: Doctor’s perspective on barriers to support following early miscarriage	Doctors	Baillière's Clinical Obstetrics and Gynaecology

1.2.2. Approach To The Literature

It was evident from the literature that similar professional perspectives relating to the challenges faced in providing psychological support following early miscarriage were present across the studies. In summarising the content, it therefore made sense to capture these within themes that encompassed all the papers and the various perspectives expressed. The main areas identified were: psychological interventions, inequity of access, nuanced needs, medical-focus, blame, shame and silence, level of experience and knowledge, training, work demands, psychological impact on staff and fragmented care. Each of these areas will therefore be discussed in turn and framed using the scoping literature gathered, including direct quotes where possible. In addition, suggestions of service level development to address the barriers were derived from the literature and will also be presented in the review, along with concluding comments.

1.2.2.1. Interventions: "You can't just give them a booklet and walk away." (Nash et al., 2018, p. 800)

Despite not necessarily being in directly therapeutic roles or having had any formal experience of providing counselling, many professionals talked to the significance of empathising, listening, and supporting the specific needs of the individual following early miscarriage. They recognised the wide variety of feelings, perspectives and beliefs that could be experienced and the subsequent need to tailor their care to these (Claringbold et al., 2021). Being able to acknowledge the loss, validate feelings relating to this and provide reassurance were deemed as skills needed to offer the best support . The fact people may be seeking or expecting explanations to be provided via the support they received was recognised as a potential barrier by healthcare professionals, who pointed out how challenging it can be to manage these expectations when clear causes of miscarriage are so infrequently known.

Evidence-based recommendations for guiding support following early miscarriage are lacking (Nash et al., 2018). However, in Yang et al.'s (2022) study, finding out how a woman felt about her early miscarriage was considered vital in guiding consultation and directing to support. A professional's ability to account for and talk to the cultural, spiritual and societal components influencing a response to early miscarriage is described as imperative, but also a potential barrier if they are not responsive to the need of that individual and present as uncomfortable, ill-informed and ill-prepared (Chichester & Harding, 2021). Limited availability of appropriate professionals and forms of support, such as talking therapies which could encompass themes of grief and loss, were also considered to be a barrier to access (Yang et al., 2022).

Chichester & Harding (2021) raised the importance of trauma-informed care and using communication skills to convey compassion and understanding in response to those going through early miscarriage. Employing these skills, sets up an honest and open dialogue that allows recognition that everything is not OK. Beginning statements with “I wish…” was identified as being a helpful and therapeutic communication strategy, as well as ensuring a quiet and private physical space is available. However, access to the training, time and space required to learn and implement these support skills was regularly highlighted as a barrier.

Despite most services having access to literature relating to miscarriage support services or abilities to signpost to these, it was identified that some staff lacked knowledge in this area and subsequently did not routinely offer this information (Claringbold et al., 2021). A concern was also raised regarding the potential for professionals to overfocus on action-oriented, cognitive interventions, whilst failing to see the person as someone who has lost a child. Such approaches were thought to run the risk of pathologizing normal grief responses and prematurely encouraging someone to ‘move on’ (Markin, 2016). Similarly, a tendency of professionals to assume that any difficulties arising from an early miscarriage are resolved following a subsequent pregnancy was identified as another barrier to providing useful therapeutic input. Over-focusing on the positive feelings relating to the impending birth was also identified as a potential obstacle in recognising the depth of emotions remaining from the earlier miscarriage (Markin, 2016). It is suggested that instead, professionals should validate the significance of the loss and emotions related to this through normalisation and naming of some of the ways people might respond. However, Claringbold et al. (2021) pointed out that whilst professionals may tell people that early miscarriage is common to help reduce their feelings of guilt, this can feel unhelpful and like the loss is not being acknowledged by those going through it. Research has also questioned whether these attempts to appease and reassure are actually unconscious attempts to evade the distressing reality that early miscarriage happens all the time and could therefore happen to any of us (Markin, 2016).

1.2.2.2. Inequity of access: “There is a lot of inequity, and those [who] are educated, well, probably white with good family support, are the ones that will probably be the squeaky wheels and get the most help, because they will describe how they’re feeling, they will front up, they will not DNA. People that are poor, haven’t got transport, haven’t got financial security, who can’t necessarily speak our language, who can’t necessarily understand medical jargon or hospital jargon or clinical jargon- this isn’t their place of comfort, is it? They don’t want to be here, this isn’t where they feel safe. So yeah, there is a lot of inequity.”-Maternal foetal medicine midwife. (Yang et al., 2022 p. 59)

Yang et al. (2022) explored the system-wide factors influencing the accessibility of support following early miscarriage, finding that inequity of access to services was a significant barrier identified by healthcare professionals. This related to the cost of counselling and geographic location, with the participants noting that young, Māori, Pacific Island women were missing from the service, whilst their predominant client base were Pākehā and middle-class. Whilst these findings may not be directly transferable to a UK context due to this research taking place in New Zealand, it highlights the potential impact of barriers at a socio-cultural level and the need to address these to support equity of access to psychological support following early miscarriage.

Similar perspectives have been drawn from UK-based studies. For example, Gergett and Gillen's (2014) participants described the provision of support following early miscarriage for people from ethnic minorities as challenging due to the professionals’ lack of cultural understanding, as well as more practical barriers such as lack of timely access to interpreters and suitable resources. With examples given of information booklets being only available in English, staff questioned whether insufficient resources to overcome language barriers served to disproportionately exacerbate the silence around early miscarriage for minoritized individuals. They also recognised that with the minimal research carried out in this area generally, very little had focused on diverse experiences of early miscarriage beyond a Westernised viewpoint, meaning that there were few resources from which to draw further information.

1.2.2.3. Nuanced Needs: “People have unwanted pregnancies or children who are neglected and these other people are so desperate for a baby, I find that difficult.” (Nash et al., 2018, p. 801).

Each person’s experience and response to early miscarriage is multifaceted and must be understood on an individual basis (Yang et al., 2022). Every account is unique and tells the story of loss that person has experienced, along with their future hopes and dreams (Markin, 2016). The ability to tailor information and reflect on the context of the individual’s journey to early miscarriage is therefore of great importance (Griffin et al., 2021). This might include taking the time to provide information on outpatient and community resources and delivering this information in a personalised way. Professionals recognised that whilst it was important to value and respect the loss, individuals may experience and express their emotional responses differently. They also raised concerns that many people would be resuming life in a societal context which invalidates the feelings of loss experienced following early miscarriage or views it as taboo (Griffin et al., 2021).

Professionals highlighted the need to assess the nuanced needs of each individual and offer care suited to them, recognising that in some cases the support offered can instead reflect environmental and institutional factors, and professionals’ own perspectives (Gergett & Gillen, 2014). It was recognised that conceptualisations of early miscarriage could be shaped by cultural norms, potentially resulting in a disconnect between the way individuals and professionals perceive this experience if they are coming from different cultural perspectives. This point is highlighted through this quote from a Ghanian doctor who had recently moved to practice in the UK: “It is God’s will…they don’t talk about ‘my baby’ [in Ghana…until movements are felt]. Here they have a miscarriage at six weeks and they are crying for their baby!” (Murphy & Philpin, 2010). This highlights the need for professionals to meet their patients where they are at, and spend the time required to understand their individual conceptualisation of their early miscarriage experience (Murphy & Philpin, 2010).

1.2.2.4. Medical focus: “It is very…gruesome in the way we explain it. A lot of them would grimace at even words like ‘products of conception’ and you’d try not even say those words, because it just sounds like ‘products’ [like] they aren’t a pregnancy…” (Nash et al., 2018, p. 801).

In all but one of the papers reviewed (Murphy & Philpin, 2010), it was emphasised that whilst the physical and biological elements to early miscarriage are generally well understood, psychological needs are not given the same priority (Gergett & Gillen, 2014). Whilst professionals stressed the need for compassionate and holistic care following early miscarriage, safety and physical needs were often reported to be attended to first (Griffin et al., 2021; Gergett & Gillen, 2014). This was also reflected in Claringbold et al.’s (2020) findings that any follow-up offered generally concentrated on physical management rather than the emotional elements of the loss.

Professionals have understandably pointed out that their response to early miscarriage will be at least somewhat dependent on their role and its remit. They recognised that staff members such as doctors and nurses will be accustomed to responding to quickly changing life-or-death situations, so may naturally de-prioritise someone who is emotionally hurt but physically stable following early miscarriage (Zavotsky et al., 2013). It was also recognised that for many professionals, early miscarriage is a routine part of their everyday work that they view as commonplace and minor (Murphy & Merrell, 2009), highlighting the potentially misaligned conceptualisations of a pregnancy loss between patients and caregivers (Murphy & Philpin, 2010). These perspectives draw attention to the fact that whilst physical and medical needs are being met following early miscarriage, emotional needs are often neglected.

Healthcare professionals in New Zealand described themselves as not currently being “in a space to deal with psychological as opposed to psychiatric disorders” (Yang et al., 2022). This links to the diagnosis-focus and leaning on the medical model used in clinical practice, potentially leading to the pathologization of normal reactions such as grief in response to early pregnancy loss, or the dismissal of distressing symptoms that do not meet the appropriate threshold to gain access to support (Markin, 2016). Nash et al. (2018) talked about the need for a shift towards a holistic, person-centred approach from services, addressing spiritual, psychological, emotional and social needs along with the physical. In order to work towards this, there needs to be a willingness from professionals to see the patient's experience of early miscarriage through their eyes, rather than basing their understanding on preconceived ideas and diagnostic categories.

The literature also highlights that consideration must also go into the language that is used by professionals in referring to aspects of early miscarriage. For example, using terms such as “pregnancy failure”, “chemical pregnancy”, “blighted ovum” and “products of conception” has been identified as conveying little empathy, with the preferred terms being “miscarriage” or “early pregnancy loss” (Chichester & Harding, 2021). In some cases staff recognised that such clinical terms may be experienced as insensitive and described how they would attempt to explain these more compassionately. However, staff also reflected that medical jargon could serve as a form of protection for themselves and a method for reducing the emotional overload (Gergett & Gillen, 2014). Nonetheless, this could be at the expense of their patient's wellbeing who would benefit from them dropping the professional façade and participating in emotionally present and responsive communication. Professionals can also become drawn into utilising their healthcare knowledge in an attempt to reassure or explain following an early miscarriage, for example, through pointing out that the developing baby was probably abnormal in some way, which can be experienced as problematic (Iles, 1989). The need for staff to have effective interpersonal skills that allow them to communicate beyond the comfort of their medical jargon when dealing with sensitive topics is therefore highlighted.

1.2.2.5. Blame, shame and silence: “It depends on the stage of their pregnancy loss. If it's mid-trimester or like a 24-week stillbirth, there is a lot more support; people will actually ask you, “Are you ok?”” (Nash et al., 2018, p. 800).

Yang et al.'s (2022) participants recognised that the concept of pregnancy comes with expectations that position women in a way that can add pressure and result in self-blame if the pregnancy results in early miscarriage. They reflected that in many cases, as soon as someone becomes pregnant, they are thinking about the pregnancy as a fully formed baby and the future that comes with it. They described how women often felt shame, blame and grief in response to an early miscarriage. This led to them questioning whether it was their fault and if they had done something wrong, stating that 'their bodies had let them down' (Yang et al., 2022). These are themes potentially perpetuated by the responses of healthcare professionals who are, in some cases, ill-informed about causal factors impacting the likelihood of early miscarriage or who may avoid talking about it due to the discomfort of this topic and related areas such as sex and death (Markin, 2016; Murphy & Merrell, 2010). Such a response may make it harder to consequently seek psychological support relating to the early miscarriage, for fear of further judgement or abandonment.

Those who have experienced early miscarriage have been described as "a silent voice'", recognising that they are not attended to at the same level by staff compared to those experiencing a later miscarriage or successful pregnancy and birth (Yang et al., 2022). Chichester and Harding (2021) pointed out that lack of engagement and support offered by professionals can be experienced as minimising by those going through an early miscarriage, who often report feeling forgotten and alone (Nash et al., 2018). Findings indicate that professionals with less experience are more likely to deem a loss in the earlier stages of pregnancy as a 'minor issue' and 'commonplace', making it less psychologically impactful than one that occurs later in a pregnancy, whereas this is not supported by the research overall (Robinson, 2014; Iles,1989). Professionals also recognise that that they may not give an early miscarriage the same amount of recognition as a neonatal death or stillbirth (Gergett & Gillen, 2014).

Whilst many healthcare professionals shared the view that early miscarriage is a loss that can affect both childbearing and non-childbearing partners and their families (Yang et al., 2022), Chichester & Harding (2021) recognised that the non-childbearing partner's experiences of early miscarriage can often go unacknowledged as the focus of professionals tends to be on the childbearing partner. This risks increasing the silence experienced around this event even more so for partners, highlighting the need for professionals to be aware of and responsive to the needs of the family in the context of early miscarriage.

1.2.2.6. Level of experience and knowledge: “I didn’t know a lot about it before I came here. You learn about it in college but you don’t really know the reality of it until you come across the women every day.” (Nash et al., 2018, p. 798-799)

The diverse and differing perspectives of healthcare professionals in response to early miscarriage can be confusing and add to the distress of those going through it. Whilst some professionals will have frequent, therapeutic contact with people who have experienced early miscarriage, others are not prepared or able to detect and manage the psychological impact, due to limited interaction and having received no specific teaching or training in this area (Iles, 1989). Students are described as often being kept away from people experiencing difficulties relating to early miscarriage, for fear of it being too ‘complex’, and junior staff with limited experience around early miscarriage have been identified as a potential barrier to support, with a tendency to not view distress relating to early miscarriage as a priority or fully fathom the potential impact of this event (Iles, 1989).

Chichester and Harding (2021) pointed out that even in cases where the potential psychological harm is recognised, many professionals are not comfortable providing support following early miscarriage as they think that they do not have the required confidence, experience and communication skills, to offer suitable support at this challenging time. When professionals are uncertain or unclear how they can help, they may respond by ignoring which can again feed the perceived silence around early miscarriage (Iles, 1989). These sentiments were reiterated by the professionals’ voices highlighted in studies by both Nash et al (2018) and Gergett and Gillen (2014) who described difficulties in knowing what to say, preventing them from fully engaging with people following early miscarriage. Lacking confidence in managing the varied reactions to early miscarriage, which was worsened by worries about saying the wrong thing and an absence of training, were also identified as barriers to providing optimal support. However, it was also reflected that it became easier to cope and respond appropriately the more experience they had, with more knowledgeable staff welcoming the opportunity to offer support for people after an early miscarriage and describing themselves as comfortable in expressing their own emotions during this process (Gergett & Gillen, 2014).

1.2.2.7. Training: “A study day would give us some good support and some good advice to know how best to look after people who are having early pregnancy loss.” (Nash et al., 2018, p. 800).

Understanding the emotional impact and significance of early miscarriage helps professionals to support people positively through their experience (Robinson, 2014), whereas a lack of confidence and skills in this area is disempowering and prevents them from fully engaging (Nash et al., 2018). Training therefore appears crucial in breaking the barriers to offering optimum support. However, in many cases it appears that services do not offer staff any miscarriage-specific training, meaning they are often required to learn their skills from colleagues or through experience (Claringbold et al., 2021; Gergett & Gillen, 2014). Whilst in some cases professionals described putting value on education and assuming responsibility for their own learning in relation to early miscarriage (Griffin et al., 2021), this may not be the case across all professionals and services. The views from the literature indicate that when professionals do not have the tools to provide the care they want following early miscarriage, this reduces their job satisfaction levels and leads them to question whether they are delivering adequate support (Zavotsky et al., 2013). The need for services to address the staff knowledge deficit relating to early miscarriage and provide appropriate education and training is repeated throughout the literature (Nash et al., 2018).

Many of the papers reviewed were in support of specific training provision to better equip professionals in offering support following early miscarriage. Gergett and Gillen’s (2014) research showed that the perceived ability of professionals to support the emotional needs of families experiencing early miscarriage was positively influenced by attending a bereavement programme. Similar findings were shared by Easterwood (2004) who found that staff who attended a ‘Facilitating Healing in Families Who Experience Miscarriage’ programme reported increased awareness of the nature and scope of the early miscarriage experience, as well as a desire to become more effective in caring for people going through it. However, it has been noted that even when professionals have received specific training aimed to develop their skills in supporting people following early miscarriage, they may still feel ill-prepared to provide this support. This can result in hesitation and feelings of uncertainty, due to fears of saying the wrong thing (Chichester & Harding, 2021; Zavotsky et al., 2013). Consequently, better quality training and improved channels of inter-professional learning were identified as areas for possible service improvement by the healthcare professionals in the literature (Yang et al., 2022).

1.2.2.8. Work demands: “We cannot give them the care they deserve because we just don’t have the time…” (Nash et al., 2018, p. 801).

Whilst professionals have described their ability to care for people following early miscarriage as a gift and a privilege, they also portrayed this work to be emotionally intense and frequently faced with institutional and environmental constraints (Griffin et al., 2021; Gergett & Gillen, 2014). This is often in the context of very busy and demanding work contexts, which do not always allow for time to be taken to access training, appropriate support tools or relevant study days due to factors such as staffing levels and funding issues (Nash et al., 2018; Zavotsky et al., 2013). Furthermore, staff to patient ratios can leave professionals rushing from one person to the next, meaning that they have less opportunity to develop a relationship conducive to offering meaningful support to those experiencing early miscarriage.

The emotional labour required for providing support following early miscarriage, may not be something all professionals feel willing or able to offer or fully engage with, in some cases needing to prioritise their own self-care (Griffin et al., 2021). In seeking to meet their client’s needs, professionals must also balance their own emotional responses alongside organisational priorities in increasingly outcome-based healthcare cultures (Griffin et al., 2021). Such work has been reported as exhausting, potentially leading to burnout, stress and complacency, resulting in less emotionally-responsive care (Gergett & Gillen, 2014). Environmental and time constraints are recurrent barriers highlighted by staff in a number of the studies reviewed (Griffin et al., 2021; Claringbold et al., 2021).

When given sufficient time, staff reported providing care following early miscarriage that is excellent; demonstrating high levels of dedication and enthusiasm to their role of providing psychosocial support, empathy, acknowledgement, compassion and guilt mitigation (Claringbold et al., 2021; Easterwood, 2004). However, a lack of resources are commonly reported (Gergett & Gillen, 2014). Feeling able to meet the needs of the people they support is crucial in the development of staff efficacy and self-confidence (Chichester & Harding, 2021), highlighting the potential detrimental impact it can have on staff when services are deemed to not be working efficiently. Such issues are likely to be even more salient given the current staffing issues alongside increasing demands on the NHS.

1.2.2.9. Psychological impact on staff and support available: "You have to learn to distance yourself because otherwise if you take it too much on board you just fall apart…There were days when I cried before I even left the hospital, cried all the way home and cried when I got home." (Nash et al., 2018, p. 799-800)

Caring for people with high levels of distress can result in emotional labour that poses both personal and professional challenges for staff, who may require subsequent support themselves. Repeated exposure to people going through early miscarriage has been identified as having a potentially profound emotional effect on the staff involved. In response to this, healthcare professionals report implementing coping strategies such as distancing themselves and switching off, as well as emotional responses such as feelings of frustration and stress, which could all be detrimental to their ability to provide support. When healthcare professionals experience difficulties in connecting with and supporting people going through early miscarriage, this can lead them to focus only on technical care elements that are strictly necessary, taking away from the compassion and empathy required and resulting in sub-optimal support (Nash et al., 2018).

A lack of access to their own support, potentially exacerbating mental health difficulties and leading to burnout, is highlighted as another possible barrier for staff (Chichester and Harding, 2021). In response to this, many staff across the literature have proposed that they would benefit from improved emotional support to help them face the challenges of looking after people following early miscarriage, including access to structured supervision spaces, informal debriefs, timeouts, peer group support and individual counselling (Griffin et al., 2021; Nash et al., 2018).

The fact that early miscarriage is so common, means that many health professionals will have been touched personally by this experience, potentially resurrecting their own private grief (Nash et al., 2018). This is possibly exacerbated by the disjunction between their experiences and the ways in which healthcare professionals generally respond to early miscarriage. Whilst many professionals in the literature reported lived experience relating to miscarriage, pregnancy and parenthood, as an asset to their practice (Griffin et al., 2021), it was also recognised that personal experiences may influence their responses and get in the way of them fully comprehending what someone else is going through following early miscarriage (Gergett & Gillen, 2014). Professionals also highlighted the juxtaposition of wanting to portray an image of a detached and professional carer versus endeavouring to deliver authentic support, and the dilemma this poses in terms of what they share and how they communicate with someone going through early miscarriage (Gergett & Gillen, 2014). This further highlights the need for staff to have spaces to reflect on self-disclosure and how supporting people following early miscarriage may have affected them personally.

1.2.2.10. Fragmented care: "…you can't expect them to process the news whilst they are there. It may kick-in, in an hour, a day, a week later and you've just got to think about what kind of support they would have if they went home in that situation." (Gergett & Gillen, 2014, p. 32)

Fragmented support and services available for people following early miscarriage have been reported as a barrier from healthcare professionals across the world. For example, Yang et al. (2022) identified communication gaps both within and between services and between the different service professionals, as being a barrier to psychological support through increasing the risk of co-ordinated follow-up not taking place in New Zealand. These echoed findings from Claringbold et al. (2020) who found that in Australia, people were not usually offered a referral for extra support following early miscarriage, with psychology referrals being uncommon and only made when high psychological risks were identified. By not following-up with people who have experienced early miscarriage, this leaves health professionals in the dark as to any ongoing emotional distress and biases their understanding of the potential impact (Iles, 1989).

Concerns were raised from staff that not streamlining the information sharing processes puts people at risk of re-traumatisation, through having to repeatedly share their experience with different healthcare professionals (Yang et al., 2022). Another area identified as not being routine to healthcare settings was communication regarding obstetric history and possible links to mental health. Furthermore, inaccessibility to further support was thought to be exacerbated by organisational factors and constraints on the system which was said to be set-up to support the mother-baby dyad, rather than those who had experienced early miscarriage. Across the literature, there also appeared to be differing perspectives and uncertainty from professionals as to who should provide any follow-up support required following early miscarriage, with suggestions varying from GPs to local bereavement counsellors (Gergett & Gillen, 2014).

1.2.2.11. Service-level development: The need for services to develop robust strategies in response to the needs of those experiencing early miscarriage to help manage the associated psychological morbidity risks was emphasised across the literature. In Yang et al.'s (2022) study, change-ideas from professionals focused on system-level facilitators to improve access to support following early miscarriage and included improved primary care clinical pathways to support seamless care and follow-up. The need for coordinated care and better communication was also reiterated (Yang et al., 2022). At an organisational level they proposed incorporating talking therapies into primary care and making counselling more accessible for both childbearing and non-childbearing partners. Suggestions of how to increase accessibility of psychological support included reducing or removing financial barriers, making sure the therapy on offer meets the needs of those seeking support through providing person-centred holistic care and offering community-based options (Gergett & Gillen, 2014). These may include relevant local clinical pathways with links to support services and groups, to help streamline coordinated care and follow-up. Given the diverse needs of those experiencing early miscarriage, the research also highlighted the importance of contributions from those with lived experience in leading any new service initiatives.

1.2.2.12. Limitations: Limitations of the current research in this area include a lack of studies from the UK, focusing on an NHS context. Furthermore, whilst perspectives are drawn from a wide range of healthcare professionals, it is recognised that different professions will vary in terms of their role in providing support following early miscarriage, with medical professionals such as nurses, midwives and nurses being more likely to have the majority of their time dedicated to medical management. The variety of perspectives makes it hard to focus specifically on the viewpoints of those working therapeutically who may be more likely to deliver the psychological support following early miscarriage, meaning that we may be missing out on crucial perspectives of those on the front line of delivering this support. Additionally, whilst some allusion is made to the impact of cultural variation on responses from health professionals to early miscarriage (Murphy & Philpin, 2010), no further attempts have been made to explore this area specifically.

1.2.2.13. Conclusion: Whilst staff across the literature exhibited a clear commitment to giving high quality care to people following early miscarriage within their clinical settings, there appears to be a consistent acknowledgement that there is a need for improved access to psychological support. The key messages from the existing literature are that barriers to accessing support following early miscarriage present in various forms. These range from accessibility, availability and suitability of support, issues with provision based on knowledge, skills and time and wider system issues relating to staffing, service provision and stigma. Whilst the literature has been very useful in bringing to attention some of the barriers that may be present, it does not tell us whether these same factors are creating issues with accessing support following early miscarriage from NHS-based mental health services such as IAPT.

1.3. Rationale and Relevance to Clinical Psychology

The experience of early miscarriage will become part of the life history of a substantial number of the population (Bansen & Stevens, 1992). With the potential impact of psychological difficulties following early miscarriage disproportionately affecting disadvantaged groups, theoretically spanning into future pregnancies, parenting and child development, and current calls to reform the support offered following early miscarriage (Quenby et al., 2021), it appears crucial to find ways to improve these pathways to support. Providing compassionate support that acknowledges the vast array of emotions that can be experienced in response to early miscarriage can lead to better psychological outcomes. As well as helping people feel supported, this can promote their healing and enhance their coping ability (Chichester & Harding, 2021). On the other hand, unsatisfactory support can exacerbate the distress experienced (Gergett & Gillen, 2014). However, the research indicates that despite mental health difficulties being commonly experienced following early miscarriage, psychological support is infrequently offered or accessed (Robinson, 2014).

The limited research available demonstrates that although in many cases healthcare professionals acknowledge that early miscarriage can be experienced as a significant loss, the journey to accessing psychological support is frequently fragmented and inequitable. Psychological care following early miscarriage is an area of need that is currently unmet and, considering its high frequency and potential influence on mental health, action in response to current service provision and the possible barriers to this are required. As mental health difficulties are more common following early miscarriage, the availability of screening tools and treatment options to support these must be improved, and further research is necessary to inform them. With referrals for support following early miscarriage in the UK, NHS context being likely to be made to IAPT, understanding potential barriers to this support from the perspective of those working within these services is essential for informing future development.

1.4. Aims of Current Study

With current evidence exploring staff perceptions in this area lacking (Baird et al., 2018; Gergett & Gillen, 2014) and very little of the available research on staff perspectives having taken place within a UK-based, NHS context, we clearly need more information in this area to inform future developments. Further research can support understanding of potential failings in support provision and how this might be improved. Research which assesses the impact of working with early miscarriage from the perspective of healthcare professionals in an NHS Primary Care context can help us better appreciate what they have experienced and what influences their capability to provide appropriate support (Radford & Hughes, 2015). This research is therefore interested in how services, therapists and practitioners in the NHS respond to people presenting with difficulties relating to early miscarriage, how these influence the accessibility and meaning making around the support available, and how this may be improved. With IAPT being the most highly accessed Primary Care mental health services (Clark, 2018) and IAPT perinatal champions being specifically allocated to working with people during the perinatal period when early miscarriage occurs (O’Mahen & Healy, 2020), this appears to be a logical starting point from which to further the current understanding of early miscarriage support. The purpose of this study is therefore to understand experiences of staff delivering psychological support following early miscarriage, through gathering perspectives of IAPT perinatal champions, recognised as those who perhaps should be on the front-line of providing this type of support in primary care. The aim is to identify common themes in their responses, to inform IAPT services and other primary care practitioners how to be better equipped in directing and providing support for people experiencing difficulties relating to early miscarriage. This approach will draw attention to common factors across IAPT services which impact the accessibility of support following early miscarriage in order to inform commissioning and service perspectives and initiate potential change.

1.5. Research Questions

Whilst the qualitative nature of this research cannot guarantee exactly what angle of information the data will provide, it will be informed by these general questions:

- What are the experiences of IAPT perinatal champions in providing psychological support for people following early miscarriage?
- What are their perspectives on potential barriers to these people accessing psychological support?
- How might we overcome these barriers?

CHAPTER TWO: METHOD

2.1. Overview

This chapter will discuss the chosen methodology and related epistemological positioning of the research. Ethical considerations, along with information regarding the study design, sample, data collection and analysis will also be presented.

2.2. Research Design

Research designs are comprised of a collection of theoretical and philosophical assumptions which guide, direct and provide a framework for a study (Maxwell, 2013). Researchers should be transparent regarding the theoretical framework guiding their work (Willig, 2013). This study is interested in understanding and exploring perinatal champions' perspectives of barriers in delivering psychological support for people who have experienced early miscarriage. A descriptive, qualitative design was deemed appropriate for this research, due to its practical nature. This matched with the study aim, through permitting the researcher to consider the data both holistically and comprehensively (Cesario et al., 2002). Due to being a pragmatic rather than theory-driven approach, qualitative description is well-placed to encapsulate healthcare professionals' experiences, such as perspectives on providing support following early miscarriage, using their own stories and words to identify common themes (Willis et al., 2016). Qualitative description differs from some alternative qualitative frameworks in that it originates from existing experiences and knowledge of participants, producing a focused understanding which brings to light the contextual factors that shape these (Neergaard et al., 2009). The researcher was therefore supported to stay close to the data and the meaning of events and words through using this design (Sandelowski, 2000). This research and method were particularly well-matched as participants' perspectives could be investigated whilst holding in mind the impact of their service context, guidance on best-practice, and relevant literature relating to professionals' experiences of providing post-miscarriage support. Such information is useful in supporting the development of practical recommendations and future decision making, which is especially relevant in the context of this research.

2.3. Epistemological Positioning and Self-Reflexivity

The exploratory nature of qualitative research lends itself to gaining an understanding of the meaning participants attribute to a phenomenon of interest (Willig, 2013). This study aimed to understand and explore perinatal champions' experiences of the barriers to delivering psychological support for people following early miscarriage, which is congruent with qualitative methodology. Additionally, this approach aligns with the philosophy of clinical psychology which endeavours to comprehend individuals' beliefs, values, intersubjectivity and subjectivity (The British Psychological Society, 2017).

The critical realist epistemological positioning of this study is consistent with clinical psychology practice, through its intention to seek to understand individuals' subjective experiences (The British Psychological Society, 2017). Ontologically, critical realism assumes that external realities, independent of human thinking, can only be imperfectly measured and, because of this, experiences are idiosyncratic and governed by each person's individual beliefs. Hence, critical realism takes the position of there being only one reality which may be understood in a variety of ways (Bhaskar, 2013). Epistemologically, critical realists view data as context dependent and a representation of what is happening in the world. This runs alongside the belief that it requires additional elucidation to support understanding of the structures underpinning the experience of interest (Bhaskar, 2010).

Ponterotto (2005) supports an adapted objectivity/dualist approach to research; acknowledging researchers to be innately biased and therefore in a position to potentially influence research. As such, the researcher was required to recognise that there is a reality to the event of early miscarriage, its sequelae and the support provided following this, but the perspectives of IAPT perinatal champions relating to this will be idiosyncratic and subjective. Moreover, the information emerging from the interviews with the perinatal champions reflects that individual's perspective, whilst the analysis is the researcher's interpretation, which is constructed based on their own experience, knowledge and understanding (Bhaskar, 2013). Thus, despite the intention of the study being to investigate and inform on the perspectives of perinatal champions regarding potential barriers to providing support following early miscarriage, the possibility of bias influenced by the researcher must not be ignored. In response to this, the researcher noted their assumptions and influences during the research process, using both supervision and reflective logs to support self-reflexivity. As a white British woman with a strong interest in the rights of women and personal experience of early miscarriage, the researcher's focus is likely to be on the injustice towards women, perpetuated through healthcare provision and the systems upholding this. As a result, this research has also been informed by political and ethical concerns derived from feminist scholarship (Parr, 2015). Previous clinical experience in providing post-miscarriage support may also have biased the interpretation of responses or influenced the follow-up questions asked. Whilst ideally it is hoped that these individual characteristics would not significantly affect the study, the lens through which this research is being observed and the potential for researcher bias must be acknowledged. The researcher also recognises that this research and their lens in interpreting it may in some way perpetuate the Westernised viewpoint heavily present in the literature, that early miscarriage universally results in distress which requires interventions from healthcare professionals (Murphy & Merrell, 2009). However, whilst remaining aware of these cultural scripts, the researcher also aimed to be open in hearing alternative narratives whilst drawing on the wider perspectives and differing intersecting lenses brought by the participants (Crenshaw, 2019).

2.4. Thematic Analysis

Thematic analysis is used to analyse and identify patterns of meaning across a data set (Braun & Clarke, 2021b). It is also described as a systematic process of recognising important themes relevant to a particular phenomenon being explored (Fereday & Muir-Cochrane, 2006). Thematic analysis has theoretical flexibility and is not attached to a specific research framework. This means that most kinds of qualitative data can be analysed using thematic analysis, including interview transcripts. It can also be used to explore critical realist research questions (Braun & Clarke, 2006). Thematic analysis is described as being well-fitted to elucidating the particular nature of a studied phenomenon (Joffe, 2011), with research questions exploring perspectives regarding a specific topic of interest being particularly suitable (Willig, 2013). Based on this, thematic analysis was determined to be a good match with this study's aim of understanding the perspectives of IAPT perinatal champions on barriers to providing psychological support following early miscarriage.

According to Braun and Clarke (2006; 2021a), researchers need to make a decision regarding what is considered a theme and how to analyse the data to identify themes. A theme captures an important element of the data, which represents a patterned meaning or response related to the research question. Approaches used in thematic analysis include a deductive approach, which produces themes guided by the theoretical interest of the researcher and knowledge in the area, or an inductive approach, where the themes have strong links to the data (Patton, 2002). A semi-inductive approach was deemed appropriate for this research, whereby the method aimed to be exploratory but also recognised the potential impact of the researcher's prior experience of working in IAPT services as a perinatal champion, as well as their familiarity with the research and personal experience in this area.

Themes may be identified at both latent and semantic levels (Braun & Clarke, 2006). Semantic approaches identify themes within explicit meanings present in the data, remaining close to what is stated by the participant, whilst a latent approach attempts to go beyond this, through identifying conceptualisations, ideas and assumptions. Critical realist epistemological positioning permits data coding at both semantic and latent levels (Joffe, 2011). This research aims to understand and explore the potential barriers to psychological support following early miscarriage from the perspective of IAPT perinatal champions. There is flexibility regarding the theoretical context of psychological support and the understanding around early miscarriage, meaning that they can align with the epistemology present in the research. The information drawn from the data will focus on building knowledge regarding the interviewees' perceptions, beliefs and attitudes in relation to potential barriers to support. As such, the themes should capture their meaning and reflect their experience.

2.5. Participants

2.5.1. Exclusion Criteria

Individuals who had worked within IAPT services but not as a perinatal champion, or who had been a perinatal champion in a service outside of IAPT were not included.

2.5.2. Inclusion Criteria

Participants needed to have at some point held the position of perinatal champion within an IAPT service in the UK. Each participant was asked about their professional background to ensure their eligibility.

2.5.3. Recruitment

Healthcare professionals were recruited using existing online and personal IAPT network connections and snowball methodology. Prospective participants were approached via personal email addresses and messaging platforms and sent an initial invite which briefly outlined the proposed study and what their participation would comprise of, to gauge their interest in participating (see Appendix C). Anyone interested in participating was given a participant information sheet which outlined the research and data collection, including confidentiality (see Appendix D). This was to make sure that they were fully informed about what partaking in the research would involve. It was identified that participants may experience distress when relaying their experiences and they were therefore reminded before engaging that they were free to take breaks or change timing as required and could withdraw without being required to explain their reason at any point in the study. Participants were given the opportunity to ask any additional questions before agreeing to participate, as well as further opportunities at the time of their interviews. Prior to the interviews, each participant signed and returned a consent form which provided permission for the interview to be audio-recorded (see Appendix E).

2.5.4. Participant Details

Twelve healthcare professionals who had all held the position of perinatal champion in a range of IAPT roles, including Psychological Wellbeing Practitioners (PWPs) and Cognitive Behavioural (CBT) Therapists, opted to participated in this study. This was deemed an appropriate number of participants for the type of research being conducted (Fugard & Potts, 2015). All participants were female. All participants were from the UK and all but one had been based in IAPT services in London or the South East of England. Additional demographic details, such as ethnicity, race, years in the role or personal or professional experience of early miscarriage are not recorded in the study due to the limited number of perinatal champions across services meaning that these factors could lead to a breach confidentiality through making the participants identifiable. However, it is of note that participants were from varied racial and ethnic backgrounds, a small number of them had personal experience of early miscarriage and although variable, all described at least some clinical contact with clients who had experienced miscarriage. All participants were given a participant number for confidentiality purposes.

Table 2

Overview of Participants

Participant Number	**Role**	**Location**	**Gender**
1	CBT Therapist	Surrey	Female
2	CBT Therapist	Surrey	Female
3	PWP	London	Female
4	Senior PWP	London	Female
5	Senior PWP	Surrey	Female
6	PWP	London	Female
7	CBT Therapist	Kent	Female
8	PWP	London	Female
9	PWP	London	Female
10	Senior PWP	London	Female
11	Senior CBT Therapist	Kent	Female
12	PWP	Staffordshire	Female

2.6. Data Collection

2.6.1. Interview Schedule

To permit the discovery of unexpected and new information and support the descriptive, qualitative approach (Neergaard et al., 2009), data was collected using semi-structured interviews. This was considered most appropriate as semi-structured interviews use a series of open-ended questions to gain perspectives on a phenomenon of interest with key informants. They are also helpful for seeking views on a focused topic and gaining context through institutional perspectives and background information (Hammarberg et al., 2016). Using open-ended questions helps to define the topic of the research, whilst also providing chances for the researcher and participants to go into greater detail exploring particular areas of interest (Dearnley, 2005). An important aspect of using semi-structured interviews is finding the balance between retrieving information that helps answer the research question whilst allowing the participant to have space to bring their unique perspectives to generate new insight for the researcher. Semi-structured interviews are suitable for use in exploratory research, meaning this type of data fits with thematic analysis (Braun & Clarke, 2021b).

The interviews in this research aimed to explore perinatal champions' perspectives on the barriers to people being able to access psychological support following early miscarriage. Following the initial literature search, the researcher drafted a semi-structured interview schedule in collaboration with their DoS (see Appendix F). It was also felt to be methodologically important to represent the voice of service users and people who have been through the experience of early miscarriage within this research. The researcher therefore consulted with members of a mental health service user representative group and their own personal network of prospective service-users, identified as those having previously experienced early miscarriage, to gain their input in the design of the interview schedule. The final schedule was scaled back to be less leading and included questions about participants' experiences in working with clients following early miscarriage and any challenges perceived in relation to these (see Appendix G). It also covered their perspectives on the remit of the role and suitability to be offering psychological support following early miscarriage, as well as any suggestions for service development. It was developed in a way that supported logical transition between topics, but also allowed for digression where appropriate (Kallio et al., 2016). It was therefore designed with the intention to investigate the aims of the study, whilst also permitting the discovery of unanticipated and new information. Whilst the general framework of the interview schedule remained consistent across each of the interviews, ongoing consideration and reflection of the questions took place, resulting in slight adaptations as the interviews proceeded (Roberts, 2020).

2.6.2. Interview Process

Prior to the interviews participants were informed of the likely length of the interview and an agreed time was arranged and confirmed via a Microsoft Teams invitation. At this point, the participants had received the information sheet (see Appendix D) and were therefore aware of the purpose of the interview. They had also received the consent form (see Appendix E) and been given the opportunity to ask any questions before signing and returning this prior to the interviews.

Twelve, one-to-one interviews were undertaken by the researcher via Microsoft Teams between June and August 2022. The advantage of carrying out interviews remotely was that participants located further away from the researcher were not at a disadvantage through having to travel greater distances for a face-to-face meeting (Rowley, 2012). Furthermore, when people are interviewed in a space that feels safe, secure and familiar to them, this is thought to support more open and candid disclosures (King et al., 2018). However, there are some drawbacks to conducting interviews via a video-calling platform. For example, meeting outside of a face-to-face context may impact rapport building (Glueck et al., 2013). Therefore, to support the establishment of rapport, a funnelling approach to asking questions was used (Fox & Gamble, 2005). This meant that initial introductions were followed by general conversational-style questions about role and location and finding out whether they had any questions regarding the information sheet or signed consent forms, before progressing onto more in-depth questions around specific experiences of working with difficulties relating to early miscarriage. Prompts and reflections were also used to elicit further details from the participants to provide a richer perspective (Rowley, 2012).

Conducting interviews remotely can make it harder to pick up on physical cues apparent in body language. Consequently, particular attention was paid to what could be inferred from what was visible and frequent checks were made to gauge the participants' feelings and check understanding. Interviewing via Microsoft Teams also presented the risk of technical difficulties and attempts were made to keep these to a minimum through reminding the participants to connect securely via a reliable device with suitable battery power. However, there was one case where the interview had to be paused and resumed due to connection issues and there were occasional points in the audio-recording where the sound quality was reduced. Nevertheless, such sound quality issues could just as likely occur with an in-person audio recording.

All interviews were audio-recorded and were between 28 and 51 minutes long. Both the researcher and participants found a confidential space to carry out the interview. Following the interviews, the audio files and transcripts recorded through Microsoft Teams were transferred to a secure University of East London (UEL) drive on a computer that was password-protected and retitled using the participant's identifying number. When the transcripts were confirmed to be accurate the audio files were permanently deleted. Transcript copies were not given to the participants, however, they were offered the opportunity to be kept informed of the research outcome. Participating in this research did not result in any financial reimbursement.

2.7. Data Analysis

2.7.1. Transcription

Interviews were initially recorded and transcribed via the transcription and recording function provided through Microsoft Teams. The Teams transcripts were then checked against the audio files and manually amended to confirm accuracy and produce a verbatim account, whilst attempting to retain the conversational and interactional context through using Jefferson-Lite transcribing conventions (Potter & Hepburn, 2012). The researcher also used this opportunity to familiarise themselves with the content and remove verbal fillers and any identifying material. Once completed, the audio files were listened to again and verified with the updated transcripts to confirm accuracy. Coded transcript examples are included in the appendices (see Appendices H, I and J).

2.7.2. Approaching Thematic Analysis

Braun and Clarke's (2006) six-phase, reflexive approach to thematic analysis supported the researcher to analyse, identify and report patterns in the data. This approach was deemed most appropriate due to its broad application and fit with critical realist epistemology.

2.7.2.1. Stage one-familiarisation: The first step was for interview transcripts to be read closely and familiarised with to draw out both apparent and critical meaning.

2.7.2.2. Stage two-generating preliminary codes: During the process of familiarisation, a selection of key phrases from the data were identified, allowing the transcripts to be split into units via the identification of patterned responses and repeated meaning (Braun & Clarke, 2006). These were then coded separately and systematically across each transcript, to express the meaning of the phrases across the full data set. The researcher initially coded by hand (see Appendix H), transferring the information into an electronic version (see Appendix I) before using QSR International's NVivo 12 Software to review each transcript and identify preliminary themes (see Appendix J).

2.7.2.3. Stage three-looking for themes: Coding the content from each of the interviews supported the developing themes and sub-themes across the 12 transcripts. 59 codes were grouped together into possible themes. Provisional themes were identified by noticing patterns of meaning both in and beyond the transcript content, at both latent and semantic levels, and linking all data associated with each theme. Data was analysed until no new themes emerged.

2.7.2.4. Stage four-reviewing themes: The elicitation of themes and categories was subjected to many refinements and several versions were produced (see Appendices K, L, M & N). This involved checking for fit against both the initial codes and the data set as a whole, to make sure they formed clear patterns fitting with the suggested theme. This comprised of assessing for both external heterogeneity and internal homogeneity to make sure that each theme was distinct whilst retaining internal consistency (Patton, 2002). The second stage of reviewing the themes related them back to the complete data set to make sure they were representative of it. This was demonstrated via a thematic map (Braun & Clarke, 2021a; see Appendix O). At this point, an initial ten themes were subsumed into four which were thought to better match the meanings. The result was a map that encompassed the overall categories and core themes from all transcripts (see Appendix P).

2.7.2.5. Stage five-naming and defining themes: Further analysis was required to refine themes and generate clear definitions. The initial theme names represented the content, however this refinement aimed to name them in relation to the story that they were telling whilst remaining concise, punchy and ensuring they continued to actively reflect the participants' perspectives (Braun & Clarke, 2006).

2.7.2.6. Stage six-reporting the findings: The final stage was to identify transcript extracts to help represent themes within the write-up of the report.

2.8. Ethics

2.8.1. Ethical Approval

An ethics application was submitted for this study (see Appendix Q) and approval received from UEL's School of Psychology Research Ethics Sub-Committee (see Appendix R). Although participants included NHS employees, NHS ethical approval was not required as participants were not directly recruited via NHS lines of communication and the interviews did not take place on NHS premises. This research was carried out in line with guidance on The Conduct and Ethics for Students (Health & Care Professions Council, 2016), The Code of Ethics (The British Psychological Society, 2018) and The Code of Human Research Ethics (The British Psychological Society, 2021).

2.8.2. Informed Consent

All participants received an information sheet (see Appendix D) with the chance to ask questions about the study before agreeing to participate. Once their participation was confirmed, all 12 participants signed and returned their consent forms (see

Appendix E) and a day and time for the interview was agreed. They were made aware of their right to withdraw from the research at any point with no detriment to themselves or requirement to provide a reason for this. It was also explained that if they did choose to withdraw, the researcher reserved their right to use the anonymised data from the interview transcripts in the research write-up and any further dissemination. Participants were given contact details for the researcher in case they wished to withdraw, however none of them chose to do so.

2.8.3. Anonymity and Confidentiality

All information regarding participants and their interviews remained confidential and was anonymised. Data collection and treatment was in line with the General Data Protection Regulation (GDPR) data protection principles outlined in The Data Protection Act (HM Government, 2018) to protect participants' privacy. Data was stored in accordance with a UEL approved data management plan (see Appendix S). It was agreed that confidentiality would only be broken via discussion with supervisors if the researcher had concerns regarding anyone's safety and when possible, would first be discussed with the individual involved. However, such a breach was not required.

To preserve anonymity, participants were assigned a unique participant number and any identifiable features such as service names, were changed in the transcripts, thesis and any other ensuing publications. All participants were told that their confidential documents were going to be saved in a secure drive on a locked device and that all interviews were transcribed by the interviewer and only them, their DoS and examiners would have access to them. They were also made aware that all anonymised data would be passed to the DoS for storage following assessment and that this would be saved securely on the UEL repository for a minimum of 3 years after the research is complete.

2.8.4. Debrief

After the interviews, participants were offered an informal debrief with the chance to ask further questions relating to the research or the content that had come up in the interviews. They were all then emailed a debrief sheet (see Appendix T) including information about the study along with researcher and DoS contact details. The researcher was aware this research had the potential to elicit distress in participants relaying their experiences related to working with people following early miscarriage. The debrief sheet therefore also contained contact details for relevant support services such as The Miscarriage Association. Despite the focus on the potentially distressing topic of early miscarriage, and the fact that some participants chose to disclose relevant, personal experience relating to this subject, no adverse responses were witnessed or reported by the participants.

CHAPTER THREE: RESULTS

3.1. Overview of Themes

This chapter describes the findings from the thematic analysis, demonstrating the barriers to providing support following early miscarriage identified by the perinatal champions. The participants' experiences of providing psychological support following early miscarriage are captured in four overarching themes and related sub-themes produced from analysing the interview transcripts. For each theme, an in-depth narrative is provided, including interview excerpts to demonstrate the way in which the analysis was approached.

Table 3

Thematic map of the participants' perspectives on barriers to providing psychological support following early miscarriage.

Main Theme	**No. Participants Associated with Theme (Majority >6, Minority <6)**	**Sub-Themes**	**No. Participants Associated with Sub-Theme (Majority >6, Minority <6)**
1) Unclear Guidance and Uncertainty	Majority (11)	-Marketing and Advertising -Lacking Clarity	Majority (9) Majority (10)
2) Service Centred Care	Majority (12)	- Diagnosis-Focus -Structural Constraints	Majority (12) Majority (12)
3) Journey to the Role (of Perinatal Champion)	Majority (9)	- Autonomy and Choice - Personal Experience - Diversity - Training	Minority (4) Majority (9) Majority (7) Majority (8)
1) Perpetuating Societal Stigma	Majority (8)	- Shame, Blame and Silence - Invalidation - Partners	Minority (4) Majority (8) Minority (3)

3.2. Theme One: Unclear Guidance

Inconsistencies and unclear guidance were highlighted as a key barrier to people who have experienced early miscarriage gaining psychological support. Issues were raised with different points in accessing a service, from initial awareness of the service, referral, triage and subsequent support offered.

3.2.1. Marketing and Advertising

Marketing and advertising of IAPT services was one area proposed to impact the perceived appropriateness and access to the service for people following early miscarriage. This included factors such as how people would know about a service, where they might see it advertised and the type of difficulties and related support options it is perceived to cater for.

> *"I wonder whether there was something about advertisements for the service explicitly talking about these things, whether it be perinatal period stuff in general or early miscarriage. I don't think any of the kind of stuff we advertise in the website was rarely ever updated, and stuff actually said that about it… If you are a person looking for support in that area, personally I'm not sure I would have thought of IAPT if I was looking at the descriptions online about what IAPT does, because I'd be thinking "but that's not what I'm experiencing". And then I wouldn't even try to go down that route because I wouldn't think it was for me, so I wonder whether there is something about the way the service is presented. That misses an opportunity to encourage people to seek support"* (Participant 3; 401-414).

When asked whether potential service users would know they could access IAPT services for support following early miscarriage, there was uncertainty about whether the possibility of accessing this type of care would be apparent due to the general nature of the advertising available.

> *"I guess I don't know if they'd know that was…something they could specifically come and see us about, perhaps…I think it's quite a generic, general kind of mental health service advertisement. So I don't know if they'd*

> *necessarily be aware that that was one of the things that they could potentially speak about. And so that might be a barrier in some ways"* (Participant 7; 338-342).

Interviewees felt that it is often unclear from both within and outside IAPT services that they could offer post-miscarriage support, meaning that related services and professionals are often unaware of this and therefore do not refer. This means that in many cases those requiring support following early miscarriage are not directed to and therefore do not actually present in IAPT services. This was repeatedly pointed out by the participants who reflected that their contact with people following early miscarriage, in their role of perinatal champion, did not feel representative of what might be expected when holding in mind the number of people that experience early miscarriage and have related mental health difficulties.

> *"I don't know how many people referring like GPs would have known that we could provide support specific to these difficulties, so they might not actually refer clients in to us. So I guess that would be a barrier as well"* (Participant 3; 405-408).

> *"So I thought, why is this [early miscarriage experiences] not more prominent? Why is this not coming up more as a really distressing experience that it's impactful enough to warrant a psychological intervention?"* (Participant 11; 88-91).

> *"I think obviously that this miscarriage rate is there. Obviously, we see it [distress following early miscarriage], I don't think we see it as often…It doesn't feel like a lot of women or men come forward after a miscarriage has happened"* (Participant 12; 171-177).

3.2.2. Lacking Clarity

It was recognised that navigating this system was not always clear-cut and that guidance may differ both within and between services, depending on who was making the decisions and their level of clinical experience. The impact of differing and unclear information from within and between IAPT services was reiterated as a potential barrier to support. This uncertainty was reflected through differing responses from administrators, practitioners, managers and supervisors to people accessing the service for post-miscarriage support. Whilst there was recognition that a one-size-fits all approach to post-miscarriage support would not be appropriate, when asked about perspectives of services and supervising colleagues regarding offering post-miscarriage support, there was also reflection that clearer guidance would be beneficial in reducing the variability of responses.

> *"It really depends practitioner to practitioner and how switched on your supervisor would be that day"* (Participant 4; 116-117).
>
> *"I think we were quite disorganised that actually in the way that the service sort of I guess filtered different client groups through quite generally… I guess a better definition of what and who I was actually working with because I think that wasn't very well defined"* (Participant 6; 60-62, 122-123).
>
> *"I think it depends on the supervisor and who you ask"* (Participant 8; 255-256).

When asked about the definition of the 'perinatal period', a lack of clarity recurred throughout the interviews and was described as leaving the participants unclear whether someone who had recently miscarried or their partners were eligible for the fast-tracked and specialist support someone might receive if they were still pregnant and accessing the service.

> *"You have a really good question and I don't know. I honestly don't know… But it's such a great question … And so something I need to look into is sort of also, if you've had a miscarriage, does that come under perinatal work? And do you still have priority? Because I think that needs to happen. I don't know if it does happen…But again, perinatal is from the beginning, from struggling to conceive all the way to after giving birth to two years later. So I think that all should come under its own unique label, not just like one of these tick boxes*

> *that you've given birth within the last year or something like that"* (Participant 2; 224-233, 526-529).

> *"I don't think it was written in any policy or I don't think there was a kind of a an official descriptor of what is. You know what? When? And like a miscarriage is considered a perinatal client or not…And so I think how you define what makes a perinatal client, and whether you should prioritise them it probably varies from service to service"* (Participant 1; 16-18, 71-72).

When asked whether service users experiencing challenges relating to early miscarriage would receive perinatal priority assessment and treatment, participants explained that the lack of clear guidance on whether someone should be included under the perinatal label post-miscarriage often resulted in these people being missed and subsequently being added to the long waiting list rather than receiving perinatal priority. This meant that even if people managed to get to the point of being referred, assessed and offered support, this may not come in a timely manner that offered them support at the time they really needed it.

> *"I don't think they would have the priority of being seen sooner, which is the main thing that came with, like the perinatal label… I think all those patients should have been cast under the perinatal priority, because, you know, they should have been seen by someone who had more perinatal knowledge. They should have been prioritised, as well as the, the partners as well"* (Participant 8; 40-42, 256-259).

> *"With miscarriage I believe we offer priority, like assessments, but I don't think there will be a priority for treatment…I think someone just had a question, and was like are perinatal, are people that suffer from miscarriages, are they classed as perinatal? And I believe it was decided that priority for triages, but not for treatment"* (Participant 10; 59-66).

Lack of clarity over what was defined as 'perinatal' and who was included under this umbrella term created confusion around the remit of the perinatal champion role and whether they would be the best placed members of the team to support people following early miscarriage. A lack of understanding or explanation received around the remit of the role of perinatal champion was an issue consistently raised by the interviewees.

> *“I think we weren't really sure what we were doing and what our remit was. So I think that makes it quite challenging to answer. I think the role needs to be defined and I think if it was defined better in my service, that could be something that could be incorporated quite well…So I guess it goes back to how well the role’s defined or not as to whether it could be something that could be incorporated.”* (Participant 6; 172-178).

3.3. Theme Two: Service-Centred Care

Participants highlighted the role of care that is focused on the needs of the service as a barrier to accessing psychological support from IAPT services following early miscarriage. In contrast to person-centred care which recognises and adapts to the uniqueness of each individual (Santana et al., 2018), service-centred care focuses on the needs of the service and takes a blanket approach to supporting those that access it (Duggan et al., 2006).

3.3.1. Diagnosis-Focus

Acceptance for support within IAPT services was described as relying on brief conversations undertaken by administrative staff who were not clinically trained and diagnosis-driven structured triage assessments often undertaken by newer and less qualified staff to ascertain the support needs of those accessing.

> *“…in a lot of ways there was quite a lot of difficulty with how triages got booked in. So it was they were booked in by the admin team who didn't sort of have the clinical training to be able to ask questions around loads of in depth things. So sometimes I think, triages got booked into clinicians where It wasn't the most appropriate fit either step 2 or step 3, because of screening got missed a little bit”* (Participant 3; 30-35).

> *“Also the way in which a Step 2 assessment’s done, which is very rigid and you don't actually, I guess you draw out the kind of information the service wants, as opposed to perhaps the information that the person wants to bring. So I guess being able to have a bit more flexibility when working with someone who might have miscarriage or a perinatal-related sort of difficulty to actually explore a bit more about what that means. Because the way the assessment worked, it would sort of like shoe horn it back to “are you depressed? Are you anxious?” as opposed to thinking about actually, what was this experience like and what support needs do you need around that? And I think having a bit more space to gather that information will then help us to make better decisions about what would be best for that person”* (Participant 6; 145-155).

The completion of the minimum data set, described as specific questionnaires designed to ascertain the ‘problem’ a client was coming into the IAPT service with, was highlighted as another potential barrier to access. It was explained that for various mental health presentations that did not fit with these questionnaires, practitioners could use alternative means of assessment. However, this was not the case with difficulties relating to early miscarriage and people were often discharged due to ‘under-scoring’ on the standard measures due to the reliance on measures that map onto diagnostic categories and related commissioning objectives.

> *“There's something as fundamental as an assessment tool that I didn't know existed because we only use the PHQ9 and GAD7, whereas for all the other presentations right, for be it anxiety or agoraphobia, every single one of those has them. But the perinatal one is not listed on [case recording system]. You mean that's where I mean, like, I feel like there is a disservice being done because it doesn't seem like enough effort and awareness is going into seeing this as a unique experience”* (Participant 2; 408-414).

> *“The other challenge that we had quite a lot was that they [clients] would under-score on the measures. So The PHQ9 and the GAD7 would not capture what the client, the service user came with… And if people don't*

> *score high enough on the depression scale or on the anxiety scale, what do you do with it…?"* (Participant 11; 675-679, 826-828).

Screening processes which pit the information gathered from assessment against the service's eligibility criteria to determine whether or not someone was offered support were identified as another barrier drawn from the culture of service-centred care. If people did not fit a particular mental health diagnosis or category they would likely be discharged from the service. This approach was described as concentrating on the service's own diagnosis-focused agenda as opposed to recognising the nuanced experience of the presenting client that may not fit within these specifications.

> *"The problems that you would work with that, that I imagine it probably would have been a bit too inflexible to accommodate for early miscarriage work"* (Participant 4; 106-107).

> *"Because it's [challenges following early miscarriage] not something that comes up in the DSM-V, yes, so it's not a disorder. It's just something that kind of falls between"* (Participant 11; 822-825).

It was also pointed out that many of the psychological responses to early miscarriage are very normal and expected in the context of loss, and trying to label this experience as a diagnosis with an aim of recovery can be experienced as pathologizing.

> *"The way in which there's a focus on I guess recovery as well, and I'm not sure if that's an appropriate term to be thinking about in the context of an experience such as miscarriage"* (Participant 6; 166-168).

> *"Erm, I just felt like I wasn't qualified to know how to support them, just because obviously you know their worries are very real"* (Participant 8; 164-166).

Participants also described how someone might be deemed too ‘complex’ for IAPT based on their responses, mental health history and difficulties linked to early miscarriage. They also reported not working with certain ‘presentations’ such as grief, indicating that the service viewed those accessing in terms of their diagnostic categories as opposed to individuals with their own lived experiences.

> *“…and it might have been just, instantly stepped up as well because it might be deemed as quote on quote ‘complex”* (Participant 4; 110-111).

3.3.2. Structural Constraints

Participants frequently brought up the fact that somebody may be discharged and signposted elsewhere if they were determined to be below the threshold through not demonstrating enough symptoms indicative of certain ‘problem descriptors’. This meant clients were discharged from the IAPT service, despite not knowing what support these other services would actually be able to provide, which could result in increased levels of distress.

> *“They would be signposted to low cost therapy or a different service, and there wasn't even another service that would work specifically on that. So they, they would actually get quite upset about that”* (Participant 11; 679-682).

> *“The times I did triage someone who had experienced an early miscarriage recently, and that was sort of that reason for coming to IAPT I don't think any of them ever got transferred over to the perinatal team because I remember signposting people to like low cost counselling places specific to early miscarriage. But then I remember feeling quite frustrated myself with the way that IAPT handled this because the primary place that we tried to refer people to was often not accepting referrals. I think at one point received no funding so was gonna close down potentially and yet that was what we were told was the route to send people if they'd experienced early miscarriage. And I don't know why that was the decision rather than the perinatal team, yeah…I felt really bad about it because this person had made the decision to come to IAPT to talk about this experience and then we were just shoving them off to somewhere that probably wasn't even gonna see them because they didn't*

> *have any funding anyway. And so they were kind of left with nothing”* (Participant 3; 122-131, 346-350).

Many raised concerns about the lack of time and resources that get in the way of providing support for people following early miscarriage. Perinatal support was frequently described as an add-on with no dedicated or protected space to carve out its specialist function. Instead, the focus was said to be on things such as key performance indicators measuring staff output, as opposed to the needs of the clients accessing the service.

> *“…there wasn't any additional time allocated to [being a perinatal champion]. Kind of just work on your role of being a perinatal champion. So for me it was kind of something I, yeah, I probably could have done better at that role if I had had more time I might have been able to do a do a bit, you know, champion a bit more, champion a bit better if I'd have more time”* (Participant 1; 221-227).

> *“I think the perinatal champions, as they are in IAPT services at the moment, they don't have enough resource to do that work…Because I think a lot of the, a lot of the resources are on KPIs and making the service effective and recovery rates. But some of these very important clinical issues are completely left aside”* (Participant 11; 730-732, 923-927).

Whilst a range of support options were reported, including cognitive behavioural therapy (CBT), computerised support, counselling, group sessions and low intensity psychological interventions, in many cases these were described as continuing on from the diagnosis-focused assessment through the use of protocol-based therapeutic strategies based on the earlier defined ‘problem descriptors’. Participants reflected that with some flexibility these modalities could have offered useful psychological support for people following early miscarriage. However, they were often described as structured, time-limited sessions, the content of which would be determined by the pre-agreed diagnostic category and the limited clinical skills of the practitioner. In some cases, where services stuck more rigidly to this protocol, this resulted in confusion when the support package offered did not meet the needs of the individual following early miscarriage.

> *"…if we did treat them [clients presenting following early miscarriage], it would be more sort of if that was something in someone's perhaps history that was taken, but they it was very clear they wanted to focus on something like depression or GAD… I think it makes the work very prescriptive. Which then I guess doesn't necessarily capture the needs of people that don't fall into a straightforward you know GAD, depression."* (Participant 6; 41-43, 162-164).

> *"We would sometimes also work with people within the service if they'd had a prior miscarriage and they were had a, a recent pregnancy and they were worried about the viability of that pregnancy and it's causing sort of anxiety and sort of pre-natal anxiety then we might do some work in the service with them then… But if it was a more generic presentation where the miscarriage was part of that, than we might do some work in the service… So it wasn't necessarily directly working with the miscarriage experience itself, but more how that experience would impact them in other ways and how we might be able to support them with that"* (Participant 9; 25-33, 87-89).

> *"I guess they [clients] might also think like" ohh, I've been told I'm, I've been told I can only have 6 sessions". Erm, and like, you know, perhaps if you've kept a lid tightly on something and it's… you know, you might not want to start a conversation about something when you know beyond 6 sessions, you're going to be kind of dealing with yourself. You know you're not gonna have your therapist long term. So that might be a barrier"* (Participant 1; 306-311).

3.4. Theme Three: Journey to Role

The journey they had taken to becoming a perinatal champion was another factor consistently spoken about in relation to barriers to accessing support. This related to how they had come to be offered the post and the route in getting there, including prior experience, knowledge and interest in the area of perinatal support, as well as training needs and service protocol.

3.4.1. Autonomy and Choice

Whilst participants described a variety of experiences in terms of their experiences of being allocated the role of perinatal champion, with some fuelled by a passion and interest in this area, a large proportion of the participants reported lacking autonomy and choice in the process. When reflecting on their journey to becoming perinatal champions, in many cases it was described as more of a tick box exercise where every person at a certain stage had to be allocated to a 'speciality' which they may or may not have a genuine interest in.

> *"…so it was something that was sort of, yeah, fell into rather than sort out, I guess…I think the team grew and they wanted to move to a model where everyone was a champion. So sort of, they then I guess like gave people things to be champions of and I think that didn't work quite as well because some people ended up with ones that they were less passionate about. I think I got quite lucky in the sense that I really enjoyed the work. I found it really interesting but it could have also gone the other way had I not been that interested"* (Participant 6; 8-9, 113-118).

> *"…so it was more sort of from the IAPT service, they wanted each qualified PWP to have like a different area of being a champion. I think they just sort of allocated them, they asked us to rate our preferences. But then I think they sort of ignored that and just allocated them anyway"* (Participant 8; 72-75).

3.4.2. Personal Experience

Whilst many participants reported a desire to take up the role of peri-natal champion that was fuelled by personal experience, this led to challenges when a client's experiences triggered feelings relating to what a practitioner had been through. Participants frequently reported not feeling fully supported to address the potential impact of this.

> *"The lack of space for reflection means that if a practitioner was triggered by working with the client who'd miscarried, or even just in general it is a*

> *distressing thing to talk about. There isn't probably much space to process that and to deal with that"* (Participant 4; 431-434).

> *"I suppose getting support kind of as a practitioner if that, you know, that work isn't easy. It's pretty emotionally draining and heavy. You know, obviously I remember having a I think in assessment, not with [child's name] with [child's name] and the client had had like 5-6 miscarriages. Something like that, and that I found particularly hard myself just because, you know, I'm sitting there pregnant at the time, so yeah, I think getting support as a clinician"* (Participant 5; 186-192).

> *"There was little understanding around us encountering a difficulty when treating a particular presentation. So we would bring it up in supervision, but there was a lot of pushback around "well, this practitioner. It sounds like the person you're supervising can't work with LTC because their mom had a heart attack. They can't see a pregnant woman because they had a miscarriage. What can they work with?". So they were quite uncompassionate with the staff " (Participant 11; 394-403).*

3.4.3. Diversity

A lack of diversity, particularly in relation to gender, was reported in those allocated to perinatal champion roles, with all participants stating that they had only been aware of females taking up this role. Whilst this may to some extent have been influenced by those motivated by personal experience, it also suggests that services may be perpetuating gender stereotypes through the allocation of roles.

> *"I was invited to do the role in both services and I wonder if whoever was doing the, the like, managing the champion roles kind of thought "Oh, she's a mum. She'll, she'll be good, she'll know"* (Participant 1; 47-50).

> *"Like from my experience, everyone has been female that was a perinatal champion. And I'm just trying to think about whether that's helpful or not and if I would think about, I would definitely think about recruiting some females. I think often like new mothers request to see someone that's female, even*

> *though that person might not have any experience of having children themselves. I do wonder if I would think about recruiting males specifically and I guess that would be helpful if there are male partners that have come under that label. So, yeah, I guess it would be good to have a range of like demographics of people as perinatal champions, the same way you would want a range of sort of different demographics of therapists in general”* (Participant 8; 404-413).

3.4.4. Training

An absence of knowledge and training impeding their capability and confidence in supporting people following early miscarriage was repeatedly mentioned. For those that had received specific perinatal training, very few described a significant focus on miscarriage, despite all participants reflecting that this would be beneficial.

> *“But I think there's just a lot that I don't know that I wish I knew. And I think sometimes you can think you know, but you only know what you know and you don't know what you don't know. And I think the training issue really brought that to my attention of how much I thought I knew and how much I still don't know”* (Participant 2; 293-297).

> *“I guess it's about a bit more experience or a bit more training around that sort of thing because as I said, I think I kind of felt like I was thrown into it a little bit and without a huge amount of training, and I just think that would be really useful to know a little bit more about, perhaps more the physical side of it, if that makes sense that you know, I can, the emotional stuff, but I think it actually so you don't have to necessarily, you know it's a really, sensitive subject anyway, so without having to go completely into all of that in depth information, I think for the client would be really useful to know a little bit more about that*” (Participant 7; 216-223*).*

3.5. Theme Four: Societal Stigma

Finally, the role of IAPT services in perpetuating societal stigma around early miscarriage was emphasised as another potential barrier to accessing support.

3.5.1. Shame, Blame and Silence

Fears around stigma associated with early miscarriage and the potential shame and blame those going through it might be exposed to were noted. It was recognised that societal responses to early miscarriage can make it harder to talk openly about the experience and any subsequent emotional challenges, which perpetuates the silence around this experience and increases challenges in getting support.

> *"So, you don't know when you bring up that topic [miscarriage] if the person that you're speaking to has experienced a loss, and they're not talking about it either…so it's a bit tricky I guess that so maybe people kind of think "OK, well, then I'll just, I won't say anything. I'll just. I'll just keep that aspect of what's going on for me quiet""* (Participant 1; 315-319).

> *"I think probably for some people there is…still the element of stigma…I think unfortunately stigma and fear of judgement is still there"* (Participant 5; 151-160).

> *"So the I guess the stigma around that sort of thing, the stigma around mental health at the moment…I think a lot of women often feel shame around it or feel guilt around it" (*Participant 7; 93-94, 124-125).

> *"And destigmatising it as well, in the sense of like, so that women don't suffer in silence because…I genuinely feel like so many women experience it and you won't know because people don't talk about it. I don't know if it's because of shame. I don't know if it's because of just sorrow and the loss and the bereavement of it, but it's definitely something that I don't think is talked enough about"* (Participant 10; 330-335).

> *"And I'm not sure why. I don't know whether that's because of a shame or a guilt aspect of it. Whether it's because society kind of makes us bounce back quite quickly after something like that happens"* (Participant 12; 177-179).

3.5.2. Invalidation

Doubts about client's entitlement to support and the legitimacy of their feelings in response to an early loss were all highlighted as potential barriers to support, possibly fuelled further by a service that is ill-equipped to offer the advice and support and might minimise the impact of an early miscarriage in comparison to a later pregnancy loss. Telling the story of early miscarriage and its impact, only to be responded to with a discharge, potentially invalidates and minimises the client's experience whilst perpetuating difficulties in accessing support for fear of similar responses and dismissal.

> *"There's potentially a view and, I hate saying this because I do not agree with this myself, but I think there's a view that it's not really a baby when it's early miscarriage and so it's somehow perceived as less of a loss or less of a big deal. But that's not all taking into account the person's perspective themselves, that's more just like a physical drawing a line under something that services do I think, because then it's easier not to have to think about it and not to have to plan what services will be suitable. But then I think these people get missed because their experience is being really dismissed. That's not something explicitly being said anywhere, but that's kind of the vibe that I got, maybe just from like, how it's presented in the media and stuff sometimes as well. That's kind of the general way people think about things sometimes"* (Participant 3; 322-332).

> *"Sometimes there's this, like you don't have the right to be as upset as you are or it's OK, get over it. You're gonna have another baby or you have a child. You're lucky already. And I think that can sometimes be a big hurdle to get past. Where people are kind and sympathetic, but there's almost a, the person who has given birth, who lost her child, is significantly more worse off than you because your baby wasn't really alive. Your baby didn't really exist, whereas for the woman it most definitely really existed. You know, and I and you know, like I think I think that's a big hurdle"* (Participant 2; 196-203).

3.5.3. Partners

It was highlighted that as a society, focus often turns to the child-bearing partner following an early miscarriage, with the expectation on partners to be the one providing support. This lack of recognition of the potential psychological impact of early miscarriage on non-childbearing partners and family, seems to permeate service provision and fuel difficulties in accessing support for non-childbearing partners.

> *"And so I think recognising the, the impact of something like early miscarriage isn't just for the person carrying the baby, but also for people who are around them and people who are linked to that, that child in other ways. It's something that's really missed in services and can potentially be quite traumatic and dismissing for people"* (Participant 3; 391-395).

> *"But imagine being with someone that is carrying your child and let's say they've had multiple miscarriages. You're seeing your partner, or whoever, in pain and grieving. But you need to be strong for them as well, so you also can't process and grieve as well. But no one ever talks about how the psychological impacts on the other party as well. It's always the person carrying the child that gets the most, erm, I say sympathy and so forth. But it's, there's two people in it, I feel as well. So also offering support for, for the partners. I feel like it, it's really important because, yeah…it needs to be holistic I feel because it can really have an impact. How to communicate after miscarriage amongst partners. How to grieve the loss and move forward and potentially try again. There's…so many things. How as a partner, how to support your partner through miscarriage, even physically. Because they still have to go to work as well. Like it's you still have to continue with your life. Both the person that's lost a child and the person that is supporting you still have to continue with life and go to work and do all these other things, they might have other children… because…if you're the non-childbearing parent, I would get the notion that they would feel bad to express their emotions and feelings about it because they're not the one that's gone through it physically. So I feel like in some instances they will probably put their feelings to the side*

> *and put the childbearing person In front and try and get them the…support"* (Participant 10; 375-402).

3.6. Overview of Findings

This study was aiming to find out what challenges someone might face in attempting to access support following early miscarriage and the factors that influence it, from the perspective of IAPT perinatal champions. The analysis showed that participants identified a variety of potential barriers present, which may differ depending on what point a person was in accessing a service. Unclear guidance was thought to act as a barrier in both referrals being directed to and accepted within services. Descriptions of inconsistency and uncertainty in terms of how difficulties relating to early miscarriage would be responded to were unanimously present. Services were reported to be built around prioritising commissioning objectives over client need, resulting in a system that was not set-up for providing the individualised support required following early miscarriage. Participants described varying journeys to their roles of perinatal champions, often lacking the autonomy, training, support and resources they felt they required to carry out this job to the best of their ability, with challenges also reflecting broader conceptual confusion in the services. Finally, participants spoke of the societal stigma that can act as a barrier to accessing support following early miscarriage, and how things such as shame, blame, silence and invalidation can be perpetuated by the way in which healthcare professionals and services respond or do not respond to somebody's support needs.

CHAPTER FOUR: DISCUSSION

4.1. Outline

This chapter considers the findings of the study in relation to the research questions and aims, contextualising these within the broader literature. Using Willig's (2013) suggested structure as a guide for discussing qualitative research, a summary of the findings will be presented. The findings are then situated within the previous literature, with reference to how they fit with what we already know and any new information this research has brought to light. This then leads into looking at how the study produced knowledge, whilst critically assessing its limitations and strengths, including reflection on the impact of both epistemological and personal reflexivity in the context of this research. Finally, the wider clinical implications for clinical psychology and recommendations will be discussed, with suggestions for future research.

4.2. Summary of Findings

The aim of qualitative research is to study complex phenomenon through the investigation of individual experiences and perspectives. It is the method of choice when the field being researched has limited related theory (Watson et al., 2008). This study aimed to build understanding of the barriers to accessing psychological support following early miscarriage, from the viewpoint of IAPT perinatal champions, which is a perspective that has not been explored in the previous literature. The findings demonstrated which barriers were most salient and the impact these can potentially have on someone requiring support after an early miscarriage.

The analysis revealed repeated accounts of work as a perinatal champion in IAPT services being shrouded in uncertainty about the role and in supporting people following early miscarriage, fuelled by unclear guidance, which acted as a barrier to support being accessed and provided. The uncertainty experienced within the services was also thought to be impacting incoming referrals, affecting the ways in which they marketed and advertised themselves, potentially putting off referrers or self-referrals following early miscarriage. A lack of clarity around terminology, labelling and role-remits added to this confusion. This included being unsure about whether an IAPT service would offer support for someone experiencing difficulties following an early miscarriage, not knowing if they could be categorised as ‘perinatal’ and therefore receive prioritised, specialist treatment, or even knowing whether providing this support fell under the perinatal champion role.

Interviewees’ descriptions of their time as perinatal champions presented a picture of IAPT providing support that was motivated by commissioning objectives, with service needs prioritised over person-centred care. This was depicted through reports of a diagnosis-focused agenda that permeated every step of someone’s journey through the service, from initial screening questionnaires and assessment to the manualised and disorder-specific treatment protocol. It was recognised that someone’s support needs following an early miscarriage were unlikely to fit within the service’s specified categories, therefore leaving them vulnerable to receiving unsuitable support or being discharged from the service. When people were offered support through IAPT following early miscarriage, the participants raised questions about the appropriateness of the heavily structured, prescriptive and time-limited sessions in the context of supporting such difficulties.

All the participants reflected on their journey into the role of perinatal champion, which again highlighted some potential barriers that might influence access to psychological support following early miscarriage. Interviewees were all female and only recalled female colleagues, with some expressing belief that they had been picked for the role specifically because they were a mother. A theme of lacking autonomy and choice in undertaking the role came up, with some interviewees describing incidents of routine allocation or being told to take up the role without consultation. This meant that a number of those given the role of perinatal champion did not have previous experience or a particular interest or passion to work in this area. As such, the interviewees described being heavily reliant on training on how to work perinatally, which was often not received and when it was, was frequently described as inadequate and lacking any reference to providing miscarriage-related support. In some cases, personal experience fuelled the participant’s desire to become a perinatal champion, but services not recognising the emotional impact of working with presentations that are likely to be personally triggering and the potential support needs of practitioners was highlighted as a barrier to practitioners feeling able to provide post-miscarriage support.

Interviewees reflected on the societal barriers to accessing support following early miscarriage, and how these might be perpetuated by IAPT services. Descriptions of the shame, blame, silence, and invalidation experienced following early miscarriage came up frequently in the interviews. These were suggested to present within services as barriers at many points in accessing a service, ranging from challenges in initially plucking up the courage to access the service based on a fear of judgement from others, to staff difficulties in talking about the topic of early miscarriage fuelling silence around it. Furthermore, the potential impact on partners was highlighted as being frequently overlooked altogether.

4.3. Contextualising Findings Within the Literature

Whilst previous literature has explored perspectives on accessing support following early miscarriage from a variety of different healthcare professionals, it has mostly focused on medical professionals such as nurses, doctors and midwives (Griffin et al., 2021; Chichester & Harding, 2021; Nash et al., 2018; Zovotsky et al., 2013; Murphy & Philpin, 2010; Murphy & Merrell, 2009; Easterwood, 2004; Iles, 1989). A proportion of the studies generically refer to ‘healthcare professionals’, not specifying their roles (Markin, 2016; Robinson, 2014; Gergett & Gillen, 2014), whilst only a few include professionals directly involved in the delivery of psychological support such as counsellors and psychologists (Yang et al., 2022; Claringbold et al., 2020). Furthermore, only four papers draw their findings from a UK-based population (Robinson, 2014; Gergett & Gillen, 2014; Murphy & Philpin, 2010; Murphy & Merrell, 2009) . This research is therefore the first of its kind to specifically explore perspectives of psychological professionals, working in a UK, NHS context, in relation to the support offered to people following early miscarriage and the potential barriers in its accessibility.

4.3.1. Structural Limitations

Despite IAPT services being set up to support people experiencing mental health difficulties, challenges in acknowledging the potential for increased psychological needs to emerge following early miscarriage were clear. A combination of IAPT's diagnosis-focus and the fact that there are few evidence-based recommendations guiding psychological support following early miscarriage (Nash et al., 2018) adds to the challenges in providing this care. It was clear from the information gathered that those interviewed had many of the key skills identified in the literature as being so important in providing support following early miscarriage, such as offering a willingness to support through active listening, compassion and an empathetic stance (Nash et al., 2018). They recognised that everyone's experience of early miscarriage is unique but identified challenges in being able to tailor their care to meet these differing needs. This was exacerbated by the tendency for services to rely on diagnosis-driven, manualised, and time-limited approaches which do not necessarily fit with the experience of early miscarriage.

Services were repeatedly described as being unclear on their position of supporting people following early miscarriage, with participants reporting experiences of being given differing information, depending on who in the service they spoke to. This was not specifically mentioned in the previous literature in relation to barriers to accessing support following early miscarriage, however, other research has explored the impact of poor guidance on staff teams which may be relevant to what was reported in this research. For example, if systems and guidance are not in place to support staff in meeting their duties, this can leave them with low job self-efficacy (Schaubroeck et al., 2000). This reduced belief in their own capacity to be able to meet the demands of their role may exacerbate the already elevated psychological demands of working within high pressure IAPT services (Rimmer, 2018). Research also suggests that staff wellbeing, confidence and performance can be negatively impacted by systems not promoting self-efficacy and control (Schaubroeck et al., 2000). With confidence being implicated as a key contributor in boosting motivation at work (Chen & Schildberg-Hörisch, 2019), these interplaying factors could create a vicious negative cycle. We might therefore interpret challenges in accessing support via IAPT services following early miscarriage to reflect the high job pressure experienced by the staff team, combined with poor systems and guidance on how to support, resulting in elevated stress and reduced self-efficacy, confidence and motivation to adapt their work to meet this area of need (Wilkinson, 2015). Subsequent sub-par support being offered to those accessing the services following early miscarriage is therefore an unsurprising outcome (Williams et al., 2007).

The lack of clarity repeatedly described regarding the role of IAPT perinatal champion, the remit of this and the subsequent training provided are also likely to have influenced the support offered to people following early miscarriage. Blurred roles and permeable boundaries can serve to create a team that is flexible and responsive to the differing needs it is faced with, when members of the team feel well equipped with a broad enough knowledge and skill set to step in and offer what is required (Brown et al., 2000). However, when an unclear job description occurs in conjunction with a lack of knowledge, skills and training, this can serve to diffuse and dilute responsibility (Rubery et al., 2010), making it less likely that a member of the team will step-up to advocate and offer support to someone perceived as not fitting within their usual role-map.

Research highlights how establishing how someone feels about their early miscarriage is crucial in directing them to appropriate support (Yang et al., 2022). However, the findings from this research indicate that people accessing IAPT services are unlikely to be asked directly about experiences of miscarriage, suggesting that the opportunity to explore any meaning around this is likely often missed, due to focused questioning on areas given priority such as risk, goals, and mental health history. IAPT assessment protocol therefore appears to be missing crucial opportunities to explore nuanced needs relating to early miscarriage, stopping the clear conceptualisation required to accurately understand someone’s experience and respond accordingly (Murphy & Philpin, 2010).

Structural constraints influenced by the service-centred approach were described to create a reliance on signposting out of the service, meaning that people were described as often telling their stories of early miscarriage in an assessment, only to be faced with discharge and told that another service might be in a better position to meet their needs. Consequently they would be required to tell their potentially traumatic story yet again to someone else, which has been reported as an emotionally challenging and deeply unpleasant experience in contexts ranging from healthcare to the justice system (Ko et al., 2008). Interviewees reflected on advice they were given to signpost those who were presenting with difficulties relating to early miscarriage out of the IAPT service, describing variability in terms of knowing what was available and how to access it, which echoes previous findings (Claringbold et al., 2021). There were not clear referral routes and in some cases, participants reported being aware that they were signposting to services that were not accepting referrals or had extremely long waiting lists, replicating the fragmented care that is identified elsewhere in the literature (Yang et al., 2022). In most cases, participants explained that clients would be directed to an alternative service, as opposed to being referred directly. This means that there would not be an information sharing process between the services, requiring clients to again have to summon the courage to speak up about what they are going through and repeatedly explain their experience of early miscarriage, whilst facing the continued uncertainty of what support they were going to be offered at the end of it.

4.3.2. Knowledge and Skills Base

Whilst prior research and this study have demonstrated that many health professionals acknowledge the potential for early miscarriage to have a long-lasting and wide-ranging impact on mental health and wellbeing, discrepancies between the experiences of those going through early miscarriage and healthcare professionals' awareness of how to support this have been noted (Yang et al., 2022, Murphy, 1998). The literature acknowledges that healthcare professionals are frequently asked to provide explanations for early miscarriage which are not often possible to provide (Claringbold et al., 2021), but these challenges are enhanced by a general scarcity of knowledge surrounding early miscarriage and its potential impact. A lack of staff and service awareness, resulting in uncertainty about how best to support someone with difficulties relating to early miscarriage, may result in them being discharged or signposted to another service that may not be able to meet their needs (O'Mahen & Healy, 2020). Lacking knowledge in this area also makes it harder to tailor support through fully acknowledging the loss, providing reassurance and validating the feelings associated with it (Griffin et al., 2021).

Female tropes and stereotypes relating to motherhood and caring ability appeared to be relied upon in recruiting perinatal champions (Meyers, 2002), with a predominantly female workforce reported. With evidence suggesting that people often respond best therapeutically to those with whom they are matched on certain demographics (Pettyjohn et al., 2020), only having female staff available to offer specialist perinatal support may make it harder for male partners to access post-miscarriage support. Furthermore, with research indicating higher miscarriage rates in Black women for example (Eichelberger et al., 2016), which in itself is a concerning finding potentially indicative of structural inequity and racism, this further highlights the importance of having a diverse and culturally competent perinatal workforce to best meet the needs of those requiring support. Furthermore, whilst not specifically highlighted in the literature, picking people for a role based on general characteristics, as opposed to passion and interest, is likely to influence the reported skills deficit in working perinatally and with early miscarriage. Staff presenting as uncomfortable or uninformed can put people off sharing their experience (Chichester & Harding, 2021), furthering challenges in accessing support. Replicating previous findings (Chichester & Harding, 2021), the interviewees stressed that a lack of training in this area and in how to have these conversations exacerbated these difficulties. Additionally, when specific perinatal training was available, this rarely included anything regarding miscarriage-related support and was often cut short or not delivered in the way in which it was designed.

The literature emphasises that whilst some health professionals will have frequent contact with people following early miscarriage, and will feel well equipped in offering support, others will have little contact and feel ill-equipped (Iles, 1989). Based on their reports, the participants tended more toward the latter, with it being recognised that the number of people accessing IAPT following early miscarriage did not appear to be representative of general figures relating to miscarriage occurrences and subsequent mental health difficulties, resulting in generally limited contact. Speculation as to why people may not be presenting in services included suggestions of factors such as poor advertising and unclear referral routes. This may also relate to wider cultural discourses affecting people's willingness to share their experience and fears around the appropriateness of seeking support following such an event (Murphy & Philpin, 2010). The potential for mistrust of services among racialised minorities, based on a history of health services perpetuating whiteness and racism (Paul et al., 2022), to be influencing who presents in IAPT services following early miscarriage must also not be overlooked. This may be particularly relevant with research suggesting that racialised minorities are also over-represented in terms of miscarriage figures overall (Eichelberger et al., 2016).

Another factor evident from past research that may be relevant in influencing the limited contact the perinatal champions reported having with those who have experienced early miscarriage, is the fact that trainees and junior staff are often described as having their contact limited with anyone deemed to be ‘too complex’ (Iles, 1989). ‘Complexity’ was also a term used by the participants, in the context of IAPT determining who was able to access their services. If people who are presenting with difficulties following early miscarriage are labelled with this ‘problem’ of being ‘complex’ this is likely to reduce the likelihood of them being offered support through IAPT, lessening the contact and experience practitioners have in working with this client group and subsequently perpetuating barriers to access. This in itself is ironic, considering that the impact of early miscarriage is frequently minimised by both health services and lay people (Rowlands & Lee, 2010).

Similarly to what is reported in the previous research (Griffin et al., 2021), many of the participants reflected on how personal experience relating to parenthood, loss and the challenges associated with it, motivated them to work perinatally and fuelled a passion to want to support people following early miscarriage. This led to reflections on the difference it makes to be passionate or interested in a particular area of work and how this might influence the client experience, suggesting that people who have experienced an early miscarriage might receive a better quality of support from practitioners who have an interest in working in that area of need. However, the findings again reiterated the challenges reported in accessing staff support and spaces to discuss the personal impact of the work they were undertaking (Chichester & Harding, 2021). Experiencing a lack of support, empathy and compassion from managers and supervisors was described as leading to uncertainty and difficult decisions regarding whether to continue with perinatal work. This suggests that without provision that considers the emotional needs and self-care of its workforce, IAPT services are running the risk of losing some of the most passionate and perinatally motivated practitioners (Wilkinson, 2015).

4.3.3. Societal Responses

There was recognition from the interviewees that societal responses to early miscarriage often perpetuate silence around this topic, along with themes that blame those who have experienced loss and create shame around talking about it, which echoed arguments present in previous literature (Yang et al., 2022). The interviewees reflected on how IAPT services might reinforce silence through not specifically asking about early miscarriage or training staff to have these conversations. However, there were also differing perspectives around not assuming that early miscarriage was related to presenting challenges and therefore waiting to see if it is raised by the client, or fearing upsetting someone so not bringing it up or discussing further when mentioned. Whilst not directly acknowledged as such, these are potentially areas where the champions themselves can be drawn into being complicit in exacerbating the difficulties of speaking up following early miscarriage. Whilst it may not be the intention of practitioners to perpetuate the stigma surrounding open discussion about experiences relating to early miscarriage, these responses may be interpreted as staff collusion in silencing, invalidating and shutting down discussion about such losses. Furthermore, it is possible that such avoidance of these conversations might play into social discourses relating to the stigma of experiencing mental health difficulties as a parent (Hinshaw, 2005), encouraging people to play down their psychological challenges following early miscarriage, for fear of their fitness as a parent being called into question.

Further aggravating the difficulties in sharing challenges following early miscarriage, were the perspectives that IAPT services might respond differently to someone who has had an early miscarriage, compared to a later loss, which is also a theme present in the literature (Robinson, 2014). Biases held within services and by staff working within them indicated thoughts about early miscarriage as not being as serious or requiring the same level of support compared to others forms of loss. This is likely to be experienced as invalidating for clients, whilst again highlighting the irony and contradictory nature of playing down the experience of early miscarriage whilst at the same time deeming any related challenges as ‘too complex’ for IAPT support. It was recognised that services would likely take a case of later loss more seriously, and if not offering support directly, would signpost to a service that had a clearer remit of what it was able to offer compared to the support available following early miscarriage. These clearer referral routes and pathways to support following later miscarriages may be influenced by the more outwardly visible aspects to this type of loss and the fact that it can be more readily framed as a bereavement and therefore be anticipated to elicit a natural grief reaction (Hazen, 2003).

Interviewees explained that due to the way in which ‘priority’ labels were applied, there were examples of people accessing IAPT services whilst pregnant and being told they would be seen as a priority, only to go on to have an early miscarriage and have their priority label taken away. It is clear how such approaches can be experienced as minimising and contribute to the feelings of feeling forgotten and alone which are reported in the literature (Nash et al., 2018). Furthermore, the fact that perinatal priority and specialist support is reported to be taken away following miscarriage, suggests that the potential impact on future pregnancies and parenting is being overlooked. For example, women who have experienced a previous early miscarriage have been found to be at higher risk of experiencing psychological challenges, including anxiety and depression, in future pregnancies (Bergner et al., 2008). Pregnancy following early miscarriage has also been noted as being characterised by guarded emotions, safety behaviours and avoidance (Cote-Arsenault & Mahlangu, 1999). These factors can negatively impact maternal-foetal bonding (Tsartsara & Johnson, 2006) and even go on to detrimentally influence later attachment and parenting practices (Lamb, 2002).

Inconsistent application of the perinatal prioritisation for both members of a couple was noted both in this study and previous research (Darwin et al., 2021). Issues with services not including non-childbearing partners under priority labels further exacerbates the invalidation of this experience and perpetuates the societal response of viewing and expecting them to be a provider of support following early miscarriage, rather than someone who might require support themselves (Murphy, 1998). Despite it being part of the Long Term Plan (NHS, 2019) to also offer priority support to non-childbearing partners during the perinatal period, it is only suggested, and therefore appears to be down to the service’s discretion (South London and

Maudsley NHS Foundation Trust, 2021). This potentially harmful practice of dismissing the needs of both partners leaves services at risk of maintaining gender-role and masculine stereotypes (Gray, 2021) in the context of early miscarriage.

4.4. Critical Review

4.4.1. Personal Reflexivity

Practicing self-reflexivity whilst undertaking a qualitative study can improve the transparency of the research (Yardley, 2000). With context also being a key element of qualitative research, it is crucial to name the researcher’s other positions as both a mother who has experienced early miscarriages and someone who has also previously held the position of IAPT perinatal champion. The process of undertaking this research and subsequent interpretation of the data was therefore arguably influenced by these different roles. Professional and personal interests and experiences relating to early miscarriage were undoubtedly influential in how the research question was developed. Preconceived ideas may also have influenced the greater emphasis on the negative aspects and barriers to accessing support following early miscarriage, as opposed to the positives. The researcher’s positioning may also have inadvertently influenced their interactions with the interviewees, for example, through leading them to selectively attend to certain points or fail to clarify statements because they assumed they knew what the participants were getting at. Furthermore, the material provided in the Participant Recruitment Information (see Appendix C) meant that the interviewees were all to some extent aware of the researcher’s background and personal links to this project, which may also have influenced their responses. In an attempt to reflect on and potentially reduce the impact of these factors, a reflective journal was used to explore the responses and possible biases as the research progressed.

With previous experience in supporting people following early miscarriage in an IAPT context and hopes to continue pursuing perinatal work in the future, the motivation to carry out this research had undeniable links to the researcher’s own professional development and curiosity. The researcher’s experience of working with clients experiencing difficulties such as anxiety and low mood following an early miscarriage in an IAPT context, had resulted in client feedback which indicated that it was a beneficial experience for them. However, receiving differing guidance from supervisors in relation to this work led the researcher to wonder about the experiences of others offering this type of support within the perinatal champion role. Furthermore, personal experience of feeling dismissed by medical professionals following early miscarriages led to curiosity regarding what support is available and how services might perpetuate challenges in its accessibility. As the research progressed, the researcher began to gain a better appreciation of the perspectives of practitioners without lived experience of early miscarriage and the complexities involved in providing this type of support. It was hoped that this study would also offer the chance for practitioners to be reflective of their own involvement in providing support for people following early miscarriage and the possible barriers to doing so.

Supervision was invaluable throughout the research process, supporting general reflections and overall engagement with the study. Throughout the data analysis, supervision supported the adoption of a researcher's perspective and broadened the understanding of the content of the data to develop the themes through taking on a more interpretative analysis of the interviews. Nonetheless, it is recognised that the findings represent the researcher's understanding of the interviewees' experiences and that how they have understood what the participants shared might not reflect what they had intended. It is also acknowledged that how the data has been explained will be influenced by the researcher's own subjectivity and that it could be understood differently by another researcher. Undertaking this research whilst allocated the role of Trainee Clinical Psychologist could also have influenced what the interviewees opted to share with the researcher. For instance, those still working in the role of perinatal champion may have felt less inclined to share their negative experiences for fear of this reflecting badly in an area in which they were still actively involved.

4.4.2. Epistemological Reflexivity

A critical realist position aims to bridge between epistemological knowledge and ontological reality (Willig, 2013). The researcher's understanding of the support potentially required by people following early miscarriage therefore includes the subjective reality of the person going through the experience, along with the external realities and contextual influences that surround these experiences. This led the researcher to want to situate the role of perinatal champion within the current NHS mental health support context, seeking an understanding of how people who have worked as IAPT perinatal champions have incorporated support for people following early miscarriage into their practice and the potential barriers to doing so.

Taking a critical realist stance in the approach to this study influenced how it was conducted. The researcher took the position of assuming that beyond human consciousness, there is an independently existing subjective reality governed by an individual’s personal beliefs (Bhaskar, 2010). As such, the accounts from interviewees were not taken at face value but analysed at both latent and semantic levels. This assumed that they may not have been fully aware of all the influences on their descriptions of their experiences, therefore requiring further interpretation. However, in doing this the researcher may have influenced the data from the interviewees which also raises questions regarding power and ownership over the data gathered (Willig, 2013).

Prior to conducting the research, the researcher assumed that those working as perinatal champions in IAPT services would have chosen this career path based on a passion for this area of work. Subsequently, it was anticipated that they would hold knowledge about related challenges, such as early miscarriage. Additionally, it was presumed that despite potentially coming up against barriers, practitioners would have had experience in delivering support for people following early miscarriage and would like to raise awareness of this work. Recruitment for this study was straightforward, with offers to participate quickly snowballing to the desired amount from just a few key personal and professional links, initially reinforcing these assumptions. However, during the interview process it became apparent that the participants had varying experiences of the perinatal champion role and providing support following early miscarriage and in some cases, had actually been drawn to the study after reflecting on their own lack of experience in this area and wanting to know more.

During the interview process, there were sometimes distressing and emotional accounts provided by the participants regarding their experiences of providing support for people following early miscarriage. This was especially true when participants related elements of their perinatal champion work to personal experiences regarding miscarriage. The researcher noted the dilemma this posed in terms of wanting to learn more about how their personal experience influenced their role, whilst also being aware of not wanting to increase their distress. Whilst this desire to learn more about the links between personal experience and practice felt relevant to the study, it was also likely to have been influenced by the researcher's own experience and curiosity about the similarities and differences experienced by others in somewhat similar situations. The researcher chose not to fully self-disclose with the participants during the interview, beyond what was shared in the recruitment information (see Appendix C), but remained aware of the possible impact this could have on the space and what was disclosed from the interviewees (Ladany & Walker, 2003).

One way of attempting to alleviate any distress elicited during the interview process was to let participants know prior to the interviews that they could stop at any time. A debrief was included at the end, with the offer of follow-up support if needed and information about other services that could also offer support (see Appendix T). No participants wished to discontinue, and their motivation, resilience, and hope of using their own experiences as a platform from which to help others in similar situations and break the stigma relating to early miscarriage was clearly noticeable. At the same time, the researcher remained alert to the possible impact of power in the interviewer interviewee relationship and the inadvertent pressure that may have been felt to participate (Fisher, 2013). During the interviews, the researcher was also aware that their therapeutic training was likely to be influencing their questioning style and line of thinking. Despite efforts to maintain an awareness of their position and biases as a researcher, the researcher's subjectivity will undoubtedly have shaped the interpretation of answers given and how they proceeded to respond to these with follow-up questions.

4.4.3. Research Quality

Regular supervision was used as a key resource in ensuring the quality of this research. In terms of coding and identifying the themes, this was checked by the researcher's DoS. Although inter-coder reliability was not determined, agreement was reached via discussion, opting to value the primacy of interpretation (Braun &

Clarke, 2021a). The integrity of qualitative research can also be assessed by considering its sensitivity to context, rigour, commitment, transparency, coherence, importance and impact (Yardley, 2000).

4.4.3.1. Sensitivity to context: To remain sensitive to the relevant context, a scoping review was carried out to see what was present in the current literature prior to commencing the research. As discussed in Chapter 1, there are very few studies investigating the perspectives of healthcare professionals in providing support for people following early miscarriage and none within an NHS IAPT context. This therefore identified a gap in the research which this study served to fill with substantial discussion from the participants regarding factors specific to an NHS context. Recruitment also remained mindful of sensitivity to context through only recruiting participants who had worked as perinatal champions within IAPT services to make sure of highlighting shared experiences in this specific area. The use of semi-structured interviews aimed to support participants in being able to talk freely without being overly influenced by the researcher's own agenda. Direct quotes taken from the transcripts were used to showcase participant voices and evidence the information from which the researcher drew their interpretations. Furthermore, potential researcher bias in engaging with the data was reflected on throughout the process.

4.4.3.2. Rigour and commitment: Commitment to this research was evidenced via a process of engagement with relevant resources, including an in-depth literature review which was gradually narrowed down to the scoping review papers (see Appendices A & B) and subsequent development of the research questions. This research also clearly demonstrates rigour through outlining the data collection and analysis processes from which the findings were drawn (see Appendices H, I & J). As discussed, the process of thematically analysing the transcript data was reviewed and checked on multiple occasions by the researcher's DoS to check for potential bias or discrepancy and in the process some themes were merged, removed, renamed or modified (see Appendices K, L, M, N, O & P).

4.4.3.3. Transparency: It was felt important to remain transparent throughout every aspect of the research (Yardley, 2000). This was demonstrated through the clear documentation of all processes including methodology, sampling, data collection and analysis (See Appendices). Transparency was also maintained regarding epistemological positioning and personal experience relating to the research.

4.4.3.4. Coherence: Rational links are present between the research question, methodology and philosophical positioning. The literature review identified gaps in the research which led to the development of the research question and aim of exploring perspectives of healthcare professionals regarding the barriers to providing support for people following early miscarriage. The decision to focus on perspectives of IAPT perinatal champions was based not just on personal interest fuelled by work and life experience, but also on the fact that IAPT services are the most highly accessed provider of psychological support in the UK (Clark, 2018) and are referenced by miscarriage support services as a potential source of support following early miscarriage (Miscarriage Association, 2022). Furthermore, the remit of perinatal champions is to work with people within the ’perinatal period’, which is the time at which a miscarriage would take place (O’Hara & Wisner, 2014), suggesting that they might be the most likely members of the team to have provided post-miscarriage support. Thematic analysis was determined to be the most suitable qualitative methodology to analyse the data, given its capability to provide rich results when exploring perspectives on a particular topic. Furthermore, the critical realist positioning of the study fits with the thematic methodology, along with the researcher’s perspective that to some extent all experiences are subjective and determined by an individual’s beliefs.

4.4.3.5. Importance and Impact: One of the main strengths is that this study is the first to investigate the barriers to psychological support following early miscarriage from the perspective of IAPT perinatal champions. With regard to the practical implications and potential contributions of this study, the importance of research in this area is highlighted throughout the literature and outlined in the rationale. This emphasises the lack of knowledge in the area and the need for this to be expanded to better inform commissioning and service perspectives and support the initiation of potential change.

4.4.3.6. Limitations: The process of recruitment used in this research relied on snowball methodology and existing connections which may have resulted in a sample that was not representative of all IAPT perinatal champions. Whilst snowball sampling can help to access participants that may otherwise be hard to reach (Faugier & Sargeant, 1997), issues with this type of recruitment resulting from the narrow, deep-diving approach include the participants' limited service and geographical locations, along with the potential influences of the researcher's positioning and subsequent connections (Geddes et al., 2017). The hope was for participants to have worked for IAPT services from different commissioning areas, to provide a sample representative of services across the UK. However, the snowball approach resulted in a limited sample from across the UK, with the majority having practiced around the Southeast and London. Having professional links to the researcher may also have influenced the responses, possibly increasing the risk of eliciting socially desirable and therefore biased responses. Conversely, many of the participants still held their role as perinatal champion which may have held them back from reporting negative experiences from their services, for fear of this harmfully impacting the perception of their role or service. It is also possible that IAPT Perinatal Champions who were most passionate about the provision of support following early miscarriage were more likely to participate. Furthermore, with personal experience relating to miscarriage being a seemingly motivational factor to be part of the study for several of the participants, this may have impacted responses through bringing personal biases into reflections on IAPT services (Lilienfeld & Basterfield, 2020). Future research may therefore benefit from broadening the recruitment process through using methods such as using additional researchers with relevant professional links from different backgrounds and locations or recruiting via different means such as directly through services or via relevant social media platforms (Geddes et al., 2017).

4.5. Clinical Implications of Findings and Recommendations

The findings from this research have implications relating to both clinical practice and governance. Improved clinical pathways, channels of inter-professional learning and more accessible psychological support for people following early miscarriage are all suggested as being key areas for possible service improvement.

It is clear from this study, that perinatal champions are likely to be equipped with many of the clinical skills required to support people following early miscarriage. However, the barriers to providing this support must be addressed in order improve accessibility. It highlights the need for IAPT-specific guidelines in providing post-miscarriage support and the roles of the perinatal champions in doing this. This should include clearer definitions on when a ‘perinatal priority’ label can be used with specific reference to the inclusion of those who have experienced miscarriage at any point in their pregnancy. This information should be shared at every level to influence service organisation, supervisory processes, and direct therapeutic work, all of which are areas likely to be led by clinical psychologists or other psychologically trained professionals.

Sharing the findings from this research with IAPT services would support them in understanding the links between staff training and the team’s knowledge around the impact of early miscarriage, and in addressing related challenges in accessing psychological support. The research suggests that additional training would be likely to improve service delivery and the subsequent service-user perspective on the accessibility of psychological support following early miscarriage. Given the challenges reported in accommodating miscarriage support within some of the IAPT services, it would be important to consider what form this training might take and whether the service would be able to think conceptually about what was required. It is also likely that services would benefit from more integration to streamline issues with fragmented care, including liaison and joined up approaches with other local teams such as GPs, health visitors, midwives and EPUs.

With research suggesting cultures of fairness, learning and good teamwork are key to developing effective working environments (Kaufman & McCaughan, 2013), this highlights the need for the management in IAPT services to be responsive to what has been highlighted by their staff in this research. What is striking from the research is that those interviewed had many ideas of how they might adapt their standard approaches to better fit in the context of early miscarriage, suggesting that existing

IAPT staff teams are likely to already hold so much knowledge that can be built on. Their ideas included: recognising that early miscarriage is a bereavement and the importance of normalising the feelings associated with it, and drawing on concepts such as shame and self-blame in formulating an approach to therapy and working with partners. With regard to tailoring support to better meet the needs of people accessing IAPT following an early miscarriage, this might include setting up therapeutic groups and offering perinatally-minded assessments and support which takes account of the impact of early miscarriage.

IAPT teams would also benefit from seeking the perspectives of service users who have accessed IAPT services for support following early miscarriage or prospective users to help better understand the barriers from their perspective. This is an area which would likely benefit from facilitation from psychologically trained members of the team to both support conversations and analyse any data arising from it. For example, service user perspectives could be compared to the findings from the perinatal champions to identify where similarities and differences occur in terms of the barriers identified. This could also be used to support the sharing of experiences between both parties, helping them to see each other's perspectives and encouraging more effective communication. Viewing service users as experts of their own experience and responding to this (Kennedy, 2003) can assist services in making important improvements and help people who have experienced early miscarriage to feel heard and supported, whilst not reinforcing narratives of being unresponsive to those who have bravely shared their miscarriage experiences.

There are also implications for General Practice stemming from this research, relating both to referrals made to GPs and onward referrals to IAPT made by GPs. Additional information to increase awareness about the impact of early miscarriage should therefore be provided to GPs and the services potentially referring to them such as local hospitals and maternity services. This should include details of the type of support available, such as that offered through IAPT, in order to increase referrals to direct support and reduce signposting to services that are not able to offer what is required.

4.6. Future Research

Whilst the literature highlights issues of inequity in accessing post-miscarriage support, the interviewees found it hard to pinpoint those at a specific disadvantage due to such limited contact overall with those who had experienced early miscarriage. Consequently, research may benefit from further exploration into who is accessing support via IAPT services following early miscarriage, helping to identify who may be missing and system-wide factors influencing this (Yang et al., 2022). This might include further consideration of the influence of gender roles on support-seeking in the context of miscarriage and more detailed exploration into the perspectives of non-childbearing partners, including same-sex couples who are starkly missing from the current literature.

It is also recognised that the predominant perspectives represented in the literature and interviews present a Westernised view of early miscarriage. Comparing and contrasting perspectives of practitioners and prospective service users from a wider breadth of backgrounds, may also help draw attention to how approaches to early miscarriage are affected by different cultural norms. This also relates to the earlier points made regarding the disproportionate rates of miscarriage seen in racially minoritized individuals (Eichelberger et al., 2016) which does not appear to be represented in those accessing support. Whilst it might be hypothesised that this represents a mistrust of services (Paul et al., 2022) or cultural differences in how a miscarriage is responded to (Murphy & Philpin, 2010), this area is clearly in need of further research to highlight which factors are influential in order to improve the equity of the post-miscarriage support available.

Limiting the research to focus specifically on early miscarriage, was deemed appropriate due to the very limited amount of research that has focused solely on experiences of loss and providing support for this, within the first 12 weeks of pregnancy. This was in recognition of the fact that early miscarriage is often overlooked in terms of its potential impact (Robinson, 2014). However, a broader focus on miscarriage support overall in the context of IAPT services and the work of perinatal champions may have provided further information regarding specific cases and pieces of work from which examples could be drawn, which were limited in the interviews conducted. Future research may therefore want to consider comparing the support available for pregnancy loss in the first 12 weeks, to that available following later miscarriage. This offers the potential to draw attention to biases in the system that influence the support available following early miscarriage, highlighting any discrepancies and the theoretical foundations on which these are based, which can go on to be addressed directly.

4.7. Conclusion

The previous literature had gathered perspectives of various healthcare professionals on some of the potential barriers to accessing psychological support following early miscarriage. However these were not specific to accessing support within the UK or from mental health services positioned within the NHS. This study aimed to investigate and better understand the perspectives of individuals who have worked as perinatal champions within UK IAPT services, and find out whether they had noticed any particular barriers to access for people following early miscarriage. This may benefit clinical psychology in supporting understanding around the difficulties people face in accessing support following such events and subsequently assist with the facilitation of positive change.

The findings revealed that whilst IAPT services are positioned within UK mental health service provision in a way that could make them the ideal candidate for providing psychological support following early miscarriage, there are numerous barriers that would need to be addressed to support them in doing so. These include addressing unclear guidance and uncertainty across various areas of service provision, evaluating the impact of service-centred care, improving training, identifying specially trained staff and building awareness and being responsive to how services can perpetuate stigma.

This research offers a foundation for future research into the provision of psychological support following early miscarriage within UK-based, NHS settings. This may include exploration into the perspectives of those who have accessed psychological support following early miscarriage. As the stigma and silence around experiences of early miscarriage continues to be broken, through social media campaigns and the increased sharing of stories from high profile individuals, this may serve to increase healthcare professionals’ awareness of the potential psychological need relating to this frequently experienced life event. Additional interest and more studies conducted in this field will only advance our skills and ability as clinical psychologists in delivering therapy and setting up services that are in a better position to provide such support.

REFERENCES

Abboud, L., & Liamputtong, P. (2005). When pregnancy fails: Coping strategies, support networks and experiences with health care of ethnic women and their partners. *Journal of Reproductive and Infant Psychology*, *23*(1), 3–18. https://doi.org/10.1080/02646830512331330974

Adolfsson, A., Berterö, C., & Larsson, P.-G. (2006). Effect of a structured follow-up visit to a midwife on women with early miscarriage: A randomized study. *Acta Obstetricia et Gynecologica Scandinavica*, *85*(3), 330–335. https://doi.org/10.1080/00016340500539376

Arksey, H., & O'Malley, L. (2005). Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*, *8*(1), 19–32. https://doi.org/10.1080/1364557032000119616

Athey, J., & Spielvogel, A. M. (2000). Risk factors and interventions for psychological sequelae in women after miscarriage. *Primary Care Update for OB/GYNS*, *7*(2), 64–69. https://doi.org/10.1016/S1068-607X(00)00023-8

Baird, S., Gagnon, M. D., deFiebre, G., Briglia, E., Crowder, R., & Prine, L. (2018). Women's experiences with early pregnancy loss in the emergency room: A qualitative study. *Sexual & Reproductive Healthcare*, *16*, 113–117. https://doi.org/10.1016/j.srhc.2018.03.001

Baldwin, S., Kelly, P., & Walker, M. (2018). Implementing a Perinatal Mental Health Champion programme in north-west London. *Journal of Health Visiting*, *6*(4), 176–180. https://doi.org/10.12968/johv.2018.6.4.176

Bansen, S., & Stevens, H. (1992). Women's experiences of miscarriage in early pregnancy. *Journal of Nurse-Midwifery*, *37*(2), 84–90. https://doi.org/10.1016/0091-2182(92)90142-P

Bergner, A., Beyer, R., Klapp, B. F., & Rauchfuss, M. (2008). Pregnancy after early pregnancy loss: A prospective study of anxiety, depressive symptomatology and coping. *Journal of Psychosomatic Obstetrics & Gynecology*, *29*(2), 105–113. https://doi.org/10.1080/01674820701687521

Beutel, M., Willner, H., Deckardt, R., Von Rad, M., & Weiner, H. (1996). Similarities and differences in couples' grief reactions following a miscarriage: Results from a longitudinal study. *Journal of Psychosomatic Research*, *40*(3), 245–253. https://doi.org/10.1016/0022-3999(95)00520-X

Bhaskar, R. (2010). *Reclaiming reality: A critical introduction to contemporary philosophy*. Routledge.

Bhaskar, R. (2013). *A realist theory of science*. Routledge.

Bottomley, C., & Bourne, T. (2009). Diagnosing miscarriage. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *23*(4), 463–477. https://doi.org/10.1016/j.bpobgyn.2009.02.004

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021a). Can I use TA? Should I use TA? Should I *not* use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Counselling and Psychotherapy Research*, *21*(1), 37–47. https://doi.org/10.1002/capr.12360

Braun, V., & Clarke, V. (2021b). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Brown, B., Crawford, P., & Darongkamas, J. (2000). Blurred roles and permeable boundaries: The experience of multidisciplinary working in community mental health: Multidisciplinary working in community mental health. *Health & Social Care in the Community*, *8*(6), 425–435. https://doi.org/10.1046/j.1365-2524.2000.00268.x

Browne, V. (2018). Radical Philosophy. *The Politics of Miscarriage*. https://www.radicalphilosophy.com/article/the-politics-of-miscarriage

Cesare, N., Oladeji, O., Ferryman, K., Wijaya, D., Hendricks-Muñoz, K. D., Ward, A., & Nsoesie, E. O. (2020). Discussions of miscarriage and preterm births on Twitter. *Paediatric and Perinatal Epidemiology*, *34*(5), 544–552. https://doi.org/10.1111/ppe.12622

Cesario, S., Morin, K., & Santa-Donato, A. (2002). Evaluating the level of evidence of qualitative research. *Journal of Obstetric, Gynecologic, and Neonatal Nursing: JOGNN*, *31*(6), 708–714.

Chen, S., & Schildberg-Hörisch, H. (2019). Looking at the bright side: The motivational value of confidence. *European Economic Review*, *120*, 103302. https://doi.org/10.1016/j.euroecorev.2019.103302

Chichester, M., & Harding, K. M. (2021). Early pregnancy loss: Invisible but real. *Nursing*, *51*(12), 28–32. https://doi.org/10.1097/01.NURSE.0000800080.92781.c5

Claringbold, L., Bilardi, J., & Temple-Smith, M. (2021). Early Pregnancy Assessment Services in Australia: What psychosocial support is available? A qualitative study. *Women and Birth*, *34*(6), e575–e583. https://doi.org/10.1016/j.wombi.2020.10.013

Clark, D. M. (2018). Realizing the Mass Public Benefit of Evidence-Based Psychological Therapies: The IAPT Program. *Annual Review of Clinical Psychology*, *14*(1), 159–183. https://doi.org/10.1146/annurev-clinpsy-050817-084833

Côté-Arsenault, D., Leerkes, E. M., & Zhou, N. (2020). Individual Differences in Maternal, Marital, Parenting and Child Outcomes Following Perinatal Loss: A Longitudinal Study. *Journal of Reproductive and Infant Psychology*, *38*(1), 3–15. https://doi.org/10.1080/02646838.2019.1579897

Cote-Arsenault, D., & Mahlangu, N. (1999). Impact of Perinatal Loss on the Subsequent Pregnancy Self: Women's Experiences. *Journal of Obstetric, Gynecologic & Neonatal Nursing*, *28*(3), 274–282. https://doi.org/10.1111/j.1552-6909.1999.tb01992.x

Crenshaw, K. (2019). *On intersectionality: Essential writings*. New Press.

Dayton, C. J., Levendosky, A. A., Davidson, W. S., & Bogat, G. A. (2010). The child as held in the mind of the mother: The influence of prenatal maternal representations on parenting behaviors. *Infant Mental Health Journal*, *31*(2), 220–241. https://doi.org/10.1002/imhj.20253

Dearnley, C. (2005). A reflection on the use of semi-structured interviews. *Nurse Researcher*, *13*(1), 19–28. https://doi.org/10.7748/nr2005.07.13.1.19.c5997

Doka, K. J. (1999). Disenfranchised grief. *Bereavement Care*, *18*(3), 37–39. https://doi.org/10.1080/02682629908657467

Duggan, P. S., Geller, G., Cooper, L. A., & Beach, M. C. (2006). The moral nature of patient-centeredness: Is it "just the right thing to do"? *Patient Education and Counseling*, *62*(2), 271–276. https://doi.org/10.1016/j.pec.2005.08.001

Easterwood, B. (2004). Silent Lullabies. *AWHONN Lifelines*, *8*(4), 356–360. https://doi.org/10.1177/1091592304269639

Eichelberger, K. Y., Doll, K., Ekpo, G. E., & Zerden, M. L. (2016). Black Lives Matter: Claiming a Space for Evidence-Based Outrage in Obstetrics and Gynecology. *American Journal of Public Health*, *106*(10), 1771–1772. https://doi.org/10.2105/AJPH.2016.303313

Faugier, J., & Sargeant, M. (1997). Sampling hard to reach populations. *Journal of Advanced Nursing, 26*(4), 790-797. https://doi.org/10.1046/j.1365-2648.1997.00371.x

Farquharson, R. G. (2017). The value of early pregnancy units. In R. G. Farquharson & M. D. Stephenson (Eds.), *Early Pregnancy* (pp 146-150). Cambridge University Press.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods*, *5*(1), 80–92. https://doi.org/10.1177/160940690600500107

Fisher, J. A. (2013). Expanding the Frame of “Voluntariness” in Informed Consent: Structural Coercion and the Power of Social and Economic Context. *Kennedy Institute of Ethics Journal*, *23*(4), 355–379. https://doi.org/10.1353/ken.2013.0018

Fox, J., & Gamble, C. (2005). Consolidating the assessment process: The semi-structured interview. *Working with Serious Mental Illness: A Manual for Clinical Practice*, 133.

Franche, R.-L., & Mikail, S. F. (1999). The impact of perinatal loss on adjustment to subsequent pregnancy. *Social Science & Medicine*, *48*(11), 1613–1623. https://doi.org/10.1016/S0277-9536(98)00438-9

Frost, J., Bradley, H., Levitas, R., Smith, L., & Garcia, J. (2007). The loss of possibility: Scientisation of death and the special case of early miscarriage: The scientisation of death and early miscarriage. *Sociology of Health & Illness*, *29*(7), 1003–1022. https://doi.org/10.1111/j.1467-9566.2007.01019.x

Fugard, A. J. B., & Potts, H. W. W. (2015). Supporting thinking on sample sizes for thematic analyses: A quantitative tool. *International Journal of Social Research Methodology*, *18*(6), 669–684. https://doi.org/10.1080/13645579.2015.1005453

Geddes, A., Parker, C., & Scott, S. (2017). When the snowball fails to roll and the use of 'horizontal' networking in qualitative social research. *International Journal of Social Research Methodology, 21*(3), 347-358. https://doi.org/10.1080/13645579.2017.1406219

Gergett, B., BSc, RM, RGN, & Gillen, P., PhD, FHEA, MSc, BSc, RM, RGN. (2014). Early pregnancy loss: Perceptions of healthcare professionals. *Evidence Based Midwifery*, *12*(1), 29–34. ProQuest Central.

Glueck, D., Myers, K., & Turvey, C. L. (2013). Establishing therapeutic rapport in telemental health. *Telemental Health: Clinical, Technical and Administrative Foundations for Evidence-Based Practice*, 29–46.

Gray, H. (2021). The Age of Toxicity: The Influence of Gender Roles and Toxic Masculinity in Harmful Heterosexual Relationship Behaviours. *Canadian Journal of Family and Youth / Le Journal Canadien de Famille et de La Jeunesse*, *13*(3), 41–52. https://doi.org/10.29173/cjfy29621

Griffin, G., Ngulube, M., Farrell, V., & Hauck, Y. L. (2021). Caring for women through early pregnancy loss: Exploring nurses' experiences of care. *Collegian*, *28*(3), 268–274. https://doi.org/10.1016/j.colegn.2020.08.011

Hammarberg, K., Kirkman, M., & de Lacey, S. (2016). Qualitative research methods: When to use them and how to judge them. *Human Reproduction*, *31*(3), 498–501. https://doi.org/10.1093/humrep/dev334

Hammerslough, C. R. (1992). Estimating the probability of spontaneous abortion in the presence of induced abortion and vice versa. *Public Health Reports (Washington, D.C.: 1974)*, *107*(3), 269–277.

Hardy, S., & Kukla, R. (2015). Making Sense of Miscarriage Online. *Journal of Social Philosophy*, *46*(1), 106–125. https://doi.org/10.1111/josp.12089

Hazen, M. A. (2003). Societal and Workplace Responses to Perinatal Loss: Disenfranchised Grief or Healing Connection. *Human Relations*, *56*(2), 147–166. https://doi.org/10.1177/0018726703056002889

Health & Care Professions Council. (2016). *Guidance on Conduct and Ethics for Students*. https://www.hcpc-uk.org/globalassets/resources/guidance/guidance-on-conduct-and-ethics-for-students.pdf?v=637106442980000000

Hemminki, E. (1998). Treatment of Miscarriage: Current Practice and Rationale. *Obstetrics & Gynecology*, *91*(2), 247–253. https://doi.org/10.1016/S0029-7844(97)00606-6

Hiefner, A. R. (2020). "A Silent Battle": Using a Feminist Approach to Support Couples after Miscarriage. *Journal of Feminist Family Therapy*, *32*(1–2), 57–75. https://doi.org/10.1080/08952833.2020.1793563

Hinshaw, S. P. (2005). The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal of Child Psychology and Psychiatry*, *46*(7), 714–734. https://doi.org/10.1111/j.1469-7610.2005.01456.x

HM Government. (2018). *Data Protection Act*. https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

HM Government. (2021). *The Best Start for Life: A Vision for the 1001 Critical Days.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf

Hutchon, D. J. R., & Cooper, S. (1998). Terminology for early pregnancy loss must be changed. *BMJ*, *317*(7165), 1081–1081. https://doi.org/10.1136/bmj.317.7165.1081

Iles, S. (1989). 5 The loss of early pregnancy. *Baillière's Clinical Obstetrics and Gynaecology*, *3*(4), 769–790. https://doi.org/10.1016/S0950-3552(89)80064-1

Joffe, H. (2011). Thematic Analysis. In D. Harper & A. R. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy* (1st ed., pp. 209–223). Wiley. https://doi.org/10.1002/9781119973249.ch15

Jonas-Simpson, C., & McMahon, E. (2005). The Language of Loss When a Baby Dies Prior to Birth: Cocreating Human Experience. *Nursing Science Quarterly*, *18*(2), 124–130. https://doi.org/10.1177/0894318405275861

Kallio, H., Pietilä, A.-M., Johnson, M., & Kangasniemi, M. (2016). Systematic methodological review: Developing a framework for a qualitative semi-structured interview guide. *Journal of Advanced Nursing*, *72*(12), 2954–2965. https://doi.org/10.1111/jan.13031

Kaufman, G., & McCaughan, D. (2013). The effect of organisational culture on patient safety. *Nursing Standard*, *27*(43), 50–56. https://doi.org/10.7748/ns2013.06.27.43.50.e7280

Keep, M. (2021). The silence around miscarriage hurts health care and bereaved parents. *Medical Journal of Australia*, *215*(8), 343. https://doi.org/10.5694/mja2.51272

Kennedy, I. (2003). Patients are experts in their own field. *BMJ*, *326*(7402), 1276–1277. https://doi.org/10.1136/bmj.326.7402.1276

Kevin, C. (2017). Maternal Responsibility and Traceable Loss: Medicine and miscarriage in twentieth-century Australia. *Women's History Review*, *26*(6), 840–856. https://doi.org/10.1080/09612025.2016.1210955

Khan, L. (2015). *Falling Through the Gaps: Perinatal mental health and general practice.* https://maternalmentalhealthalliance.org/wp-content/uploads/RCGP-Report-Falling-through-the-gaps-PMH-and-general-practice-March-2015.pdf

King, N., Horrocks, C., & Brooks, J. (2018). *Interviews in qualitative research*. sage.

Knez, J., Day, A., & Jurkovic, D. (2014). Ultrasound imaging in the management of bleeding and pain in early pregnancy. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *28*(5), 621–636. https://doi.org/10.1016/j.bpobgyn.2014.04.003

Ko, S. J., Ford, J. D., Kassam-Adams, N., Berkowitz, S. J., Wilson, C., Wong, M., Brymer, M. J., & Layne, C. M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, *39*(4), 396–404. https://doi.org/10.1037/0735-7028.39.4.396

Ladany, N., & Walker, J. A. (2003). Supervisor self-disclosure: Balancing the uncontrollable narcissist with the indomitable altruist. *Journal of Clinical Psychology*, *59*(5), 611–621. https://doi.org/10.1002/jclp.10164

Lamb, E. H. (2002). The Impact of Previous Perinatal Loss on Subsequent Pregnancy and Parenting. *The Journal of Perinatal Education*, *11*(2), 33–40. https://doi.org/10.1891/1058-1243.11.2.33

Larsen, E. C., Christiansen, O. B., Kolte, A. M., & Macklon, N. (2013). New insights into mechanisms behind miscarriage. *BMC Medicine*, *11*(1), 154. https://doi.org/10.1186/1741-7015-11-154

Lee, C., & Slade, P. (1996). Miscarriage as a traumatic event: A review of the literature and new implications for intervention. *Journal of Psychosomatic Research*, *40*(3), 235–244. https://doi.org/10.1016/0022-3999(95)00579-X

Lilienfield, S.O., & Basterfield, C. (2020). Reflective practice in clinical psychology: Reflections from basic psychological science. *Clinical Psychology Science and Practice, 27*(4), 220. https://doi.org/10.1111/cpsp.12352

Lind, E. R. M., & Deveau, A. (Eds.). (2017). *Interrogating pregnancy loss: Feminist writings on abortion, miscarriage, and stillbirth*. Demeter Press.

Maker, C., & Ogden, J. (2003). The Miscarriage Experience: More Than Just a Trigger to Psychological Morbidity? *Psychology & Health*, *18*(3), 403–415. https://doi.org/10.1080/0887044031000069343

Markin, R. D. (2016). What clinicians miss about miscarriages: Clinical errors in the treatment of early term perinatal loss. *Psychotherapy*, *53*(3), 347–353. https://doi.org/10.1037/pst0000062

Maxwell, J. A. (2013). Qualitative research design. *Applied social research methods series, 4*(5), 41.

McCallum, K., & Holland, K. (2018). ‘To drink or not to drink’: Media framing of evidence and debate about alcohol consumption in pregnancy. *Critical Public Health*, *28*(4), 412–423. https://doi.org/10.1080/09581596.2017.1414150

Meyers, D. T. (2002). *Gender in the mirror: Cultural imagery and women’s agency*. Oxford University Press.

Miscarriage Association. (2021). *Counselling after a miscarriage*. https://www.miscarriageassociation.org.uk/your-feelings/counselling-after-a-miscarriage/

Miscarriage Association. (2022). *Background information: Miscarriage.* https://www.miscarriageassociation.org.uk/media-queries/background-information/#:~:text=Miscarriage%20More%20than%20one%20in%20five%20pregnancies%20ends,they%20can%20happen%20up%20to%20the%2024th%20week.

Murphy, F. A. (1998). The experience of early miscarriage from a male perspective. *Journal of Clinical Nursing*, *7*(4), 325–332. https://doi.org/10.1046/j.1365-2702.1998.00153.x

Murphy, F., & Merrell, J. (2009). Negotiating the transition: Caring for women through the experience of early miscarriage. *Journal of Clinical Nursing*, *18*(11), 1583–1591. https://doi.org/10.1111/j.1365-2702.2008.02701.x

Murphy, F., & Philpin, S. (2010). Early miscarriage as ‘matter out of place’: An ethnographic study of nursing practice in a hospital gynaecological unit. *International Journal of Nursing Studies*, *47*(5), 534–541. https://doi.org/10.1016/j.ijnurstu.2009.10.011

Nash, M., Barry, M., & Bradshaw, C. (2018). Midwives’ experiences of caring for women with early pregnancy loss in an Irish maternity hospital. *British Journal of Midwifery*, *26*(12), 796–805. https://doi.org/10.12968/bjom.2018.26.12.796

National Institute for Health and Clinical Excellence. (2019). *Ectopic Pregnancy and miscarriage: Diagnosis and initial management*. https://www.nice.org.uk/guidance/ng126

Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description – the poor cousin of health research? *BMC Medical Research Methodology*, *9*(1), 52. https://doi.org/10.1186/1471-2288-9-52

NHS. (2019). *NHS Mental Health Implementation Plan 2019/20-2023/24*. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf

Nybo Andersen, A. M., Wohlfahrt, J., Christens, P., Olsen, J., & Melbye, M. (2000). Maternal age and fetal loss: Population based register linkage study. *BMJ (Clinical Research Ed.)*, *320*(7251), 1708–1712. https://doi.org/10.1136/bmj.320.7251.1708

Nynas, J., Narang, P., Kolikonda, M. K., & Lippmann, S. (2015). Depression and Anxiety Following Early Pregnancy Loss: Recommendations for Primary Care Providers. *The Primary Care Companion For CNS Disorders*. https://doi.org/10.4088/PCC.14r01721

O’Hara, M. W., & Wisner, K. L. (2014). Perinatal mental illness: Definition, description and aetiology. *Best Practice & Research Clinical Obstetrics & Gynaecology*, *28*(1), 3–12. https://doi.org/10.1016/j.bpobgyn.2013.09.002

O’Mahen, H., & Healy, S. (2020). *IAPT Perinatal Competency Framework.* https://www.iptuk.net/uploads/1/2/9/0/12909346/item_5_paper_perinatal_competency_framework_v01_

Parr, S. (2015). Integrating critical realist and feminist methodologies: Ethical and analytical dilemmas. *International Journal of Social Research Methodology*, *18*(2), 193–207. https://doi.org/10.1080/13645579.2013.868572

Patton, M. Q. (2002). Two decades of developments in qualitative inquiry: A personal, experiential perspective. *Qualitative Social Work*, *1*(3), 261–283.

Paul, E., Fancourt, D., & Razai, M. (2022). Racial discrimination, low trust in the health system and COVID-19 vaccine uptake: A longitudinal observational study of 633 UK adults from ethnic minority groups. *Journal of the Royal Society of Medicine*, *115*(11), 439–447. https://doi.org/10.1177/01410768221095241

Petals. (2023). *Petals The Baby Loss Counselling Charity.* https://petalscharity.org/impact/

PettyJohn, M. E., Tseng, C., & Blow, A. J. (2020). Therapeutic Utility of Discussing Therapist/Client Intersectionality in Treatment: When and How? *Family Process*, *59*(2), 313–327. https://doi.org/10.1111/famp.12471

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, *52*(2), 126.

Potter, J., & Hepburn, A. (2012). Eight challenges for interview researchers. *Handbook of Interview Research*, *2*(1), 541–570.

Puddifoot, J. E., & Johnson, M. P. (1997). The legitimacy of grieving: The partner's experience at miscarriage. *Social Science & Medicine*, *45*(6), 837–845. https://doi.org/10.1016/S0277-9536(96)00424-8

Quenby, S., Gallos, I. D., Dhillon-Smith, R. K., Podesek, M., Stephenson, M. D., Fisher, J., Brosens, J. J., Brewin, J., Ramhorst, R., Lucas, E. S., McCoy, R. C., Anderson, R., Daher, S., Regan, L., Al-Memar, M., Bourne, T., MacIntyre, D. A., Rai, R., Christiansen, O. B., … Coomarasamy, A. (2021). Miscarriage matters: The epidemiological, physical, psychological, and economic costs of early pregnancy loss. *The Lancet*, *397*(10285), 1658–1667. https://doi.org/10.1016/S0140-6736(21)00682-6

Radford, E. J., & Hughes, M. (2015). Women's experiences of early miscarriage: Implications for nursing care. *Journal of Clinical Nursing*, *24*(11–12), 1457–1465. https://doi.org/10.1111/jocn.12781

Reiheld, A. (2015). "The Event That Was Nothing": Miscarriage as a Liminal Event. *Journal of Social Philosophy*, *46*(1), 9–26. https://doi.org/10.1111/josp.12084

Rimmer, A. (2018). Staff stress levels reflect rising pressure on NHS, says NHS leaders. *BMJ*, k1074. https://doi.org/10.1136/bmj.k1074

Roberts, R. (2020). Qualitative Interview Questions: Guidance for Novice Researchers. *The Qualitative Report*. https://doi.org/10.46743/2160-3715/2020.4640

Robinson, J. (2014). Provision of information and support to women who have suffered an early miscarriage. *British Journal of Midwifery*, *22*(3), 175–180. https://doi.org/10.12968/bjom.2014.22.3.175

Rowlands, I. J., & Lee, C. (2010). ‘The silence was deafening’: Social and health service support after miscarriage. *Journal of Reproductive and Infant Psychology*, *28*(3), 274–286. https://doi.org/10.1080/02646831003587346

Rowley, J. (2012). Conducting research interviews. *Management Research Review*, *35*(3/4), 260–271. https://doi.org/10.1108/01409171211210154

Rubery, J., Grimshaw, D., & Marchington, M. (2010). *Blurring boundaries and disordering hierarchies: Challenges for employment and skills in networked organisations*.

San Lazaro Campillo, I., Meaney, S., Sheehan, J., Rice, R., & O’Donoghue, K. (2018). University students’ awareness of causes and risk factors of miscarriage: A cross-sectional study. *BMC Women’s Health*, *18*(1), 188. https://doi.org/10.1186/s12905-018-0682-1

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing & Health*, *23*(4), 334–340. https://doi.org/10.1002/1098-240X(200008)23:4<334::AID-NUR9>3.0.CO;2-G

Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H., & Lu, M. (2018). How to practice person-centred care: A conceptual framework. *Health Expectations*, *21*(2), 429–440. https://doi.org/10.1111/hex.12640

Schaubroeck, J., Lam, S. S. K., & Xie, J. L. (2000). Collective efficacy versus self-efficacy in coping responses to stressors and control: A cross-cultural study. *Journal of Applied Psychology*, *85*(4), 512–525. https://doi.org/10.1037/0021-9010.85.4.512

Séjourné, N., Callahan, S., & Chabrol, H. (2009). La fausse couche: Une expérience difficile et singulière: *Devenir*, *Vol. 21*(3), 143–157. https://doi.org/10.3917/dev.093.0143

Sobotka, T. (2010). Shifting Parenthood to Advanced Reproductive Ages: Trends, Causes and Consequences. In J. Tremmel (Ed.), *A Young Generation Under Pressure?* (pp. 129–154). Springer Berlin Heidelberg. https://doi.org/10.1007/978-3-642-03483-1_7

Sorrel, W. E. (1967). Abortion: Its Psychodynamic Effects. *Psychosomatics*, *8*(3), 146–149. https://doi.org/10.1016/S0033-3182(67)72003-4

South London and Maudsley NHS Foundation Trust. (2021). *Involving and supporting partners and other family members in specialist perinatal mental health services: Good practice guide.* https://www.england.nhs.uk/wp-content/uploads/2021/03/Good-practice-guide-March-2021.pdf

Stratton, K., & Lloyd, L. (2008). Hospital-based interventions at and following miscarriage: Literature to inform a research-practice initiative. *The Australian and New Zealand Journal of Obstetrics and Gynaecology*, *48*(1), 5–11. https://doi.org/10.1111/j.1479-828X.2007.00806.x

The British Psychological Society. (2017). *Practice Guidelines: Third Edition*. https://cms.bps.org.uk/sites/default/files/2022-06/BPS%20Practice%20Guidelines%20%28Third%20Edition%29.pdf

The British Psychological Society. (2018). *Code of Ethics and Conduct*. https://cms.bps.org.uk/sites/default/files/2022-06/BPS%20Code%20of%20Ethics%20and%20Conduct.pdf

The British Psychological Society. (2021). *BPS Code of Human Research Ethics*. https://cms.bps.org.uk/sites/default/files/2022-06/BPS%20Code%20of%20Human%20Research%20Ethics%20%281%29.pdf

Tommy's. (2022). *Tommy's National Centre for Miscarriage Research.* https://bwc.nhs.uk/tommys#:~:text=It%20has%20been%20brought%20into%20being%20by%20Tommy%E2%80%99s%2C,%27recurrent%27%20losses.%20Miscarriage%20is%20an%20intensely%20personal%20experience.

Tsartsara, E., & Johnson, M. P. (2006). The impact of miscarriage on women's pregnancy-specific anxiety and feelings of prenatal maternal–fetal attachment during the course of a subsequent pregnancy: An exploratory follow-up study. *Journal of Psychosomatic Obstetrics & Gynecology*, *27*(3), 173–182. https://doi.org/10.1080/01674820600646198

Visa, M., & Briones-Vozmediano, E. (2020). "Es algo que no se cuenta": Relatos sobre pérdidas gestacionales en youtube. *Enfermería Global*, *19*(3), 193–213. https://doi.org/10.6018/eglobal.394321

Watson, R., McKenna, H., Cowman, S., & Keady, J. (2008). *Nursing Research Design and Methods* (pp. 16–17). Elsevier.

Wilkinson, E. (2015). UK NHS staff: Stressed, exhausted, burnt out. *The Lancet*, *385*(9971), 841–842. https://doi.org/10.1016/S0140-6736(15)60470-6

Williams, E. S., Manwell, L. B., Konrad, T. R., & Linzer, M. (2007). The relationship of organizational culture, stress, satisfaction, and burnout with physician-reported error and suboptimal patient care: Results from the MEMO study. *Health Care Management Review*, *32*(3), 203–212. https://doi.org/10.1097/01.HMR.0000281626.28363.59

Williams, H. M., Topping, A., Coomarasamy, A., & Jones, L. L. (2020). Men and Miscarriage: A Systematic Review and Thematic Synthesis. *Qualitative Health Research*, *30*(1), 133–145. https://doi.org/10.1177/1049732319870270

Willig, C. (2013). *EBOOK: introducing qualitative research in psychology*. McGraw-hill education.

Willis, D. G., Sullivan-Bolyai, S., Knafl, K., & Cohen, M. Z. (2016). Distinguishing Features and Similarities Between Descriptive Phenomenological and Qualitative Description Research. *Western Journal of Nursing Research*, *38*(9), 1185–1204. https://doi.org/10.1177/0193945916645499

Winkler, N. (2014). Babies After 40: Is the “Biological Clock” Really Ticking? In D. L. Barnes (Ed.), *Women’s Reproductive Mental Health Across the Lifespan* (pp. 195–213). Springer International Publishing. https://doi.org/10.1007/978-3-319-05116-1_11

Wong, M. K., Crawford, T. J., Gask, L., & Grinyer, A. (2003). A qualitative investigation into women’s experiences after a miscarriage: Implications for the primary healthcare team. *The British Journal of General Practice: The Journal of the Royal College of General Practitioners*, *53*(494), 697–702.

Yang, J., Dowell, A., & Filoche, S. (2022). Views of health professionals on the impact of early miscarriage on women’s mental health and the accessibility of services and support. *The New Zealand Medical Journal*, *135*(1548), 54–64.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, *15*(2), 215–228. https://doi.org/10.1080/08870440008400302

Zavotsky, K. E., Mahoney, K., Keeler, D., & Eisenstein, R. (2013). Early Pregnancy Loss and Bereavement in the Emergency Department: Staff and Patient Satisfaction With an Early Fetal Bereavement Program. *Journal of Emergency Nursing*, *39*(2), 158–161. https://doi.org/10.1016/j.jen.2012.08.006

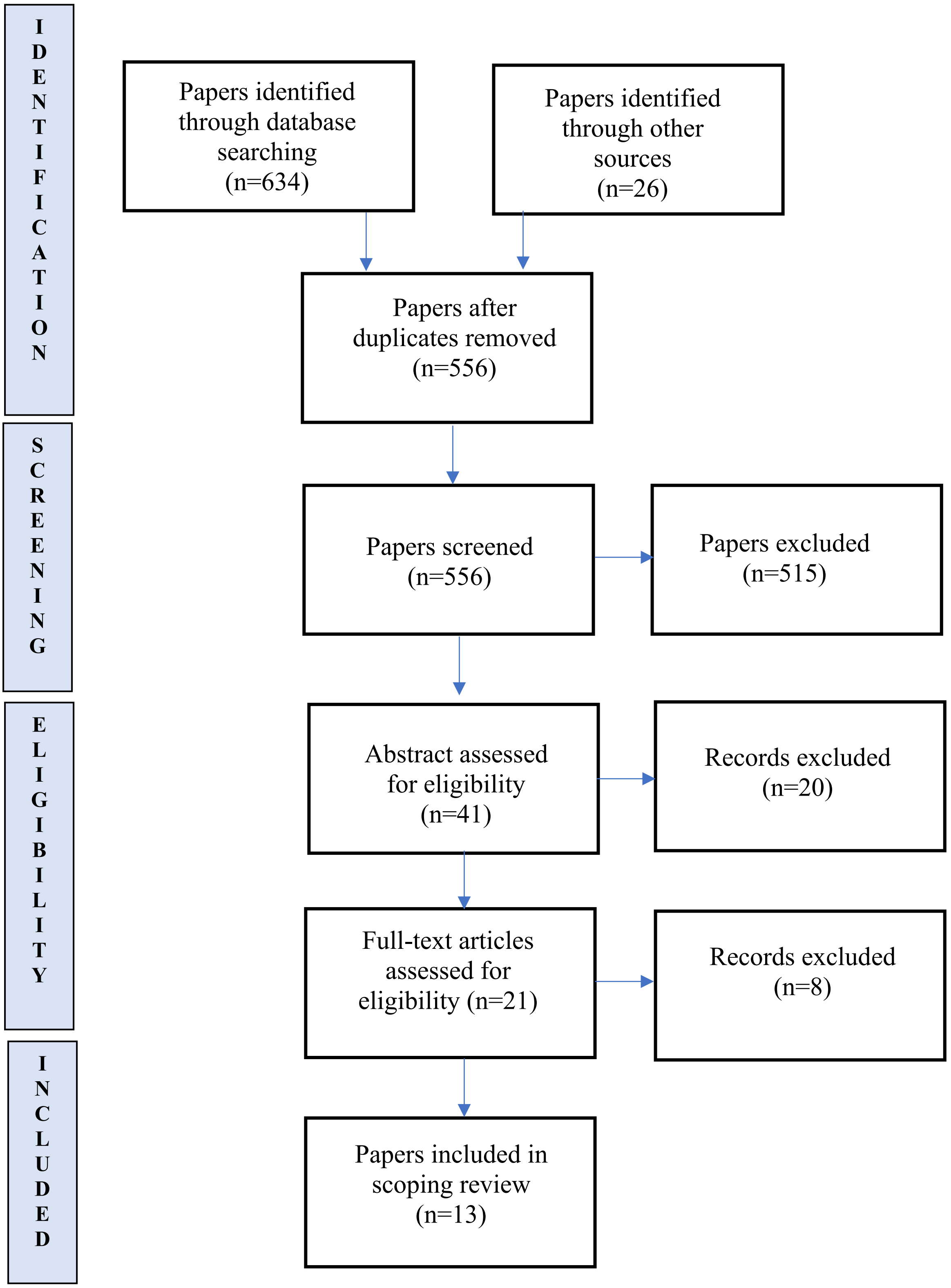
Zucker, J. (2021). *I had a miscarriage: A memoir, a movement* (First Feminist Press edition). The Feminist Press at the City University of New York.

Appendix A: Literature Search Strategy Information

Search Number	Search Terms	Limiters/Narrow By	Number of Articles	Database	Date
1	DE “spontaneous abortion” OR “miscarriage”	-Academic journals -Published in English	1,150	PsychInfo (EBSCO)	13/6/2022
2	DE “treatment” OR psychological support		704,286		
3	DE “spontaneous abortion” OR “miscarriage” AND DE “treatment” OR psychological support		**274**		
1	“miscarriage”	-Academic journals -Published in English	15,013	Academic Search Ultimate (EBSCO)	18/7/2022
2	“psychotherapy” OR “psychological support”		149,220		

3	“miscarriage” AND “psychotherapy” OR “psychological support”		**157**		
1	“miscarriage” AND “psychological support”	-Academic journals -Published in English	**99**	CINAHL (EBSCO)	18/7/2022
1	“miscarriage” AND “psychological support”	-Academic journals -Published in English	**28**	SCOPUS	25/7/2022
1	“miscarriage” AND “psychological support”	-Search terms in “title, abstract or author-specified keywords”	**42**	Science Direct	25/7/2022
1	Miscarriage [MeSH Terms]	-Published in English -MeSH Terms	29,633	PubMed	25/7/2022
2	Miscarriage [MeSH Terms] AND “psychological support”		**34**		

Appendix B: Literature Search Prisma Diagram



Appendix C: Participant Recruitment Information

Shared with IAPT practitioners/perinatal champions via email, messaging platforms and/or online forums:

“Are you an IAPT perinatal champion? Do you know anyone who has experienced an early miscarriage? Would you like to help improve access to support for people experiencing difficulties following early miscarriage? I am a second year student from the University of East London, completing my Doctorate in Clinical Psychology. Having had close personal experiences of the challenges associated with early miscarriage, and recognising the difficulties some people experience in accessing psychological support following early miscarriage, I have decided to focus my doctoral research on this topic. This is in the hope of improving access to support for people in the future. My research will focus on IAPT staff across the UK, and will be set up to explore potential barriers in providing support following early miscarriage, from their perspective. I am therefore looking for anyone who has previously or currently holds the position of IAPT perinatal champion to take part in a short interview to discuss their experiences. Please get in contact to express interest or request further information.”

Appendix D: Participant Information Sheet

University of East London
School of Psychology, Stratford Campus
Water Lane, London, E15 4LZ
The Principal Investigator(s)
Name: Jinny Carthew
School of Psychology
Email: u2075231@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this information sheet is to provide you with the information you need to consider in deciding whether to participate in this research study which is being completed as part of my Clinical Psychology Doctorate degree at the University of East London.

Project Title

Barriers to accessing psychological support following early miscarriage. Perspectives of the IAPT perinatal champion.

Project Description

The aim of this research is to understand the experiences and perspectives of IAPT perinatal champions in supporting individuals following early miscarriage, in order to inform services on how they might be better equipped to direct and provide support for people experiencing difficulties relating to early miscarriage. The finished research will be in the form of an academic thesis. The researcher may use the research to write additional articles to be submitted for publication in academic or practice journals and the findings may be disseminated to IAPT services and/or commissioning bodies.

The research involves interviews with people who have at some point held a position as an IAPT practitioner, talking about their experience of working with people following early miscarriage in this role. The questions will be semi-structured and therefore be dependent on what is brought up during the interview, however, if you decide to go ahead, you might be asked things like: “ what was your role in the IAPT service”. “What was your experience of working with early miscarriage in IAPT?”. “Did you ever receive any training specific to miscarriage or the perinatal period?” There are no specific risks or dangers involved in taking part, although it is possible that you might feel distress or get upset if you were talking about something you found difficult. This might be particularly relevant if you have personal experience of pregnancy loss, infertility or difficulties relating to the perinatal period. If you were to experience any distress, the researcher can provide you with contact details for services that can offer support.

Confidentiality of the Data

All information regarding participants and their interview content will remain confidential. This would only be broken via discussion with supervisors if the researcher has concerns regarding anyone’s safety and when possible, would first be discussed with the individual involved. To preserve anonymity, any identifiable features e.g. service names, will be changed in the transcripts, thesis and any other ensuing publications and will only remain identifiable to the research through a uniquely assigned participant number. All confidential documents will be stored in a secure drive (UEL OneDrive for business) on a locked device. All interviews will be transcribed by the interviewer and only them, their director of studies (DOS) and examiners will have access to them. All anonymised data will be passed to the DOS for storage on a secure drive only accessible by the research team following assessment. This will be stored for three years, in line with Research Councils UK (RCUK) guidance, after which data will be destroyed and all files deleted. Interview extracts will be used for publication and/or dissemination, but will not be identifiable.

Online data protection
Each interview will be with me [Jinny Carthew]. The interview will be recorded via the Microsoft Teams recording function and only I [Jinny Carthew] will listen to the recordings in order to transcribe. Any names that are mentioned, including your name or the name of services that you have worked in, and anything else that would make you or others identifiable will be altered in the transcript. The typed transcript may be read by the researcher's supervisor at the University of East London and by the examiners assessing the thesis. No one else will have access to the transcripts. The audio file and transcripts will be stored on a secure drive on a computer that is password protected.
After examination, the audio recordings will be deleted by the researcher. The transcript will be kept on a computer for three years and might be used for additional publications, articles and dissemination based on the research.
The thesis is likely to include some quotes from the interviews.

Location
Interviews will take place via an online video-calling platform such as Microsoft Teams or Zoom.

Disclaimer
You are not obliged to take part in this study, and should not feel coerced. You are free to withdraw at any time. If you chose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason. If you choose to withdraw, any recordings and transcripts from your interview will be destroyed and will not be used in the analysis and write-up of the study.
Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this information sheet for reference.
If you have any questions or concerns about the study or how it has been conducted, please contact my supervisor:
Dr Kenneth Gannon, School of Psychology, University of East London, Water Lane, London E15 4LZ. 020 8223 4082 Email: k.n.gannon@uel.ac.uk
or
Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk)

Appendix E: Participant Consent form

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

Barriers to accessing psychological support following early miscarriage. Perspectives of the IAPT perinatal champion.

1. I have the read the information page relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

   - Please tick box ☐

2. I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

   - Please tick box ☐

3. I hereby freely and fully consent to participate in the study which has been fully explained to me.

   - Please tick box ☐

4. Having given this consent, I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason. I also understand that should I withdraw; the researcher reserves the right to use my anonymous data in the write-up of the study and in any further analysis that may be conducted by the researcher

   - Please tick box ☐

Only by ticking all of the above boxes can this be taken as consent to participate.

Participant’s Name (BLOCK CAPITALS)

……………………………………………………………………………………….

Participant’s Signature

………………………………………………………………………………………..

Researcher’s Name (BLOCK CAPITALS)

………………………………………………………………………..

Researcher’s Signature

……………………………………………………………………………….

Date: ……………………..…

Appendix F: Initial Draft Interview Schedule

As the plan is to develop this schedule in consultation with prospective service-users, this schedule only provides a few example questions which may be of use to the study but may also be subject to change. Furthermore, because the aim is for the interviews to remain as unstructured as possible, the exact format will be determined by the responses provided and these areas will only be used as prompts if/when required.

Introductions & Engagement

Confirm suitability of environment and set-up to support remote interview. Review confidentiality, consent and right to withdraw. Confirm approximate interview length and remind that it is OK to take breaks and/or end earlier if required.

General IAPT Experience

-Role e.g. PWP, CBT therapist, counsellor?
-Length of time with service?
-Rough dates with service (year)?
-Rough location of service e.g. South London?

Perinatal Targets

-Priority Treatment?
-Meeting targets?
-Partners included?
-Early miscarriage included as ‘perinatal’ and therefore prioritised?

Perinatal Champion Role

-Training?
-Remit of role?
-Group/individual work?

Experiences of Working With People Following Early Miscarriage

-Assessment?
-Treatment?
-Focus e.g. anxiety/trauma/low mood/bereavement?
-Most helpful for clients?
-Adaptations to treatment plans?
-Difficulties/challenges?
-Impact of own experiences/feelings?
-Barriers to offering/continuing treatment?
-Supervision?
-Client feedback?
-Learning points?

Possible Barriers to Access

-Recruitment/advertising?
-Service awareness?
-Signposting?

Debriefing

-How are you feeling following the conversation?
-Is there anything about the interview that distressed you in any way?
-Do you have concerns about anything you shared in the interview?
-Is there anything that you would like me to omit from the transcript?
-Do you have any questions?
-If any questions arise at a later point please feel free to get in contact (provide contact details)

Signposting

-Here are some details for additional support services if you feel you need to talk to someone at a later point (provide links to IAPT forums, SANDS and Miscarriage Association).

Appendix G: Final Interview Schedule

(Note: the plan is for the interview to remain as unstructured as possible, requesting the participant to feedback generally on their experiences of supporting people following early miscarriage in the role of IAPT perinatal champion. However, if the need for direction becomes apparent the following themes may be raised):

- Experience of working with challenges relating to early miscarriage as a perinatal champion?
- Experiences of services in recognising early miscarriage as a perinatal event or priority/whether partners are included in this?
- Any specific training?
- Challenges/barriers in providing support following early miscarriage as a perinatal champion?
- Anything that was helpful/might have supported conversations around early miscarriage.
- Difficulties expressed by service users in being able to access support following early miscarriage?
- Thoughts on the remit of the role and whether they should be providing support following early miscarriage as a perinatal champion?
- Suggestions for service improvement/development.

Appendix H: Hand Coded Transcript Example

0:8:1.20 --> 0:8:5.530
Jinny WADSWORTH
Yeah, yes. If a partner was pregnant with they would they both be prioritised?

0:8:5.540 --> 0:8:28.450
PARTICIPANT 11 Service development
Yes, so initially not, but I think as we advanced as the service, we started prioritising men as well who were the partner of someone who was perinatal. But there was a bit of pushback to start with because they were saying, well, it actually has to be the person who is carrying the baby, who benefits from being prioritised. recognising impact on partner.

Service unresponsive

0:8:29.120 --> 0:8:38.990
Jinny WADSWORTH
Yeah. And you mentioned it coming up in supervision. So was that in your own supervision or was that when you were supervising?

0:8:39.200 --> 0:8:54.810
PARTICIPANT 11
Both both. I think it was both when I was supervising myself and when I was being supervised by others and in my clinical management meetings and in our senior meetings, I think I remember it came up quite a lot. Relevance / recurring

0:8:57.360 --> 0:9:11.190
Jinny WADSWORTH
And you also mentioned about advancing as a service so kind of as things changed. And I wonder from your experience what helped the service to advance and kind of develop some of these new things that that adapted?

0:9:12.230 --> 0:10:8.130
PARTICIPANT 11
I think with this I think it's called a five year forward plan, isn't it that part of the IAPT initiative. I think with perinatal services and LTC issues being a priority, I think they started thinking about it more carefully so. Yeah, I think we had the, more meetings, because a lot of this was fed back into the CCGs to win contracts. It became more of a conversation because I think they were heavily misrepresented and we, I think we had some complaints as well. Can't remember precisely what started, what incentivised them to to pay more attention to this, but I just feel that we, with the perinatal and the LTC and the veterans, there was more of a push to kind of look closely at what is happening to these particular cohorts.

Service changes / responsiveness

Client experience

0:10:9.560 --> 0:10:17.400
Jinny WADSWORTH
And was that felt at both step two and three, I think you said you supervised at both levels. So did these kind of issues come up at both?

0:10:18.230 --> 0:11:30.30
PARTICIPANT 11
I felt that they came up more at step 3 because step 2 wouldn't necessarily see these people. However, because step 2s triaged a lot of the people we felt that there was a deficit in knowledge. So then we started cascading it down a bit more and

Knowledge / skills / uncertainty

Uncertainty unclear guidance

including people at Step 2 in in, in these conversations because usually we would discuss them in clinical skills meetings with the CBT therapists, so they would be quite private conversations that didn't involve anyone and everyone at the service level. So with PWPs triaging lots of the people that referred into the service, we felt that there was, and especially when I started supervising, I felt that there was a scarcity of knowledge around what's suitable, what's not what's an eligibility criteria and what's not. So we started Incorporating them more into these meetings and yeah, I think that was that was quite a an important point in advancing because I see it as an advancement, but let's say it was just a change within the service and moving more towards integration.

Service change integration

0:11:30.760 --> 0:11:36.910
Jinny WADSWORTH
Yeah. And how was that information kind of fed to the step 2s? So how did you feed that down?

0:11:37.510 --> 0:12:57.620
PARTICIPANT 11

Training - delivered

So usually we would have, I myself delivered I think 3 workshops on perinatal distress. So within these workshops we would sort of, I think I co-facilitated it with another colleague. So we would cover what it meant and give them some information on attachment and what it, you know what it essentially is so. And then we would move more towards the perinatal postnatal period and start talking about interventions and eligibility criteria and what is appropriate for an IAPT service, what is not. Things to be careful around. Red flags. I think we used one of these kind of traffic light signs around, you know what to be careful with and particularly with early miscarriage, not completely dismiss people and, yeah, things around that. So we had formal training, but we also, we also had reflective practice meetings where things would be discussed more informally and then we would sort of feed it back to upwards towards clinical managers and, yeah, so a bit of a blended approach I think, between formal meetings and more informal discussions as a team.

IAPT remit

down-playing

0:12:58.180 --> 0:13:4.30
Jinny WADSWORTH
Yeah. So did you touch upon kind of early miscarriage directly in the workshops that you were doing?

0:13:4.80 --> 0:13:43.470
PARTICIPANT 11
Yes, we did. We touched upon that. I think we looked at all sorts of presentations that can come up and I think we we also looked at sort of de-pathologising things because of course when it came to sort of, you know postnatal OCD or postnatal depression there are things that are more and more commonly recognised. But we, we talked about how someone might be presenting with, with depression or anxiety or grief and as a result of an early miscarriage. So we looked at that. I remember we included it on the slides. Yeah.

normalising not pathologising

psych impact

grief

0:13:45.270 --> 0:13:57.880
Jinny WADSWORTH

And I don't know if you know, but when the, the step 2s were doing the triages, would there have been anything in their proforma or anything that encouraged them to ask about kind of experiences of miscarriage or early miscarriage?

0:13:58.940 --> 0:14:22.230
PARTICIPANT 11
I don't think that there was a question on our assessment form that targeted specifically that, but I know there was a question around "have you recently experienced any traumas or losses or" and we would encourage them when it came to losses to kind of address that as well. Um, but there wasn't a specific question around miscarriage, as such.

silence / not asking

0:14:23.920 --> 0:14:33.310
Jinny WADSWORTH
And I'm I'm really interested to learn about how you got into the role of perinatal champion. So I wonder what process was there that encouraged you to get into that role?

lacking choice / autonomy

0:14:33.920 --> 0:15:27.490
PARTICIPANT 11
I think that wasn't something that we chose. It was something that was more assigned to us at the time. It just happened that it overlapped with with my interest at that time as well, so I was happy to, to go there But I think the minute we started integrated clinics, the senior CBT therapists, and I think we were about three, we got moved into different integrated clinics. So I also did a substance misuse one with [redacted] I think they're called or [redacted] So yes, we basically started to sort of be allocated the room within a hospital or within a substance meetings clinic and start working multidisciplinary with within their team. So it wasn't a choice as such, it was just something that we had to do as things started changing and these areas were more prioritised. service changes | lacking autonomy

integration

0:15:29.20 --> 0:15:32.250
Jinny WADSWORTH
What do you think about that process of not choosing it?

0:15:33.500 --> 0:18:44.290
PARTICIPANT 11
Well, I feel that it was a bit difficult, particularly because at the time when I was. At a time when I was sent to [HOSPITAL NAME], I actually had an early miscarriage myself. So then it became problematic and my supervisor at the time she was signed off [redacted] and she couldn't supervise me. And that was difficult because I had no supervisor at the time and I was struggling myself. Then I wrote an e-mail to her and told her about my situation and she sort of decided that I shouldn't be working there anymore without consulting me, [redacted] And my clinical manager then changed my supervisor. So I have to see someone else. And I sort of decided to carry on with it and see how I was feeling. Nothing was really distressing or nothing came up for me to stop me from doing that kind of work. But I felt that it

personal experience

lacking support as professional

dismissing experience

Appendix I: Electronic Transcript Example

P11: I think with this I think it's called a five year forward plan, isn't it that part of the IAPT initiative. I think with perinatal services and LTC issues being a priority, I think they started thinking about it more carefully so. Yeah, I think we had the, more meetings, because a lot of this was fed back into the CCGs to win contracts. It became more of a conversation because I think they were heavily misrepresented and we, I think we had some complaints as well. Can't remember precisely what started, what incentivised them to to pay more attention to this, but I just feel that we, with the perinatal and the LTC and the veterans, there was more of a push to kind of look closely at what is happening to these particular cohorts.	-Service change. Triggered by 5 year plan and CCG contracts (SERVICE DEVELOPMENT) -Negative client experience-complaints/feedback (CLIENT EXPERIENCE)
J: And was that felt at both step two and three, I think you said you supervised at both levels. So did these kind of issues come up at both?	
P11: I felt that they came up more at step 3 because step 2 wouldn't necessarily see these people. However, because step 2s triaged a lot of the people we felt that there was a deficit in knowledge. So then we started cascading it down a bit more and including people at Step 2 in in, in these conversations because usually we would discuss them in clinical skills meetings with the CBT therapists, so they would be quite private conversations that didn't involve anyone and everyone at the service level. So with PWPs triaging lots of the people that referred into the service, we felt that there was, and especially when I started supervising, I felt that there was a scarcity of knowledge around what's suitable, what's not what's an eligibility criteria and what's not. So we started Incorporating them more into these meetings and yeah, I think that was that was quite a an important point in advancing because I see it as an advancement, but let's say it was just a change within the service and moving more towards integration.	-Step 2s requiring additional skills/knowledge to support triage (SKILLS/TRAINING NEEDS) (UNCLEAR GUIDANCE) -Service change and integration (SERVICE DEVELOPMENT)

J: Yeah. And how was that information kind of fed to the step 2s? So how did you feed that down?	
P11: So usually we would have, I myself delivered I think 3 workshops on perinatal distress. So within these workshops we would sort of, I think I co-facilitated it with another colleague. So we would cover what it meant and give them some information on attachment and what it, you know what it essentially is so. And then we would move more towards the perinatal postnatal period and start talking about interventions and eligibility criteria and what is appropriate for an IAPT service, what is not. Things to be careful around. Red flags. I think we used one of these kind of traffic light signs around, you know what to be careful with and particularly with early miscarriage, not completely dismiss people and, yeah, things around that. So we had formal training, but we also, we also had reflective practice meetings where things would be discussed more informally and then we would sort of feed it back to upwards towards clinical managers and, yeah, so a bit of a blended approach I think, between formal meetings and more informal discussions as a team.	-Training delivered and received (SKILLS/TRAINING NEEDS) -Factoring in possible interventions and IAPT criteria (SUITABILITY OF IAPT/CBT). -Possible dismissal of difficulties relating to early m/c (INVALIDATING/ SILENCE)
J: Yeah. So did you touch upon kind of early miscarriage directly in the workshops that you were doing?	
P11: Yes, we did. We touched upon that. I think we looked at all sorts of presentations that can come up and I think we we also looked at sort of de-pathologising things because of course when it came to sort of, you know postnatal OCD or postnatal depression there are things that are more and more commonly recognised. But we, we talked about how someone might be presenting with, with depression or anxiety or grief and as a result of an early miscarriage. So we looked at that. I remember we included it on the slides. Yeah.	-De-pathologising/ normalising difficulties relating to early m/c (BREAKING INVALIDATION/ SILENCE) -(RECOGNISING PSYCHOLOGICAL IMPACT)
J: And I don't know if you know, but when the, the step 2s were doing the triages, would there have been anything in their proforma or	

anything that encouraged them to ask about kind of experiences of miscarriage or early miscarriage?	
P11: I don't think that there was a question on our assessment form that targeted specifically that, but I know there was a question around “have you recently experienced any traumas or losses or” and we would encourage them when it came to losses to kind of address that as well. Um, but there wasn't a specific question around miscarriage, as such.	-Not directly asking about difficulties relating to early m/c (INVALIDATING/ SILENCE)
J: And I'm I'm really interested to learn about how you got into the role of perinatal champion. So I wonder what process was there that encouraged you to get into that role?	
P11: I think that wasn't something that we chose. It was something that was more assigned to us at the time. It just happened that it overlapped with with my interest at that time as well, so I was happy to, to go there But I think the minute we started integrated clinics, the senior CBT therapists, and I think we were about three, we got moved into different integrated clinics. So I also did a substance misuse one with [SERVICE NAME]. So yes, we basically started to sort of be allocated the room within a hospital or within a substance meetings clinic and start working multidisciplinary with within their team. So it wasn't a choice as such, it was just something that we had to do as things started changing and these areas were more prioritised.	-Lacking choice/autonomy as professionals (PERSONAL QUALITIES/SKILLS) -Service change/integration impacting amount of work and increasing demands? (SERVICE DEVELOPMENT)
J: What do you think about that process of not choosing it?	
P11: Well, I feel that it was a bit difficult, particularly because at the time when I was. At a time when I was sent to [HOSPITAL NAME], I actually had an early miscarriage myself. So then it became problematic and my supervisor at the time she was signed off…And that was difficult because I had no supervisor at the time and I was struggling myself…And my clinical manager then changed my supervisor. So I have to see someone else. And I sort of decided to carry on with it and see how I was	-Personal experiences of professionals not being taken account of (PERSONAL EXPERIENCE/SUPPORT)

feeling. Nothing was really distressing or nothing came up for me to stop me from doing that kind of work. But I felt that it wasn't very well regulated in terms of processes and there were lots of things coming up, lots of projections on the sides of our managers. I remember someone said to me, “well, if she can't work with anyone, perinatal, that's her problem, it looks like you can”. But I didn't know whether I could or not. It it was just a process for me. Yes, I had to see what what was going on. But there was no backup for the service in terms of who was going to take that role if I struggled or if there was something coming up for me that was difficult at the time, so. Yes, it was uh, that was a point of uh contention let's say uh, at the time. Yeah. And I I continued working within the service. I think I saw lots of people who, I saw lots of midwives actually whom, um, struggled with traumatic births. I didn't see so many people that experienced early miscarriages to be honest with you. So it was more, I think, the work I did in [HOSPITAL NAME] was more related to sort of traumatic births and trauma related to problematic births, but I didn't really see many people who experienced early miscarriage. I, I sometimes saw people who experienced a traumatic birth and they referred to their earlier miscarriages. So it's almost like it pulled all these previous traumas or losses that weren't processed entirely, but they would not come specifically with this. And I wonder whether that was discouraged by the service or by [HOSPITAL NAME] as such as an integrated service or at the point of triage, whether they weren't even given the chance to to come into the service because they wouldn't score enough with the outcome measures. It is, is difficult to tell.	(UNCLEAR GUIDANCE) -Lacking understanding of possible impact of early m/c on professionals and their practice (INVALIDATING/ SILENCE) Impact on later pregnancies (RECOGNISING PSYCHOLOGICAL IMPACT) -Lacking understanding of possible impact of early m/c and discouraging referral (INVALIDATING/ SILENCE) -Not scoring on measures to be eligible for service (SUITABILITY OF IAPT/CBT).

Appendix J: NVivo Transcript Example

J: And what do you kind of see the remit of that role as being?

P5: So I guess it's about well improving access for mums and dads and or anyone in the kind of perinatal range, is it were or period, umm and kind of creating links with, like local services as well, things like midwives, health visitors, children's centres, family centres as they are now erm, and for us kind of a big part of it was kind of getting our perinatal group up and running as well and that's kind of rolling consistently now. So that runs kind of four times a year which is nice.

J: Did you get any particular training for the role?

P5: Not before I started. I don't know why, but since since I've been in the roll there've been a few a few things. So I know that my colleague [colleague name], who's also one of the perinatal champions, she did and training on kind of working with PTSD with clients in the perinatal period. Umm. And then I did a training day. A couple of things. I did something for, specifically aimed at Dad's, so working with dads and kind of in terms of perinatal support and kind of how to engage them and lessons learned, things that work, things that don't work. And and then I also do kind of a general I think it was IAPT specific like parental champions, sort of just the one day thing around again the sort of things that are useful to do in the role, things that have worked in other services, shared practice, that sort of thing. Yeah, so not loads but a couple kind of ad-hoc trainings.

J: Yeah. Do you remember if any of the bits are training you did talked about miscarriage or early miscarriage at all?

P5: That's a good question. Definitely wasn't a focus, erm definitely talked about and referenced erm, but for example I had an assessment, probably about six months ago and the

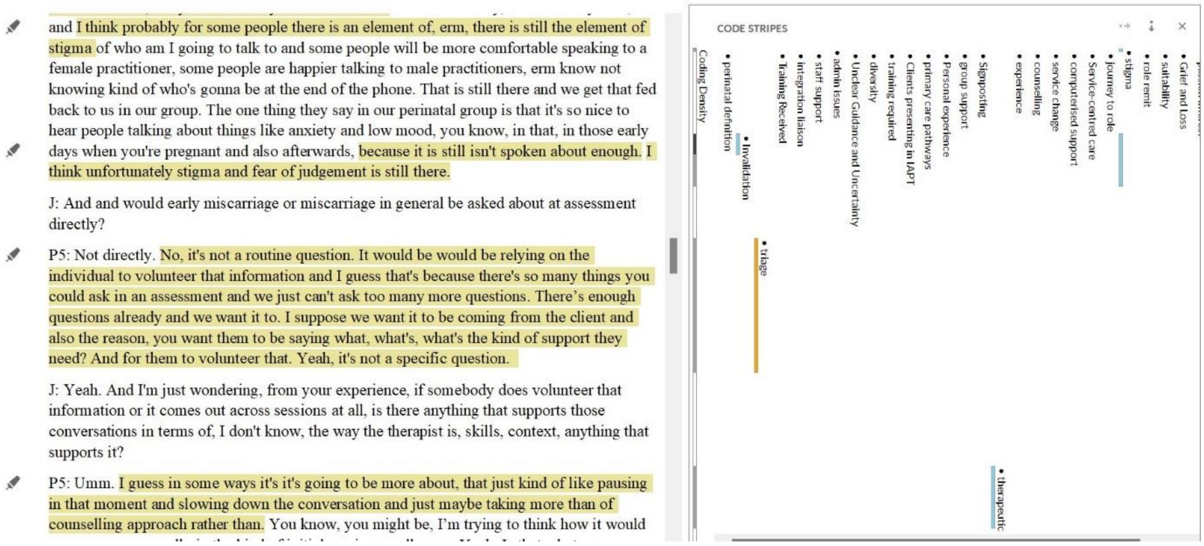
mum had experienced a miscarriage and that was why she was accessing our service and I think she was, from it was early miscarriage from memory, I think about 10-11 weeks, something like that. Erm, and I had to ask our clinical lead whether she could be a priority client because I didn't know because I kind of assumed she should be and that was what I was suggesting. They came back like yes, absolutely fine straight away, but technically she wasn't pregnant anymore it been a good few months, sort of three or four months I think since the miscarriage. And so yeah, the fact that that hasn't, that hasn't come up before for me and was a question that I needed to ask suggest that it's not something that's spoken about enough or known enough about I suppose within the IAPT services observations and talking therapies. Erm, yeah definitely did come up in training erm but I suppose also the difference between like early miscarriage and and miscarriage in general could have an influence as well and I think miscarriage in general or later miscarriages, perhaps we see that a bit more, or perhaps clients are more likely to access our service or or are told about talking therapies, whereas in those early weeks, maybe they're not.

J: Yeah. What might lead to that do you think? So Why might it not be spoken about so much in those earlier weeks?

P5: Umm. I think, so this there's probably some element in the healthcare professionals and also just in society around normalization, that it's common it's not normal, that's probably the wrong word, but it's more common in those early weeks than it is later on. So it doesn't, it's not perceived to be aa serious, it sounds horrible but, erm, I think it's something around that and then kind of because society and healthcare professionals perhaps do see it as as more common, so it is more common in those earlier weeks those people don't feel that they should or could access support. I don't know. They don't know it's OK. And not sure if I'm wording this properly but, I guess, yeah, something around that and also, I suppose, the contact you have with healthcare professionals isn't isn't as much in those early weeks. You know, if you think about your schedule of appointments when you're pregnant, it's you have your booking appointment, don't you at six weeks or something? I should probably remember this with her being so young, and then I'm sure there's like a ten week that you know there's there's one after scan isn't there and then there's, then they become more frequent as you progress through your pregnancy erm, so yeah, there's less opportunity, I suppose, for them to offer that and you know that, I mean I know from a sort of general mental health perspective that my past experience with erm, being pregnant recently, at every appointment they did ask me how you in terms of your wellbeing and mental health and I didn't have that with my first. Which is interesting as [child's name] is five, you know, five years which is a fair amount of time, but in terms of services and stuff, isn't you know that that that's really great that that has changed. Yeah, they check mental health at every appointment.

J: Yeah, having those conversations. So I guess not asking is a barrier. Are there any other perceived kind of challenges or barriers you might anticipate? So imagining someone coming in who is having difficulties after early miscarriage and that could be from the point of those early discussions, referral, assessment, is there any challenges?

P5: I mean, I think the referral process for most services could always be quicker, could always be smoother, like just the fact that you've got to do a form, even if it's free, you know our referral process is probably as quick as it could be. But it's not just pick up the phone and give your name and contact details which for some kind of voluntary sector sort of places it is as simple as that. Thinking about thinking about the services. Umm. You know you can do that telephone referral quite quickly without that much information. Umm. So yeah, I think referrals kind of always a bit barrier for some people. It's another process, isn't it? And a bit of admin and that, but you don't really want to have to. That is necessary, unfortunately. Um,



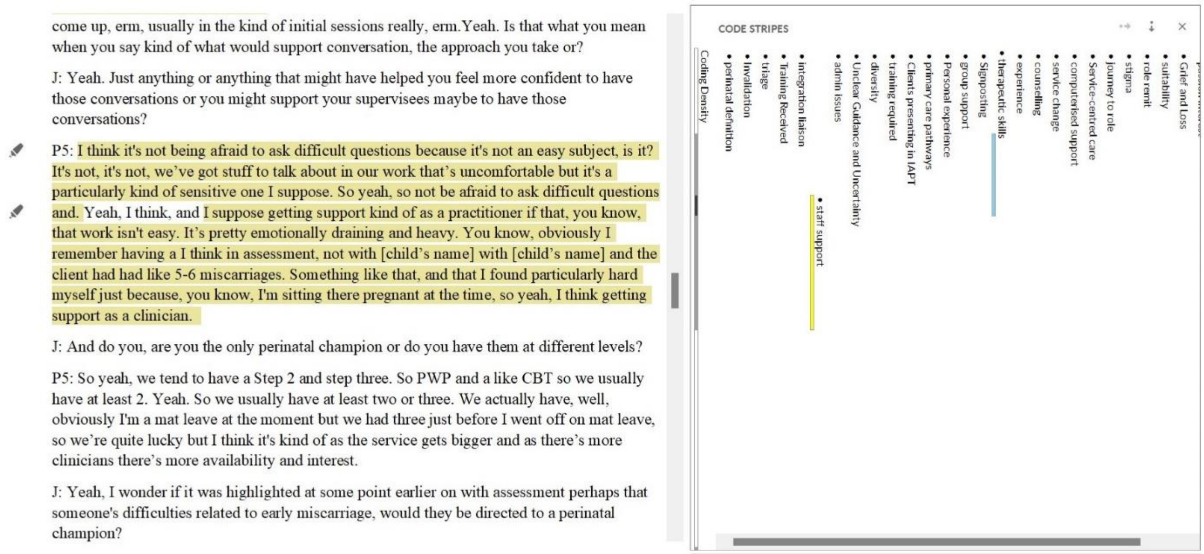
and I think probably for some people there is an element of, erm, there is still the element of stigma of who am I going to talk to and some people will be more comfortable speaking to a female practitioner, some people are happier talking to male practitioners, erm know not knowing kind of who's gonna be at the end of the phone. That is still there and we get that fed back to us in our group. The one thing they say in our perinatal group is that it's so nice to hear people talking about things like anxiety and low mood, you know, in that, in those early days when you're pregnant and also afterwards, because it is still isn't spoken about enough. I think unfortunately stigma and fear of judgement is still there.

J: And and would early miscarriage or miscarriage in general be asked about at assessment directly?

P5: Not directly. No, it's not a routine question. It would be would be relying on the individual to volunteer that information and I guess that's because there's so many things you could ask in an assessment and we just can't ask too many more questions. There's enough questions already and we want it to. I suppose we want it to be coming from the client and also the reason, you want them to be saying what, what's, what's the kind of support they need? And for them to volunteer that. Yeah, it's not a specific question.

J: Yeah. And I'm just wondering, from your experience, if somebody does volunteer that information or it comes out across sessions at all, is there anything that supports those conversations in terms of, I don't know, the way the therapist is, skills, context, anything that supports it?

P5: Umm. I guess in some ways it's it's going to be more about, that just kind of like pausing in that moment and slowing down the conversation and just maybe taking more than of counselling approach rather than. You know, you might be, I'm trying to think how it would



come up, erm, usually in the kind of initial sessions really, erm.Yeah. Is that what you mean when you say kind of what would support conversation, the approach you take or?

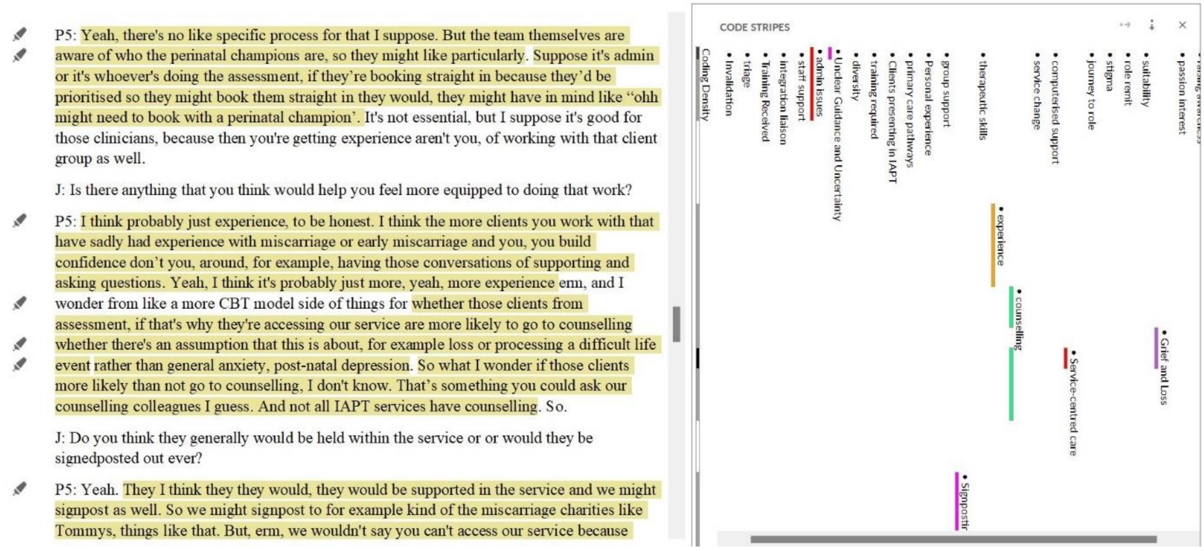
J: Yeah. Just anything or anything that might have helped you feel more confident to have those conversations or you might support your supervisees maybe to have those conversations?

P5: I think it's not being afraid to ask difficult questions because it's not an easy subject, is it? It's not, it's not, we've got stuff to talk about in our work that's uncomfortable but it's a particularly kind of sensitive one I suppose. So yeah, so not be afraid to ask difficult questions and. Yeah, I think, and I suppose getting support kind of as a practitioner if that, you know, that work isn't easy. It's pretty emotionally draining and heavy. You know, obviously I remember having a I think in assessment, not with [child's name] with [child's name] and the client had had like 5-6 miscarriages. Something like that, and that I found particularly hard myself just because, you know, I'm sitting there pregnant at the time, so yeah, I think getting support as a clinician.

J: And do you, are you the only perinatal champion or do you have them at different levels?

P5: So yeah, we tend to have a Step 2 and step three. So PWP and a like CBT so we usually have at least 2. Yeah. So we usually have at least two or three. We actually have, well, obviously I'm a mat leave at the moment but we had three just before I went off on mat leave, so we're quite lucky but I think it's kind of as the service gets bigger and as there's more clinicians there's more availability and interest.

J: Yeah, I wonder if it was highlighted at some point earlier on with assessment perhaps that someone's difficulties related to early miscarriage, would they be directed to a perinatal champion?



P5: Yeah, there's no like specific process for that I suppose. But the team themselves are aware of who the perinatal champions are, so they might like particularly. Suppose it's admin or it's whoever's doing the assessment, if they're booking straight in because they'd be prioritised so they might book them straight in they would, they might have in mind like "ohh might need to book with a perinatal champion'. It's not essential, but I suppose it's good for those clinicians, because then you're getting experience aren't you, of working with that client group as well.

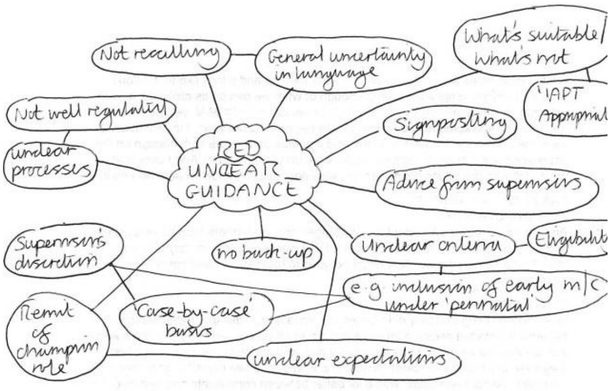
J: Is there anything that you think would help you feel more equipped to doing that work?

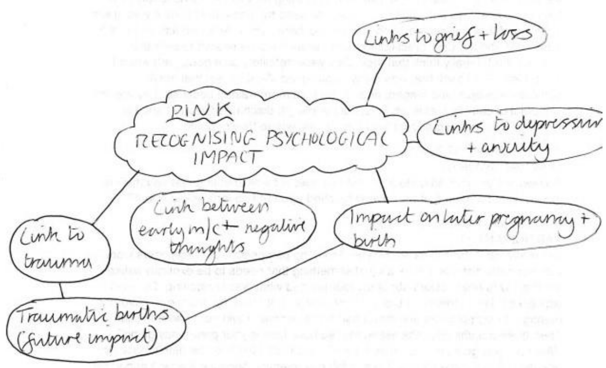
P5: I think probably just experience, to be honest. I think the more clients you work with that have sadly had experience with miscarriage or early miscarriage and you, you build confidence don't you, around, for example, having those conversations of supporting and asking questions. Yeah, I think it's probably just more, yeah, more experience erm, and I wonder from like a more CBT model side of things for whether those clients from assessment, if that's why they're accessing our service are more likely to go to counselling whether there's an assumption that this is about, for example loss or processing a difficult life event rather than general anxiety, post-natal depression. So what I wonder if those clients more likely than not go to counselling, I don't know. That's something you could ask our counselling colleagues I guess. And not all IAPT services have counselling. So.

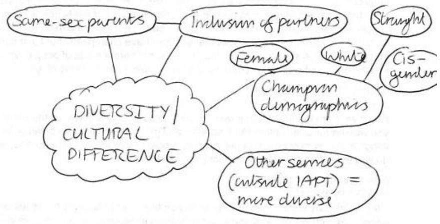
J: Do you think they generally would be held within the service or or would they be signedposted out ever?

P5: Yeah. They I think they they would, they would be supported in the service and we might signpost as well. So we might signpost to for example kind of the miscarriage charities like Tommys, things like that. But, erm, we wouldn't say you can't access our service because

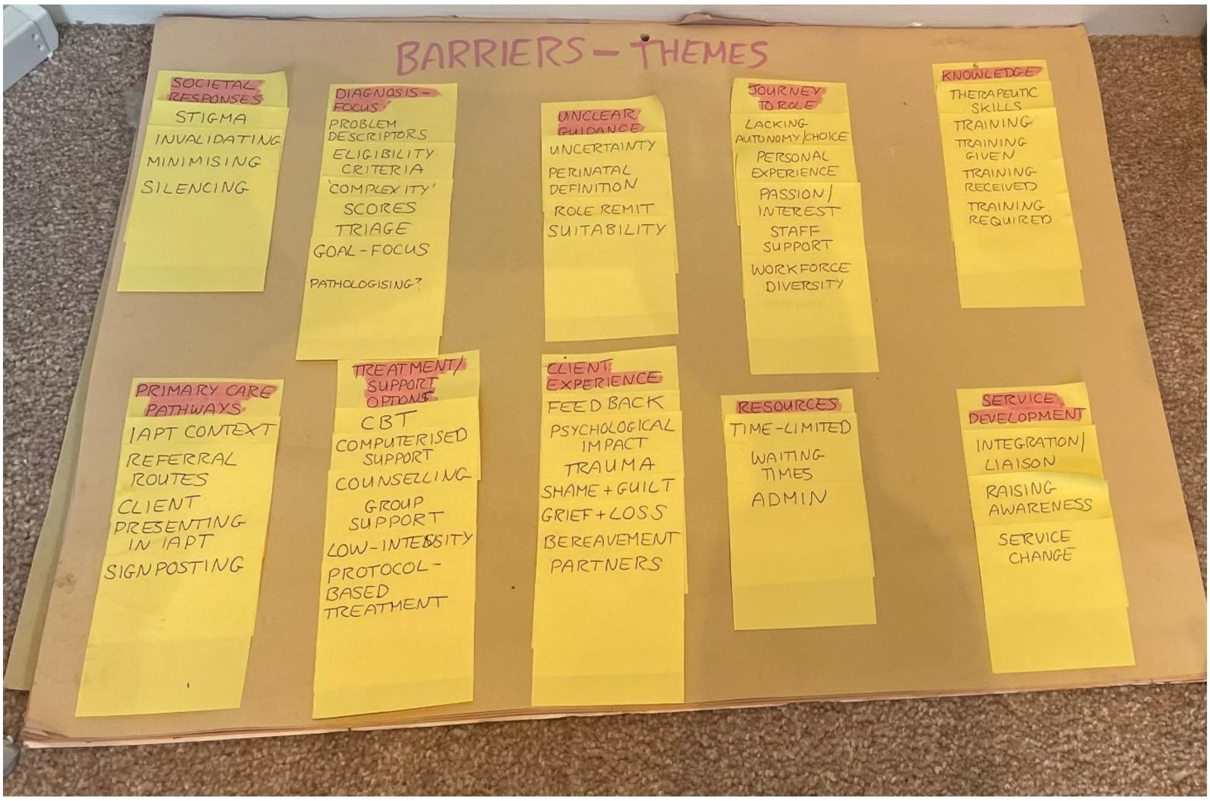
Appendix K: Identifying Themes: Step One



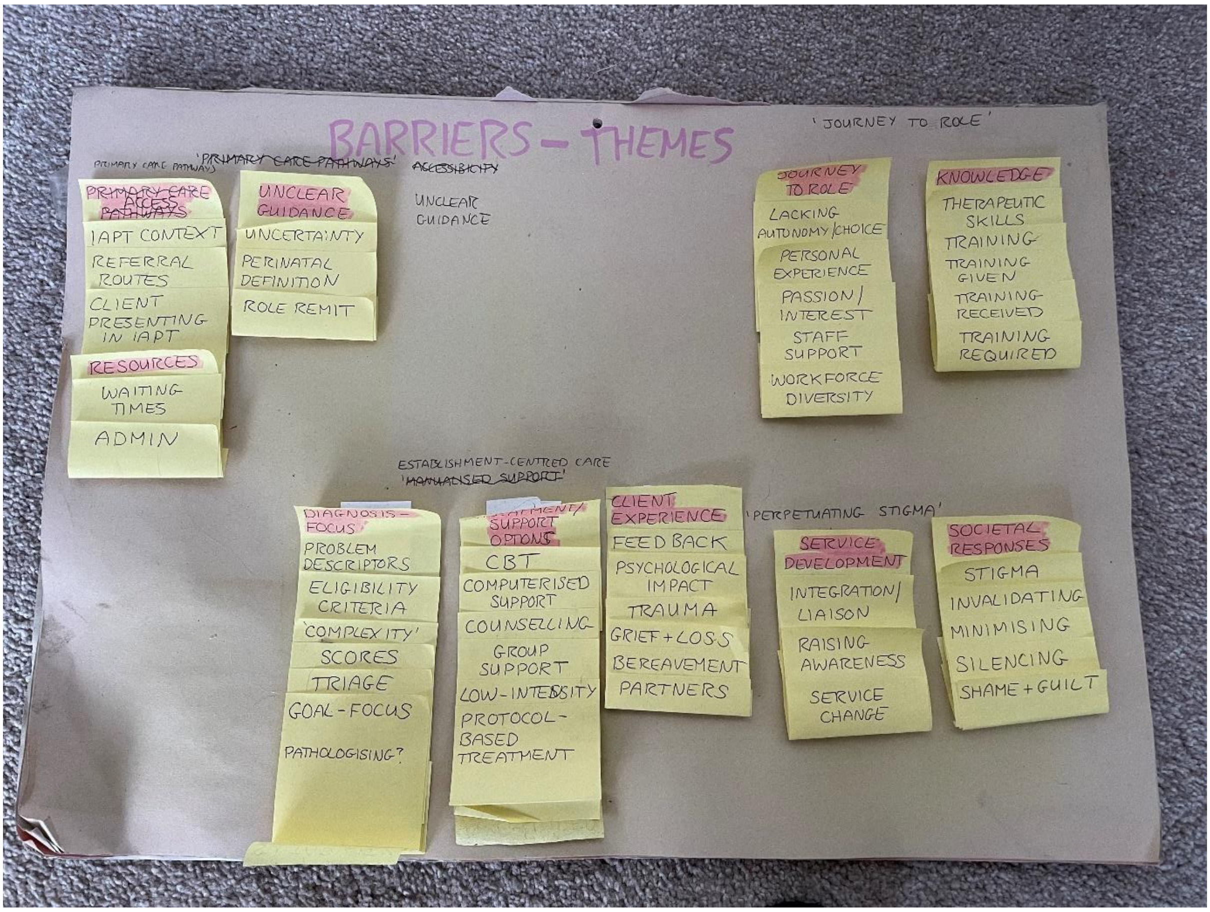




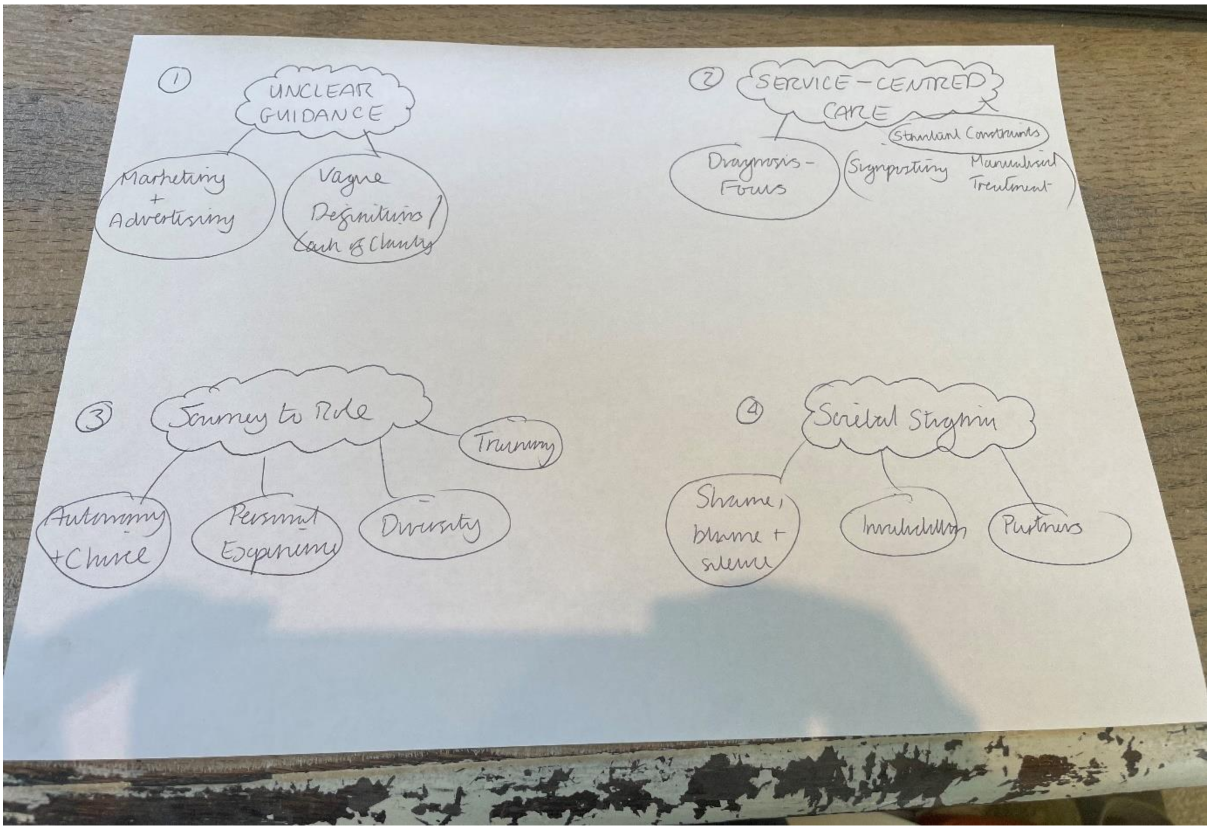
Appendix L: Identifying Themes: Step Two



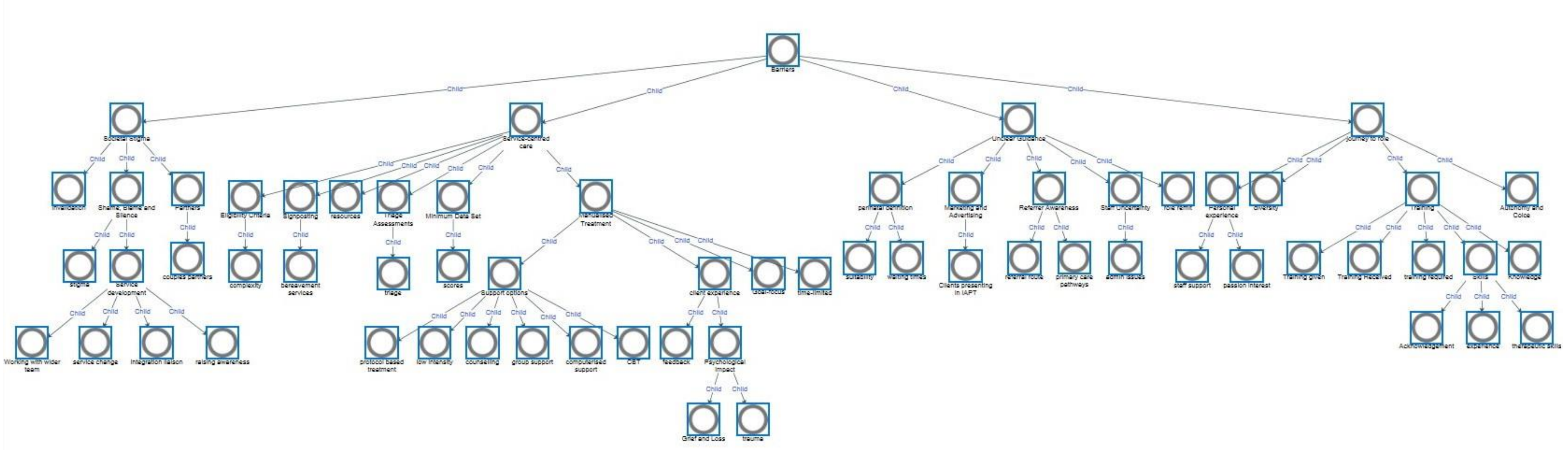
Appendix M: Identifying Themes: Step Three



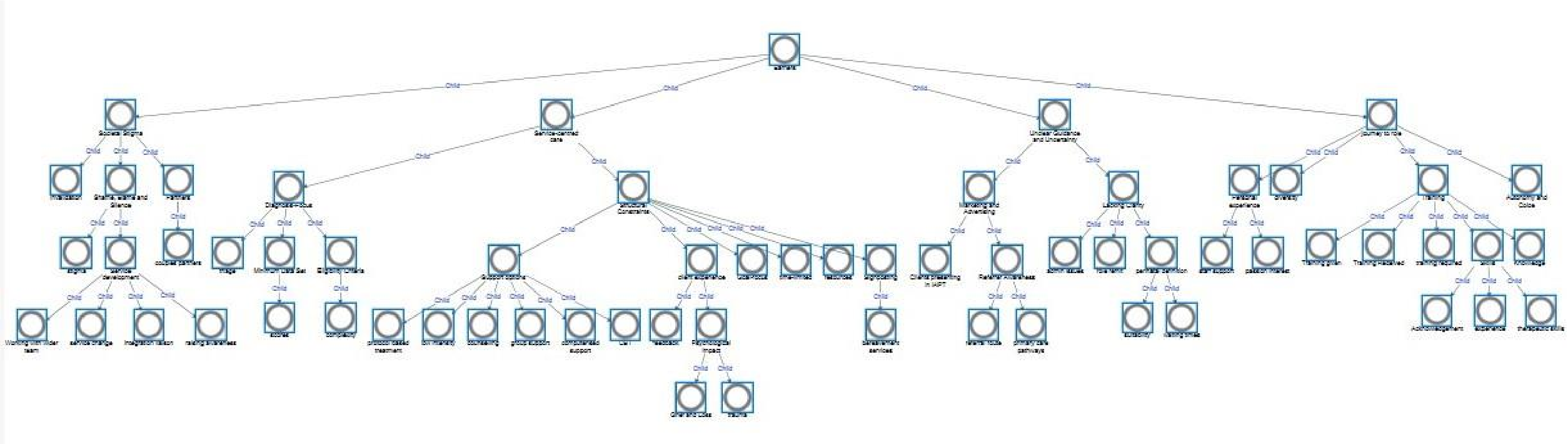
Appendix N: Identifying Themes: Step Four



Appendix O: Thematic Map Draft



Appendix P: Thematic Map Final



Appendix Q: UEL Ethics Application

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS
(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form
(please read carefully)

1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites: https://www.myresearchproject.org.uk/Signin.aspx

	https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	**Jinny Carthew**
2.2	**Your supervisor's name:**	**Dr Kenneth Gannon**
2.3	**Name(s) of additional UEL supervisors:**	**Dr Maria Qureshi**
		3rd supervisor (if applicable)
2.4	**Title of your programme:**	**Professional Doctorate in Clinical Psychology**
2.5	**UEL assignment submission date:**	**23/05/2023**

		Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	Barriers to accessing psychological support following early miscarriage. Perspectives of the IAPT perinatal champion.
3.2	**Summary of study background and aims (using lay language):**	Despite the evidence base highlighting a wide variety of psychological difficulties commonly experienced following early miscarriage, consistent challenges in accessing appropriate psychological treatment at this time are also emphasised. The proposed research aims to shed light on potential barriers to accessing support following early miscarriage, from the perspective of staff who have held the role of peri-natal champion, within IAPT (Increasing Access to Psychological Therapies). The hope is that this can inform service structure and roles within IAPT to improve pathways to support, following early miscarriage.
3.3	**Research question(s):**	•What are the experiences of IAPT perinatal champions in providing psychological treatment for people following early miscarriage? • What are their perspectives on potential barriers to these people accessing psychological support? • How might we overcome these barriers?
3.4	**Research design:**	Participants will be invited to join a semi-structured, qualitative interview designed to explore their experiences in providing psychological treatment for people following early miscarriage and their perspectives on possible barriers to doing so.
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	The study will require approximately eight participants, who have held the position of IAPT perinatal champion at some point in their career. These participants will be recruited via my personal IAPT networks. As approval to carry out research with NHS staff (normally obtained via HRA and local R&D departments) is only required when the staff are recruited directly via a trust, employer

		approval will not be required in this case. All participants must provide informed consent to take part.	
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	Participants will be recruited via online and personal networks and therefore not require employer approval as they will not be recruited directly via their employing NHS Trust. Recruitment information (see Appendix E) will be sent via personal email/social media/phone accounts. The aim will be for participants to have worked for different IAPT services, preferably from different commissioning areas, to provide a sample representative of services across the UK.	
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	The study will require access to Teams video-calling platform for the researcher and participants, audio-recording and transcribing equipment, access to the university drive to store documents and a password protected computer.	
3.8	**Data collection:** Provide information on how data will be collected from the point of consent to debrief	Consent forms will collect identifying participant data (names, ages and signatures) but no sensitive data. These will be collected via UEL email. Interviews will take place via Teams and be audio-recorded. They will remain as unstructured as possible, relying on prompts if necessary. Teams will provide an interview transcript which will be reviewed by the researcher alongside the audio-recording to confirm accuracy and familiarise with the content. Debrief forms will be sent to participants via UEL email.	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	**Will participants be reimbursed?**	**YES** ☐	**NO** ☒
	If yes, please detail why it is necessary.	If you selected yes, please provide more information here	
	How much will you offer?	Please state the value of vouchers	

	Please note - This must be in the form of vouchers, not cash.	
3.11	**Data analysis:**	'Reflexive' thematic analysis will be used to analyse the interview data. The interview transcripts will be split into units via the identification of patterned responses and repeated meaning and coded systematically. Following this, codes will be collated into possible themes, linking all data associated with each theme. Themes are likely to be split into several superordinate categories with further subordinate categories stemming from them and will require checking for fit against both the initial codes and data set as a whole, demonstrated via a thematic map. Further analysis will be required to refine themes and generate clear definitions. The final stage will be to identify transcript extracts to help represent themes within the report.

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how the data will be anonymised.	Each participant will be given a participant number (in interview chronological order). Audio files (.mp4 format) will be named in line with the corresponding participant number and clearly labelled e.g. interview recording participant 1.	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** x☐	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	All identifiable information (e.g. names, job location, identifiable scenarios) will be anonymised in the transcripts. If it is possible to re-identify participants from the transcripts prior to the anonymisation then the data will be pseudonymised until this is no longer possible.	

4.3	**How will you ensure participant details will be kept confidential?**	To preserve anonymity, any identifiable features e.g. service names, will be changed in the transcripts, thesis and any other ensuing publications. Participants will be informed all confidential documents will be stored in a secure drive (UEL OneDrive for business) on a locked device.
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	Due to Covid19, all data will be stored on UEL OneDrive for business cloud. As recordings/auto-captions are stored by default on Microsoft Stream Library, if files are downloaded for upload to OneDrive for Business, it will be ensured that any local copies made on the laptop/computer are deleted and synchronising to personal Cloud storage is switched off. Video recordings from Microsoft teams will be auto-transcribed and stored on Microsoft stream. The researcher will review and edit this transcription (removing identifiable information in the process) before downloading into a word doc. This transcription will then be stored in a password protected file on both the researcher and supervisor's secure accounts. Audio/video files and transcripts will be stored on separate password protected folders only accessible by the researcher on a UEL OneDrive for business. Anonymised transcripts will be stored on both the researchers and supervisors secure accounts (so there is a backup). Contact details and other identifiable information will be stored in a folder separate from the audio/video files and transcripts. Consent forms will be collected as attachments via UEL email and will be saved directly to the UEL OneDrive for Business.
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	All interviews will be transcribed by the interviewer and only them, their director of studies (DOS) and examiners will have access to the anonymised versions. All anonymised data will be passed to the DOS for storage following assessment.
4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	Electronic copies of consent forms will be kept until the thesis has been examined and passed. They will then be erased from the secure server. Audio and video files will be deleted as soon as they have been

		transcribed. All anonymised transcripts will be passed to the research supervisor for storage following assessment.	
4.7	**What is the long-term retention plan for this data?**	Following assessment, transcripts will be kept by the research supervisor for three years on UEL's OneDrive for business, after which point they will be deleted. These are kept securely within UEL servers but may be needed for further publication following the thesis examination.	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.

5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐
	If yes, what are these, and how will they be minimised?	Potential distress to participants and public informants (prospective service users) in relaying experiences related to miscarriage. All potential participants will be provided with an information sheet and consent form to be completed before the interviews. They will be reminded before engaging that they can withdraw at any point and are free to	

		take breaks or change timing as required. Contact details for additional support, such as the Miscarriage Association, will be supplied. Researcher to monitor participants' wellbeing throughout interview and be prepared to manage any distress manifesting, in the same way the researcher would manage distress presenting in clinical work. To take any additional concerns to supervisor if necessary.		
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐	
	If yes, what are these, and how will they be minimised?	Potential distress to researcher and/or supervisor e.g. bringing up difficult feeling relating to own experiences of miscarriage. Levels of distress and any issues of concerns will be monitored via supervision. To consider use of individual support networks and/or individual therapy if required.		
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	
	If yes, where?	Home address-remote working via video call which will take place in separate office building and cannot be overheard (Little Mendips, Sparrows Green, Wadhurst, TN5 6SP).		
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒	
	If yes, where?	Please state the country and other relevant details		
	If yes, in addition to the General Risk Assessment form, a Country-	**YES** ☐		

	Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). ▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.	

Section 6 – Disclosure and Barring Service (DBS) Clearance

6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries	**YES** ☐	**NO** ☒

	outside of the UK) clearance to conduct the research project		
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** x☐	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** x☐	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	**001703131019**	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian). ▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.		

Section 7 – Other Permissions

7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☐	**NO** ☒
	If yes, please provide their details.	Please provide details of organisation	

	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	**YES** ☐
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.	

Section 8 – Declarations

8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Jinny Carthew**
8.3	**Student's number:**	**U2075231**
8.4	**Date:**	**28/01/2022**
Supervisor's declaration of support is given upon their electronic submission of the application		

UEL Risk Assessment Form

Name of Assessor:	**Jinny Carthew**	**Date of Assessment:**	**10/1/2022**
Activity title:	**Thesis: Barriers to accessing psychological support following early miscarriage. Perspectives of the IAPT perinatal champion.**	**Location of activity:**	**UEL Campuses at Docklands, Stratford and USS and remote working at researcher's home address (Little Mendips, Sparrows Green, Wadhurst, East Sussex, TN5 6SP).**
Signed off by Manager: (Print Name)	**Dr Kenneth Gannon**	**Date and time: (if applicable)**	

Please describe the activity/event in as much detail as possible (include nature of activity, estimated number of participants, etc.). If the activity to be assessed is part of a fieldtrip or event please add an overview of this below:

This study will aim to use the qualitative approach of thematic analysis to shed light on potential barriers to accessing support following early miscarriage, from the perspective of staff who have held the role of peri-natal champion, within IAPT (Increasing Access to Psychological Therapies) services. 8-12 participants will be invited to join a semi-structured, qualitative interview designed to explore their experiences in providing psychological treatment for people following early miscarriage and their perspectives on possible barriers to doing so. Their interview responses will be analysed to draw out common themes, with the aim of this informing service structure and roles within IAPT to improve pathways to support, following early miscarriage.

Overview of FIELD TRIP or EVENT:
Approximately 8 to 12 participants will be interviewed remotely via Team between April to September 2022. Each interview will last between 40 to 60 minutes and will be audio recorded and auto-transcribed via Teams, before being reviewed by the researcher.

Guide to risk ratings:

a) Likelihood of Risk	**b) Hazard Severity**	**c) Risk Rating (a x b = c)**
1 = Low (Unlikely)	1 = Slight (Minor / less than 3 days off work)	1-2 = Minor (No further action required)
2 = Moderate (Quite likely)	2= Serious (Over 3 days off work)	3-4 = Medium (May require further control measures)
3 = High (Very likely or certain)	3 = Major (Over 7 days off work, specified injury or death)	6/9 = High (Further control measures essential)

Hazards attached to the activity

Hazards identified	**Who is at risk?**	**Existing Controls**	**Likelihood**	**Severity**	**Residual Risk Rating (Likelihood x Severity)**	**Additional control measures required (if any)**	**Final risk rating**

Potential distress to participants relaying experiences related to miscarriage.	Participants	All potential participants will be provided with an information sheet and consent form to be completed before the interviews. They will be reminded before engaging that they can withdraw at any point and are free to take breaks or change timing as required. Contact details for additional support, such as the Miscarriage Association, will be supplied.	2	1	2	Researcher to monitor participants' wellbeing throughout interview and be prepared to manage any distress manifesting, in the same way the researcher would manage distress presenting in clinical work. To take any additional concerns to supervisor if necessary.	2
Potential distress to public informants relaying experiences related to miscarriage.	Public	Researcher will seek permission from administrators to post information on relevant online public forums. Public informants will be provided with a trigger warning. An overview of the study focus will be provided so they can make an informed decision on their involvement. They will be reminded that their input is entirely optional and voluntary and they can choose to disengage at any point. Contact details for additional support will be supplied.	2	1	2	Researcher to monitor informants' wellbeing throughout any communication and be prepared to manage any distress manifesting, in the same way the researcher would manage distress presenting in clinical work. To take any additional concerns to supervisor if necessary.	2

Potential distress to researcher and/or supervisor e.g. bringing up difficult feeling relating to own experiences of miscarriage.	Staff	Levels of distress and any issues of concerns will be monitored via supervision.	1	1	1	To consider use of individual support networks and/or individual therapy if required.	1
Possibility of data breach e.g. confidential participant information being made visible in the public domain.	Staff Public Participants	Data management plan complete. To preserve anonymity, any identifiable features e.g. service names, will be changed in the transcripts, thesis and any other ensuing publications. Participants will be informed all confidential documents will be stored in a secure drive on a locked device. All interviews will be transcribed by the interviewer and only them, their director of studies (DOS) and examiners will have access to them. All anonymised data will be passed to the DOS for storage following assessment.	1	2	2		2

Review Date

2/2/2022

Appendix R: Ethical Approval Letter

University of East London

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details

Reviewer:	**Mark McDermott**
Supervisor:	**Kenneth Gannon**
Student:	**Jinny Carthew RESUBMISSION**
Course:	**Prof Doc in Clinical Psychology**
Title of proposed study:	**Barriers to accessing psychological support following early miscarriage. Perspectives of the IAPT perinatal champion.**

Checklist

(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☒	☐
Detailed account of participants, including inclusion and exclusion criteria	☒	☐	☐
Concerns regarding participants/target sample	☐	x☐	☐
Detailed account of recruitment strategy	☒	☐	☐
Concerns regarding recruitment strategy	☐	x☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☒	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	x☐	☐	☐
Clear and detailed outline of data collection	☒	☐	☐

Data collection appropriate for target sample	☐x	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☒
If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☒
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☒	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☒	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☒	☐
If required, General Risk Assessment form attached	x☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐x	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☒	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☒
If required, a DBS or equivalent certificate number/information provided	☒	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☒
All relevant information included in the participant information sheet (PIS)	☒	☐	☐
Information in the PIS is study specific	☒	☐	☐
Language used in the PIS is appropriate for the target audience	☒	☐	☐
All issues specific to the study are covered in the consent form	☒	☐	☐
Language used in the consent form is appropriate for the target audience	☒	☐	☐
All necessary information included in the participant debrief sheet	☒	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☒	☐	☐
Study advertisement included	☐	☐	☒
Content of study advertisement is appropriate (e.g., researcher's personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☒

Decision options	
APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student's confirmation to the School for its records.

	Minor amendments guidance: typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	**APPROVED**

Minor amendments

Please clearly detail the amendments the student is required to make

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

	YES	**NO**
	☒	☐

Has an adequate risk assessment been offered in the application form?	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature

Reviewer: (Typed name to act as signature)	**M.R.McDermott**
Date:	**14/03/2022**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data

Student name: (Typed name to act as signature)	Please type your full name
Student number:	Please type your student number
Date:	Click or tap to enter a date

Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required

Appendix S: Approved Data Management Plan

UEL Data Management Plan

Completed plans must be sent to researchdata@uel.ac.uk for review

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	Jinny Carthew
PI/Researcher ID (e.g. ORCiD)	0000-0002-9154-5879
PI/Researcher email	U2075231@uel.ac.uk
Research Title	Barriers to accessing psychological support following early miscarriage. Perspectives of the IAPT perinatal champion.
Project ID	N/A
Research Duration	January 2022-September 2023

Research Description	The study aims to shed light on potential barriers to accessing support following early miscarriage, from the perspective of staff who have held the role of peri-natal champion, within IAPT (Increasing Access to Psychological Therapies) services. Participants will be recruited via online and personal IAPT networks and invited to join a semi-structured interview designed to explore their experiences in providing psychological treatment for people following early miscarriage and their perspectives on possible barriers to doing so. Their interview responses will be analysed using the qualitative approach of thematic analysis to draw out common themes, with the aim of this informing service structure and roles within IAPT to improve pathways to support, following early miscarriage.
Funder	N/A – part of professional doctorate
Grant Reference Number (Post-award)	N/A
Date of first version (of DMP)	6/1/2022
Date of last update (of DMP)	11/1/2022
Related Policies	Research Data Management Policy UEL Data Backup Policy UEL Statement on Research Integrity UEL Statement on Research Ethics The Data Protection Act
Does this research follow on from previous research? If so, provide details	N/A
Data Collection	

What data will you collect or create?	Consent forms will collect identifying participant data (names, ages and signatures) but no sensitive data. These will be collected via UEL email. 8-12 participants who have held the role of IAPT perinatal champion will be interviewed virtually via Microsoft Teams by the researcher. Interviews will be approximately 40 – 60 minutes in length. The data that will be created is recordings in .mp4 format (the format used by Teams) and transcripts in .docx format.
How will the data be collected or created?	Due to Covid19 and wanting to encourage participants from across the country, interviews will be conducted via Microsoft Teams. Each participant will be given a participant number (in interview chronological order). Audio files (.mp4 format) will be named in line with the corresponding participant number and clearly labelled e.g. interview recording participant 1. All identifiable information (e.g. names, job location, identifiable scenarios) will be anonymised in the transcripts. If it is possible to re-identify participants from the transcripts prior to the anonymisation then the data will be pseudonymised until this is no longer possible. The transcripts will be saved as Word documents (.docx file formats). To organise the transcripts for analysis by the researcher each file will be named in line with the corresponding participant number and clearly labelled e.g. interview transcript participant 1. The audio recordings and anonymised transcripts will be stored on OneDrive and accessed using one password protected computer for the purpose of review by the researcher. Recordings will not be kept for longer than is necessary to complete transcription.
Documentation and Metadata	

What documentation and metadata will accompany the data?	Participant information sheets, consent forms, list of guide interview questions and debrief sheet. Participant contact information and anonymisation process of data (transcripts).
Ethics and Intellectual Property	
Identify any ethical issues relating to the data and/or data collection and how these will be managed	UEL Ethics approval will be sought before recruitment can take place. All potential participants will be provided with an information sheet and consent form to be completed before the interviews. Both participants and public informants may experience distress when relaying their experiences and will therefore be reminded before engaging that they can withdraw at any point and are free to take breaks or change timing as required. Written consent will be gained, and participants will be de briefed post interview. Any distress occurring during the interview will be managed in the same way the researcher would manage distress in clinical work. Contact details for additional support, such as the Miscarriage Association, will be supplied. All information regarding participants and their interview content will remain confidential. This would only be broken via discussion with supervisors if the researcher has concerns regarding anyone's safety and when possible, would first be discussed with the individual involved. To preserve anonymity, any identifiable features e.g. service names, will be changed in the transcripts, thesis and any other ensuing publications. Participants will be informed all confidential documents will be stored in a secure drive (UEL OneDrive for business) on a locked device. All interviews will be transcribed by the interviewer and only them, their director of studies (DOS) and examiners will have access to them. All anonymised data will be passed to the DOS for storage following assessment.
Identify any copyright and Intellectual Property Rights issues and how these will be managed	**N/A**

Storage and Backup	
How will the data be stored and backed up during the research?	Due to Covid19, all data will be stored on UEL OneDrive for business cloud. As recordings/auto-captions are stored by default on Microsoft Stream Library, if files are downloaded for upload to OneDrive for Business, it will be ensured that any local copies made on the laptop/computer are deleted and synchronising to personal Cloud storage is switched off. Video recordings from Microsoft teams will be auto-transcribed and stored on Microsoft stream. The researcher will review and edit this transcription (removing identifiable information in the process) before downloading into a word doc. This transcription will then be stored in a password protected file on both the researcher and supervisor's secure accounts. Audio/video files and transcripts will be stored on separate password protected folders only accessible by the researcher on a UEL OneDrive for business. Anonymised transcripts will be stored on both the researchers and supervisors secure accounts (so there is a backup). Contact details and other identifiable information will be stored in a folder separate from the audio/video files and transcripts. Consent forms will be collected as attachments via UEL email and will be saved directly to the UEL OneDrive for Business.
How will you manage access and security?	Only the researcher, supervisor and examiners will have access to anonymised transcripts. UEL systems and storage will only be accessed using a password protected laptop and multi-factor authentication. The screen will be locked when away from the laptop. Anonymised transcripts will be shared with the research supervisor via secure links through UEL OneDrive for Business. File names will be participant numbers e.g. Participant 1.
Data Sharing	

How will you share the data at project end	Short extracts of transcripts will be provided in the final write-up of the research and any subsequent publications or presentation of the study. The final write-up will be uploaded onto UEL repository. Identifiable information will not be included in these extracts.
Are any restrictions on data sharing required?	Only anonymised data will be shared.
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	Electronic copies of consent forms will be kept until the thesis has been examined and passed. They will then be erased from the secure server. Audio and video files will be deleted as soon as they have been transcribed. All anonymised transcripts will be passed to the research supervisor for storage following assessment
What is the long-term preservation plan for the data?	Following assessment, transcripts will be kept by the research supervisor for three years on UEL's OneDrive for business, after which point they will be deleted. These are kept securely within UEL servers but may be needed for further publication following the thesis examination
Responsibilities and Resources	
Who will be responsible for data management?	Jinny Carthew Dr Ken Gannon (Supervisor): retention of data post-project and deletion of data at the end of this retention period.

What resources will you require to deliver your plan?	The study will require access to Teams video-calling platform for the researcher and participants, audio-recording and transcribing equipment, access to the university drive to store documents and a password protected computer.
Review	
	Please send your plan to researchdata@uel.ac.uk **We will review within 5 working days and request further information or amendments as required before signing**
Date: 13.01.2022	Reviewer name: Penny Jackson Assistant Librarian (Research Data Management)

Guidance

Brief information to help answer each section is below. Aim to be specific and concise. For assistance in writing your data management plan, or with research data management more generally, please contact: **researchdata@uel.ac.uk**

Administrative Data

Related Policies

List any other relevant funder, institutional, departmental or group policies on data management, data sharing and data security. Some of the information you give in the remainder of the DMP will be determined by the content of other policies. If so, point/link to them here.

Data collection

Describe the data aspects of your research, how you will capture/generate them, the file formats you are using and why. Mention your reasons for choosing particular data standards and approaches. Note the likely volume of data to be created.

Documentation and Metadata

What metadata will be created to describe the data? Consider what other documentation is needed to enable reuse. This may include information on the methodology used to collect the data, analytical and procedural information, definitions of variables, the format and file type of the data and software used to collect and/or process the data. How will this be captured and recorded?

Ethics and Intellectual Property

Detail any ethical and privacy issues, including the consent of participants. Explain the copyright/IPR and whether there are any data licensing issues – either for data you are reusing, or your data which you will make available to others.

Storage and Backup

Give a rough idea of data volume. Say where and on what media you will store data, and how they will be backed-up. Mention security measures to protect data which are sensitive or valuable. Who will have access to the data during the project and how will this be controlled?

Data Sharing

Note who would be interested in your data, and describe how you will make them available (with any restrictions). Detail any reasons not to share, as well as embargo periods or if you want time to exploit your data for publishing.

Selection and Preservation

Consider what data are worth selecting for long-term access and preservation. Say where you intend to deposit the data, such as in UEL's data repository (https://repository.uel.ac.uk) or a subject repository. How long should data be retained?

Appendix T: Participant Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Barriers to accessing psychological support following early miscarriage. Perspectives of the IAPT perinatal champion.

Contact person: Jinny Carthew

Email: u2075231@uel.ac.uk

Thank you for participating in my research study on the perspectives of IAPT perinatal champions in providing psychological support following early miscarriage. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.) through journal articles, conference presentations, talks, magazine articles and feedback to relevant services. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as personally identifying information will be removed and anonymised.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr Kenneth Gannon for a maximum of 3 years, following which all data will be deleted.

What if I been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

- The Miscarriage Association: Pregnancy loss information and support
- Miscarriage - Afterwards - NHS (www.nhs.uk)
- Support after a miscarriage | Tommy's (tommys.org)
- Mental health - NHS (www.nhs.uk)

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Contact person: Jinny Carthew
Email: u2075231@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor Dr Kenneth Gannon. School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: K.N.Gannon@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking part in my study