The Lived Experience of Perinatal Anxiety: A Longitudinal Interpretative Phenomenological Analysis

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Abstract

Background: Perinatal anxiety has deleterious effects on the fetus, newborn, infant, older child and mother, and is more commonly experienced yet less well investigated than perinatal depression. There is a paucity of qualitative evidence examining lived experience of anxiety over the continuum of pregnancy and the first year post-birth, which limits the ability of healthcare professionals to recognise and fully understand the condition and to provide appropriate care for women and birthing people.

Aims: This doctoral study aimed to address the lack of evidence, by exploring how women are impacted by perinatal anxiety to and gaining a rich understanding of their experiences. The findings inform recommendations for clinical practice, research and education.

Methods: A qualitative longitudinal design was chosen, using in-depth interviews and Interpretative Phenomenological Analysis to elicit a deeper understanding of perinatal anxiety. Five women were interviewed each at three timepoints: antenatal, early postnatal and late postnatal, producing 15 datasets.

Findings: Nine Group Experiential Themes were developed, underpinned by three Longitudinal Experiential Concepts which explicated the common threads of experience over time: Maternal Eyes, Transforming Existence and Emotional Kaleidoscope. The lived experience of perinatal anxiety has been revealed as socially constructed, with aspects of relationships with self, others, and the world key. The collision between anxiety and motherhood as social constructs provides perinatal anxiety with its unique characteristics.

Conclusion: Midwives and other healthcare professionals should understand the significance of anxiety as a potentially problematic and destructive psychological experience and provide space for women to discuss stigmatising and uncomfortable feelings without judgement. Further research examining whether screening tools used by midwives, health visitors and GPs identify the less immediately evident characteristics of perinatal anxiety, and effectively flag the need for intervention, is recommended. Education for clinicians to understand the significance of perinatal anxiety is essential.

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PUBLISHED PAPER RELATED TO THIS THESIS:

Folliard, K. Crozier, K. & Wadnerkar Kamble, M. (2020). "Crippling and unfamiliar". Analysing the concept of perinatal anxiety; definition, recognition and implications for psychological care provision for women during pregnancy and early motherhood. *Journal of Clinical Nursing* **29:** 4454-4468.

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List of acronyms

ADHD	Attention Deficit and Hyperactivity Disorder
AN	Antenatal
CBT	Cognitive Behavioural Therapy
DASS	Depression, Anxiety and Stress Scale
DSM	Diagnostic and Statistical Manual of Mental Disorders
EPN	Early postnatal
GAD	Generalised Anxiety Disorder
GET	Group Experiential Theme
GP	General Practitioner
HPA axis	Hypothalamic-pituitary-adrenal axis
HRA	Health Research Authority
IPA	Interpretative Phenomenological Analysis
JARS	Journal Article Reporting Standard
LEC	Longitudinal Experiential Concept
LIPA	Longitudinal Interpretative Phenomenological Analysis
LPN	Late postnatal
MMHA	Maternal Mental Health Alliance
NHS-E	NHS England
NHSE/I	NHS England and Improvement
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
NSPCC	National Society for the Prevention of Cruelty to Children
OCD	Obsessive Compulsive Disorder
PERMA	Positive Emotion, Engagement, Relationships, Meaning and Accomplishment
PET	Personal Experiential Theme
PMHT	Perinatal Mental Health Team
p-OCD	perinatal Obsessive Compulsive Disorder
PPI	Patient and Public Involvement
PQR	Phenomenology as qualitative research
RCOG	Royal College of Obstetricians and Gynaecologists
WHO	World Health Organisation

CHAPTER 1: BACKGROUND

1.1 Mental ill health during the peripartum: economic and personal cost

Poor mental health is recognised by WHO as a key global health priority. In the WHO European Region mental health disorders are the leading cause of disability and the third leading cause of overall disease burden (measured in disability-adjusted life years) after cardiovascular disease and cancers, and as such mental health is one of the most significant public health challenges (WHO, 2017). In the UK poor mental health at work carries an estimated annual cost to employers of £34.9bn, equating to around £1300 for every employee (Parsonage and Saina, 2017). Once costs for treatment and social support are accounted for, the annual cost to the UK of poor mental health is £94bn (OECD, 2018).

The cost of mental illness in the perinatal population (people who are pregnant and up to the first year post-birth) is no less stark than for the general population, with a long-term cost to society of £8.1 billion per year (Bauer et al., 2014). Perinatal anxiety (classified as generalised anxiety, panic disorders, phobias, obsessive compulsive disorder and post-traumatic stress disorder, not co-morbid with depression) costs around £35k per case. £21k of this cost relates to the mother due to increased use of public services, loss of quality-adjusted life-years and productivity losses, and £14k to the child, covering four key outcomes: pre-term birth including cognitive impairment, emotional and conduct problems, and chronic abdominal pain (Bauer et al., 2014). Poor mental health can drive a 50% increase in costs of physical care (NHS-E, 2016). During pregnancy alone, the physical impact can be seen in increased contact with health professionals, and clinical decisions made based on a picture of worsening mental health. This raises important questions about containment: supporting women with psychological challenges before an escalation in mental ill health triggers clinical interventions. The human cost of severe perinatal mental illness is demonstrated in the Confidential Enquiry into Maternal Deaths and Morbidity, which continues to find that suicide is the leading direct cause of maternal death in the first year (Knight et al., 2021). In recent years policymakers have recognised that the personal impact is equally as urgent as the economic.

"The human, clinical and financial case for ensuring women have access to timely and effective mental health care during the perinatal period is clear and compelling" (NHS-E/I, 2018, p.5)

The Five Year Forward View for Mental Health (FYFVMH) and the NHS Long Term Plan describe the history and context from which current Government mental health strategy has emerged (NHS-E,

2016; NHS-E/I, 2019). The perinatal period has been recognised as an area of priority within policy. Specific care pathways for perinatal mental health now address the unique nature of this period, however geographical inequity in provision of specialist perinatal mental health services and access to psychological therapy for anxiety remain despite advances in provision, alongside concerns about the sustainability of new services (NHS-E/I, 2018; MMHA 2020). An aim was set to substantially increase the number of women with access to specialist services to 30,000 by 2020/21 and the subsequent NHS Long Term Plan (NHS-E/I, 2019) aims for provision to 66,000 women by 2023/24, with support extended until two years after birth and with mental health assessment and signposting to include partners.

1.2 The perinatal context

The perinatal period is a time when women are at risk of mental health vulnerabilities, as the adjustment to pregnancy and motherhood, as well as economic, work, physical and relationship stresses, can contribute to mothers' ability to recover from mental ill health (Hine et al., 2018, Steen and Thomas, 2016). Women from socially vulnerable groups and black and minority ethnic groups are at higher risk of poor perinatal mental health (Steen and Thomas, 2016). Perinatal distress is mismatched with a societal expectation of pregnancy and motherhood as a time full of joy (Miller, 2005). Mental health stigma is amplified during the perinatal period, as women struggle to live up to the behaviour and feelings that are expected of them (Dolman et al., 2013). This internal conflict can serve to exacerbate feelings of psychological distress.

While the presentation of a perinatal mental health condition may be similar to that of the non-perinatal population, there is an urgent need for effective support that accounts for the potential longer term sequalae for mother, infant and family. The Maternal Mental Health Alliance (MMHA) has been instrumental in contributing to policy developments and key voices within the MMHA are those representing the health of the infant and child, within the context of perinatal mental wellbeing. The link between maternal distress and anxiety in pregnancy and the behavioural development and emotional regulation of children in infancy and beyond, is well documented (Porter et al., 2019; Glover and Barlow, 2014; Bendiksen, 2015). The NSPCC Prevention in Mind report examined the impact of perinatal mental illness on children, and called for appropriate psychological support for women with mild to moderate illness alongside countrywide provision of mother and baby units for women with the most severe perinatal mental illness (Hogg, 2013).

It is 100 years since women in France were awarded motherhood medals for producing more than five children in response to the loss of life in the 1918 flu pandemic, and Douglas Winnicott coined the term 'good enough mother' in his exploration of the dynamics of the mother-infant dyad: this was a pivotal time in a new psychological understanding of motherhood (Appignanesi, 2008). Still now women strive for an elusive perfection - the motherhood medal remains, albeit as a figurative prize linked not to quantity but perceived quality in the raising of their offspring. The stigma of perinatal mental health conditions is felt keenly by women sensing they have become far removed from the mothers that society expects them to be. A report from the Royal College of Obstetricians and Gynaecologists (RCOG) showed that 28% of 2323 women surveyed felt there was stigma attached to maternal mental ill health and a further 28% felt embarrassed about their mental health, with the ability to seek support influenced by this stigma (RCOG, 2016; Fonseca et al., 2018). For women who do find the strength to seek help, there is sometimes a complex path to navigate among service providers.

1.3 Defining perinatal anxiety

Of the 285,000 women estimated to suffer from perinatal mental illness in the UK each year, 240,000 suffer from symptoms classed as mild to moderate including anxiety states and distress (Hogg, 2013). Establishing the prevalence of perinatal anxiety is a challenge due to the range of methodological approaches used, however systematic reviews and meta-analyses (including self-report and clinical diagnosis) have cited rates of up to 39% (Leach et al., 2017; Dennis et al., 2017). Defining perinatal anxiety raises several questions, including whether it is a unique condition that is distinct from anxiety experienced by the non-perinatal population. The author's concept analysis seeking clarity on the definition of perinatal anxiety, found the condition can present similarly to non-perinatal anxiety, however the occurrence of the condition during the perinatal period sets it apart, with associated characteristics to do with the transition to motherhood, stigma, and depression. The following definition is based on the concept analysis (Folliard et al., 2020, p. 10):

"Perinatal anxiety does not have a unique somatic or mental presentation, albeit the focus of worry will often relate to parenting concerns. This type of anxiety is an unfamiliar concept which causes health professionals issues with identification and treatment and presents women with psychological challenges bound up in the biopsychosocial aspects of transitioning to motherhood."

The concept analysis revealed that the condition is not well understood by comparison to perinatal depression and that there is a lack of evidence that explores women's subjective accounts of living with perinatal anxiety. The findings from this concept analysis provided the basis on which this doctoral research was proposed, with the aim of addressing the gap in evidence by exploring the lived experience of perinatal anxiety.

The primary research question addressed by this study was "How do women experience anxiety during the perinatal period?". Within this examination of lived experience there were two key aims:

1. To explore women's experiences of living with perinatal anxiety to gain a deeper understanding of the phenomenon from the perspective of women suffering from the condition.

2. To contribute new knowledge and advance professional practice by broadening discussion on how midwives and other health professionals can most effectively support women with perinatal anxiety.

A qualitative approach was taken, using interviewing as the method of data collection. This is detailed further in chapter 4. However, broadly the interviews aimed to explore varied aspects of how it feels to live with perinatal anxiety, including issues such as symptom management, support, services, impact on daily functioning or relationships and the psychological experience of pregnancy and new motherhood. The outcomes for the study were therefore:

- Improved understanding of the lived experience of perinatal anxiety.
- The ability to make recommendations regarding support and services taking the findings into account.

1.4 Researcher position

During my midwifery career I have assumed various roles, including learner, clinician, researcher, teacher, mentor, and specialist practitioner. I have therefore been exposed to much informal and formal learning as well as transformational experiences, including in my personal life becoming a mother and supporting a close relative with significant mental health difficulties. This thesis has been approached with my unique worldview, with reflexivity at all stages key to both facilitating

understanding of self and position within the context of this work and ensuring transparency (Woods and Murfet, 2004).

1.5 Structure of the thesis

The thesis will first present a literature review exploring the background to perinatal anxiety, providing justification for this area of research and detailing the theoretical underpinning to the research proposal. The starting point for this is the published concept analysis of perinatal anxiety undertaken in preparation for developing the doctoral research proposal (Folliard et al., 2020). The methodology will next be detailed and critiqued (chapters 3 and 4) before presentation of the findings and analysis (chapter 5). Finally, the findings will be discussed in the context of extant knowledge (chapter 6) prior to outlining reflections, conclusions and recommendations for clinical practice, education and research (chapter 7).

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

A broad background to perinatal mental health as a complex health and social issue and the reasons that perinatal anxiety is a specific area of interest have been presented. My understanding of perinatal anxiety has been informed substantially by experiential learning in midwifery practice alongside efforts to understand how it can be theoretically defined. The completion of a concept analysis has extended this theoretical understanding in two ways. First, by defining perinatal anxiety as the existence of anxiety during pregnancy and/or the first postpartum year, influenced by biopsychosocial factors and with potential negative sequelae for fetal, infant, child and maternal health, and secondly by identifying some of what is already known about the condition (Folliard et al. 2020).

The concept analysis (appendix 1) revealed a paucity of qualitative data relating to the lived experience of anxiety through the perinatal continuum. This lack of data has shaped both the research question and methodological approach to this doctoral study, which will examine how anxiety is experienced through pregnancy and the first year post-birth. This scoping literature review, as the foundation of this doctoral work, aimed to build on the concept analysis findings, recognising that the concept analysis provided context to the phenomenon but did not explore the characteristics of perinatal anxiety in detail. This has been achieved by providing a more detailed biopsychosocial view, through the following questions:

- What is the biological aetiology of perinatal anxiety?
- What psychosocial factors are associated with perinatal anxiety?
- What is the impact of perinatal anxiety on the fetus, infant, older child and mother?

Understanding how perinatal anxiety is experienced can only be achieved through clarity around its origins and manifestation. Appreciation of the far-reaching impact of perinatal anxiety underscores the need for research which provides greater understanding of the condition.

Papers for this literature review were identified through searching the databases CINAHL, Medline, EMBASE, PsycINFO, and Emcare, focusing on biological aetiology, psychosocial and impact factors of perinatal anxiety; for inclusion and exclusion criteria see table 1.

Table 1: inclusion and exclusion criteria for literature search

Inclusion criteria
• English language • Female study population • Perinatal anxiety defined as during pregnancy and in first year postpartum • Examine aetiology relating to anxiety • Explore psychosocial factors relating to anxiety • Investigate impact of anxiety
Exclusion criteria
• Non-English language • Non-female population • Studies relating to other mental health conditions (with or without presence of anxiety) • Study protocols or editorials

The searches included English language papers published from 2012-2022. Search terms used were 'perinatal' AND 'anxiety' OR 'perinatal anxiety' AND '?etiol' AND 'psychosocial' AND 'impact'. The search yielded 415 papers which were reviewed by title and/or abstract with a final selection of 43 papers incorporated, see figure 1.

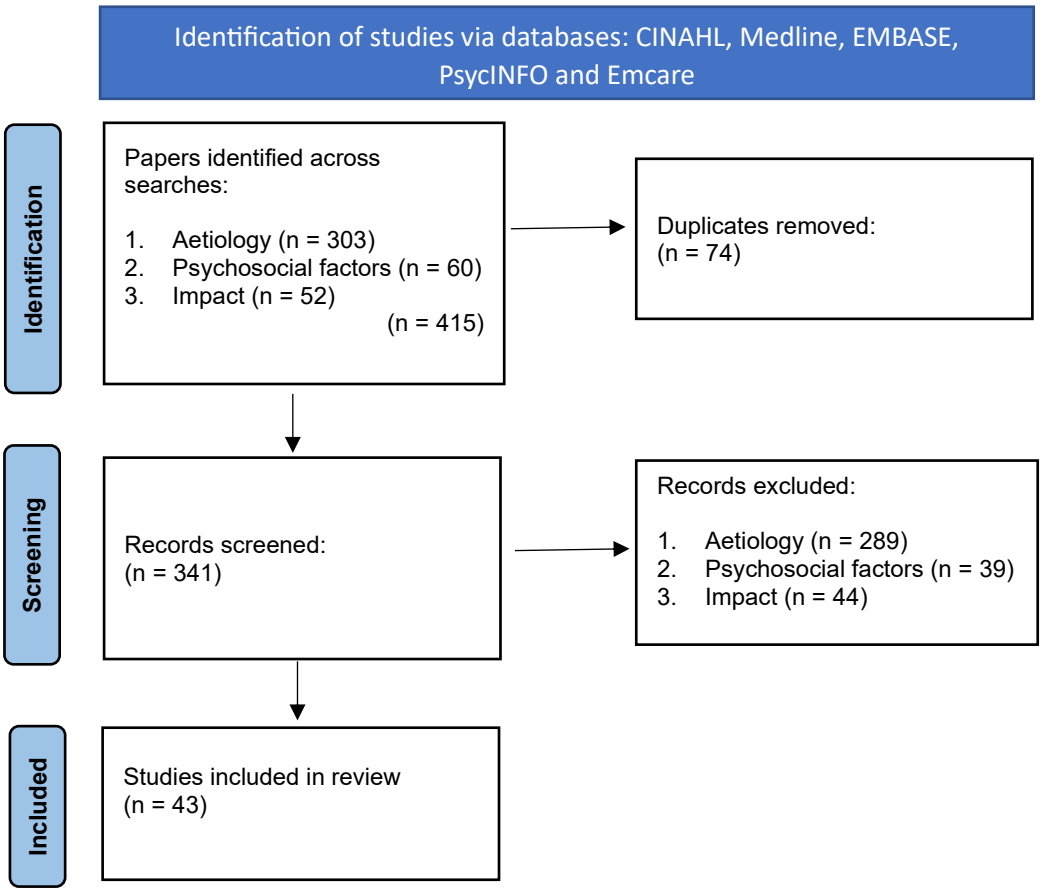

Figure 1: Flow chart showing literature search process

2.2 Biological aetiology of perinatal anxiety

Examination of the physiological, environmental, cognitive and behavioural aspects of anxiety has generated theories accounting for presentations across several different anxiety disorders and approaches to treatment, and in the context of different genetic and environmental influences (Phoenix and Johnson in Fitzpatrick, 2012). Physiological antecedents for perinatal anxiety may include pregnancy itself (Anniverno et al., 2013; Buist in Castle et al., 2006), disordered sleep (Farrell, 2017; Palagini et al., 2019; Osnes et al., 2020), or medical comorbidities or pregnancy conditions (Furber et al., 2009; Thorsness et al., 2018). In the case of pregnant women, the anxiety response extends beyond the maternal condition to affect the fetal environment, including impacting fetal neurocognitive development via genetic and epigenetic changes in placental structure and function, and the stress response regulated by the hypothalamic-pituitary-adrenal (HPA) axis (Tuovinen et al., 2020). Akbaba et al. (2018) also noted the relationship between maternal anxiety disorders and changes in fetal neuroinflammatory responses.

2.2.1 Genetic responses

Heritability for anxiety can be examined using linkage or association studies with cohorts of twins to identify environmental factors and the involvement of specific genes (examining the presence and frequency of genetic expression associated with anxiety). However as noted by Gregory and Eley (in Silverman et al., 2011) anxiety is influenced by multiple genes of small effect size as well as environment, which makes it difficult to draw conclusions about the significance of findings within these types of studies. The authors also note that the variable nature of anxiety and the manifestation of the condition across a heterogenous population makes heritability hard to fully understand. These challenges can only be addressed by breaking down presentations, disorders, and characteristics of populations to examine the impact of a particular illness (Gregory and Eley in Silverman et al., 2011). Lewis et al. (2015) note that, although maternal mental ill health may have a clear link with child developmental outcomes, the processes and influencers involved are highly complex; research is in its relative infancy and further studies are needed that incorporate analysis of known covariates alongside examining biological mechanisms of transmission.

2.2.2 Epigenetic responses

Barker et al. (2011) note that epigenetic factors also contribute to the relative health of offspring. Through epigenetics the expression of genes is mitigated by environmental factors: while the DNA sequence remains unchanged, epigenetic changes influence the activity within a DNA segment. The resultant changes make up a person's epigenotype which forms during development and remains somewhat throughout a person's lifetime (van Vliet et al., 2007). Non-human animal studies have shown the impact of stress on epigenetic mechanisms, including in utero and during infancy; there is growing interest in examining long term outcomes for human animals and undertaking further research on the implications epigenetic processes have for the development of anxiety disorders (Nieto et al., 2016; van Vliet et al., 2007).

Increased understanding of the possible impact of the maternal stress response on the uterine environment has led to greater awareness of the importance of reduced fetal stress in pregnancy, including that exerted through maternal anxiety, smoking or drinking (Van Den Bergh and Marcoen, 2004). Ponder et al. (2011) examined gene expression in the human placenta and found that maternal anxiety and depression altered the genetic expression of placental human serotonin transporter, suggesting a possible pathway for the influence of maternal mood disorders on fetal programming. The potential role in 'fetal programming' of placental gene function, alongside the hypothalamic-pituitary-adrenal (HPA) axis and its central function in controlling fetal readiness for birth, has further been discussed by Glover et al. (2015), with an association noted between antenatal anxiety and genotypes related to cognitive and emotional outcomes.

2.2.3 Physiological responses to maternal stress and anxiety

The role of the HPA axis has become a focal point in discussion regarding the impact of the uterine environment, the physiological response to stress, and fetal programming. The HPA axis adjusts the neuroendocrine response to maintain homeostasis, for example in response to a 'fight or flight' situation and is a dynamic mechanism that behaves differently at specific times over the life-course. During late pregnancy the HPA axis is hyporesponsive, which may offer some protection for the fetus against stress. However, it is still possible for this state of low arousal to be disrupted in the case of prolonged or excessive stress which can ultimately result in programming of lifelong anxiety and stress coping behaviour (Brunton, 2010). Additional external factors such as antenatal alcohol exposure can also result in hyperactivity of the HPA axis (Hellemans et al., 2010).

In non-human studies other environmental factors regulating the activity of the HPA axis and anxiety behaviour have been examined, such as high fat diet, which altered inflammatory responses with increased expression of corticosterone receptors (Sasaki et al., 2013). However, the relevance of this to anxiety symptoms is not strongly determined; the proinflammatory state was investigated by Blackmore et al. (2011) in a study of 145 pregnant women and no link between the generalised proinflammatory state and anxiety was found. Sherer et al. (2018:26) discuss the potential impact of immunological changes on brain and neural function contributing to altered perinatal mood, identifying potential mechanisms within the "psychoneuroimmunology of pregnancy". The contradictory state of evidence in this field is noted by Osborne (in Payne and Osborne, 2020) in their discussion of future research directions in perinatal obsessive-compulsive disorder. Nevertheless, the role of the HPA axis in mediating the impact of antenatal stress on the fetus has possibly been the most widely examined element of fetal programming (Glover et al., 2018). However, Tiemeier (2017) cautions against drawing hasty conclusions as the evidence base is evolving and the methodological approaches of many studies leave unanswered questions. For example, regarding confounding factors and the lack of differentiation between maternal disorders, citing studies grouping anxiety and depression together as an example of this.

2.2.4 Cognitive behavioural responses to anxiety and models of intergenerationality

The cognitive response to anxiety is inherently linked to an individual's capacity for emotional regulation (the brain's ability to control the expression of emotion). Grecucci et al. (in Durbano and Marchesi, 2016) discuss appraisal, cognitive emotion and experiential-dynamic emotion regulation theories, noting that ultimately psychological suffering depends on the level of emotional dysregulation. Therefore, emotional regulation is central to any psychological therapeutic intervention, such as cognitive behavioural therapy. Post-birth the potential negative sequalae of maternal anxiety continue as antenatal anxiety is likely to persist postnatally. Anxiety can therefore have ongoing consequences for the young infant and older child due to impaired parental emotional regulation and the impact on parenting behaviours (Glover et al., 2018). A study examining longitudinal cohort data in Finland found that in the case of severe parental illness leading to psychiatric admission, offspring were found to have a two to threefold higher chance of a psychiatric diagnosis in adulthood, and the association was stronger in women than in men (Paananen et al., 2020). This cross-generational impact highlights the importance of effective support for women to

lessen the severity of perinatal anxiety and harness the perinatal period as an opportunity for recovery.

Gar et al. (in Hudson and Rapee, 2005) discuss two key concepts behind the manifestation of anxiety across generations: transgenerational multifinality and transgenerational equifinality. Multifinality is the idea that one risk factor can lead to a variety of different outcomes depending on the context in which it occurs, therefore the potential nature of the outcome varies. Equifinality posits that an anxiety disorder will not result from one risk factor alone, and that a combination of routes (i.e. differing parental presentations) can lead to the development of the same disorder: thus the development of anxiety is multidirectional and involves a number of interacting variables. Van Santwoort et al. (in Reupert et al., 2015) further describe these different potentially overlapping models of intergenerational mental ill health, including transgenerational concordance or transgenerational specificity, where the child develops a presentation related to the parental condition. The authors note that it is therefore unhelpful to describe people suffering from anxiety in homogenous terms particularly when considering interventions to support recovery as the potential for differentials is considerable. As noted by Gar et al. (in Hudson and Rapee, 2005: 139):

"Because human behaviour and interaction, as well as child-rearing and development, is so very complex with a multitude of variables, only persistent, careful, systematic and sophisticated future research will begin to tease out the role of each ingredient in the multi-factorial puzzle of the influence of family factors in the creation or perpetuation of anxiety disorders".

2.3 Psychosocial factors associated with perinatal anxiety

These complexities of human behaviour and interaction are revealed in the psychosocial factors associated with perinatal anxiety which are described in two systematic reviews. Furtado et al.'s (2018) systematic review and meta-analysis examined 11 studies which assessed risk factors for new onset and worsening perinatal anxiety (from pregnancy to 12 months post-birth) and found an association between new onset anxiety and lower educational attainment, living with extended family members, multiparity, a family history of psychiatric disorders, hyperemesis gravidarum, co morbid sleep disorders, and antenatal oxytocin exposure. Worsening perinatal anxiety was associated with comorbid psychiatric disorders and antenatal oxytocin exposure. The authors noted that some papers were excluded due to not stating whether participants had pre-existing anxiety disorders, therefore

some relevant data may not have been included. Nevertheless, the review provides a sense of a range of biopsychosocial risk factors for perinatal anxiety.

An earlier systematic review by Biaggi et al. (2016) supported the broad nature of these psychosocial findings, citing the factors most associated with anxiety and depression in pregnancy as a lack of social support or partner, a history of abuse or intimate partner violence, adverse life events, pregnancy complications and loss and a history of mental illness. This review considered both anxiety and depression together, unlike the concept analysis which specifically focused on studies which separated anxiety from depression (Folliard et al. 2020). It is common that anxiety and depression are considered alongside one another due to being frequently comorbid, with comorbidity ranging from 10-50% according to Wenzel et al. (2005). This is particularly the case during the antenatal period, with antenatal anxiety one of the strongest risk factors for depression (Biaggi et al., 2016; Verreault et al., 2014).

Although the comorbidity of perinatal anxiety and depression is frequently referenced, depression as a condition is far more thoroughly investigated than anxiety (Martini et al., 2013; Henshaw et al., 2017). This may contribute to the lack of distinction of perinatal anxiety as a standalone entity, despite work that evidences its distinctiveness from state/trait anxiety (Anderson et al., 2019) and perinatal stress (Rallis et al., 2014). A lack of public awareness of the condition may also contribute to this; an Australian survey of 1201 adults showed that perinatal anxiety was less well recognised than depression (Smith et al., 2019). The systematic reviews give a broad sense of psychosocial aspects associated with perinatal anxiety, and the studies discussed below provide a further flavour of this in relation to some of the more prominently discussed environmental and personal factors.

2.3.1 The social and pregnancy environment

Several socio-demographic environmental factors associated with antenatal anxiety were noted in a review by Henderson and Redshaw (2013) including younger age, black and minority ethnic status, single parenthood, living in a disadvantaged area and having an unwanted pregnancy. Wenzel et al. (2005) similarly noted that lower socio-economic status, and younger age as well as an absence of breastfeeding predicted anxiety symptoms. Ahmed et al. (2018) studied antenatal risk factors for women exhibiting an anxiety trajectory through the perinatal period and found that risk factors were past depression, stress levels and income level, supporting earlier findings regarding socio-economic

status. Observations made regarding perinatal anxiety during the Covid-19 pandemic may also provide some useful clues about social environmental factors which impact anxiety.

Bottemanne et al. (2022) cite covid-19 public health policies including social distancing, isolation and changes to healthcare accessibility as having a detrimental effect on maternal mental health. Anxiety among pregnant women was found to be raised during the first wave of the pandemic, with anxiety that may be considered usual in pregnancy heightened with additional worries regarding infection concerns, poor birth preparedness and access to healthcare (Ilska et al. 2022; Awad-Sirhan et al. 2022). Social and health discourse around the pandemic was naturally prominent, and concerns about the implications for pregnancy and maternal behaviour and choices were a focal point (Jullien & Jeffery, 2022). Rowe and Fisher (2015) interpreted maternal perceptions of contributors to anxiety in the context of social and health discourse around the perinatal period and found themes around the way public health messages are received and decisions made as well as maternal instinct and risk, which provide a sense of how perinatal anxiety may have been further raised through the pandemic.

Of course, commonly anxieties relate to the circumstances of the individual, such as the socio-demographic factors mentioned above, and include the experience of pregnancy complications, noted by Biaggi et al. (2016), as contributing towards perinatal anxiety. In a cross-sectional study of 43 couples with pregnancies at high risk of preterm birth compared with 37 physiologically uncomplicated pregnancies, Pisoni et al. (2016) found that hospital admission due to risk of preterm birth was associated with higher levels of anxiety in parents compared to those with a 'low risk' pregnancy. The impact of potential pregnancy complications and anxiety was also examined by Gross et al. (2021) who explored the relationship between ultrasound scans in the first, second and third trimesters, observing increased anxiety in participants following indeterminate scan findings.

In recognition of the potential for medical intervention to impact anxiety, in a feasibility study for a randomised controlled trial Heazall et al. (2013) investigated women's experiences of standard compared to intensive intervention for reduced fetal movements. The authors found that both levels of intervention (ultrasound scan with induction of labour based on consultant decision vs. ultrasound scan, biomarker for placental function with induction of labour if either result was abnormal) lessened anxiety, although a greater reduction occurred in the group receiving standard treatment. This may be explained by a naturally higher level of anxiety among participants with abnormal investigations leading to their induction which was more common in the intensive management group. However, it also suggests a potential relationship between anxiety levels and antenatal interventions which would

warrant further investigation given the frequency with which medical intervention occurs during pregnancy.

Anxiety following miscarriage has not been widely studied; however, in a limited number of papers examined in a review by Brier (2004), anxiety and the risk of obsessive-compulsive disorder was raised immediately following pregnancy loss, prior to starting to diminish after a period of six months post-miscarriage. Nynas et al. (2015) note that anxiety and depression following miscarriage could persist for up to three years and symptoms are more likely to be present in people with socioeconomic challenges. Anxiety in pregnancy following previous perinatal loss was investigated by Smorti et al. (2021) who noted that among women who had experienced the loss prior to 24 weeks gestation, those with a living child were less likely to be anxious than those with no other living children, suggesting that the presence of a live child can mitigate the impact of pregnancy anxiety related to miscarriage. The psychological impact of care following perinatal loss may also have an impact on anxiety levels in future pregnancies, with debate around how hospital practices regarding memorialising the fetus or time spent with the stillborn baby, may exacerbate feelings of anxiety (Robinson, 2014).

2.3.2 Personal and relational history

A personal or family history of mental illness as a predictor of perinatal anxiety is well recognised (Leach et al., 2017). Furtado et al. (2019) found that in a sample of 35 women with pre-existing DSM-5 anxiety disorders observed for worsening anxiety symptoms, those with significant depressive or obsessive-compulsive disorder symptoms in pregnancy were more likely to experience anxiety post-birth. The relationship between eating disorders and depression and perinatal anxiety and depression was examined by Micali et al. (2013). The study showed that women experiencing eating disorder symptoms in pregnancy and with a history of depression prior to pregnancy had a higher risk for developing perinatal anxiety and depression compared to those with a past eating disorder without depression or a history of depression alone. This suggests the combination of antenatal eating disorder symptoms with past depression is significant for perinatal anxiety. The strongest association with anxiety in the perinatal period was between long-standing mental health conditions and postnatal anxiety in Henderson and Redshaw's (2013) study.

A review of the literature by Papapetrou et al. (2020) explored the link between attachment styles and maternal mental health, suggesting that insecure attachment in parents exposes vulnerability in perinatal mental health, making the perinatal period more likely to be a time of emotional challenge.

Having a personal or familial history of a mental health condition may influence one's confidence in managing as a parent; Coo et al. (2015) found that maternal distress was amplified by intrinsic beliefs about the ability to cope and negative expectations about the future. Pierce et al. (2022) undertook a qualitative analysis of maternal blog content which found two main themes related to the onset of antenatal anxiety: uncertainty and perceived lack of control, providing further indication of related personal psychological factors.

Personal relational factors have been cited as playing an important role in the development and perpetuation of perinatal anxiety. A systematic review and meta-analysis by Pilkington et al. (2015) found that emotional closeness and global support (different sources of support) could mitigate against perinatal anxiety and depression. Further evidence of this is seen in a study of 1774 Polish women during the Covid-19 pandemic, which compared anxiety and depression levels in those who attended in person antenatal classes, online classes or no classes (Ciochoń et al. 2022). The authors found statistically significant reduced levels of anxiety in the group attending classes in person, compared to those attending online or not attending at all. It was however noted that the online participants may have been predisposed to higher levels of anxiety (anxiety levels prior to the observation were not gathered), as borne out in their decision to remain isolated at home, while also missing the potentially positive impact of fully engaging with relaxation techniques taught in person. Nevertheless, this large study suggests that the peer support afforded by in person interaction during the time of the pandemic may have played a role in reducing perinatal anxiety levels. This finding was further supported by Harrison et al. (2022) who noted loneliness as a potential mediator of perinatal anxiety and depression during the pandemic.

2.3.3 A biopsychosocial model for perinatal mood disorders

This body of evidence which describes some of the psychosocial factors impacting perinatal anxiety indicates a clear co-existence of environmental, personal, social and psychological factors. Yelland et al. (2010) stress the importance of healthcare practitioners being aware of the links between social and emotional health; their study of social health issues and postpartum anxiety and depression found that women with 3 or more stressful life events or social health issues (relationship, emotional, trauma-based, financial) were 4-5 times more likely to score above the cut off point for the DASS-21 (Depression Anxiety Stress Scale). Therefore, efforts to understand the nature of perinatal anxiety need to consider these contributory factors.

Halbreich (2005) and Ross et al. (2004) proposed biopsychosocial models for the processes involved in the manifestation of perinatal mood disorders, which demonstrate the interplay between different personal, familial, biological and environmental influencing factors. Perinatal wellbeing can be viewed through the lens of social ecological theory, with core affective, psychological and physical aspects set within a model of micro and macro individual and environmental influences (Bronfenbrenner, 1979; Wadephul et al., 2020). Social interaction theory can further explicate the internal and external processes of anxiety, providing a view on the individual's cognitive and emotional responses to the world (Turner, 1988). As Buist (in Castle et al., 2006 p.145) describes the route to perinatal mood and anxiety disorders in general, "a complex, interactive aetiological pathway." It is however important to recognise that anxiety in the perinatal period can be a normal and anticipated part of the experience of the transition to motherhood (Henderson and Redshaw, 2013), indeed the state of pregnancy is itself one of inherent anxiety (Rowe and Fisher, 2015). The existence of parental-themed worries, for example to do with maternal, fetal or neonatal wellbeing, finances or returning to work is not necessarily remarkable (Goldfinger et al., 2019). More notable are the societal pressures felt by women to perform as mothers, a classic example being the ability or desire to breastfeed: the impact of such pressures is highly distressing and can increase anxiety levels (Highet et al. 2014; Rowe and Fisher, 2015).

Perinatal anxiety becomes problematic when pre-existing anxiety is exacerbated or new onset anxiety manifests in an uncontrolled fashion, the consequences of which can be debilitating (Furber et al., 2009). The processes leading to the development of anxiety and how perinatal anxiety may impact on offspring are multidimensional and depend on genetic, epigenetic, cognitive, behavioural and environmental factors both in-utero and post-birth. Further complexity occurs due to the processes involved in intergenerational mental-ill health. The drive to understand these complex processes comes from the growing body of evidence regarding the deleterious effects that high levels of anxiety can have on women and their infants, as discussed below.

2.4 Impact of perinatal anxiety on the fetus, infant, older child and mother

The impacts of perinatal anxiety can be described as events arising from the experience of perinatal anxiety which have short, medium or long-term negative sequalae for the fetus, neonate, infant, child or mother, and may be of a biological, psychological or social nature (Folliard et al., 2020). A similar spread across the biopsychosocial spectrum is observed in the impacts of perinatal anxiety as in the risk factors or predictors for the condition. Considering the impacts of perinatal anxiety paints a

picture of the far-reaching nature of the condition, in terms of its repercussions beyond one individual. It is this broader, ultimately intergenerational impact that adds weight to the critical nature of the study of perinatal anxiety (Glover, 2007).

2.4.1 Impact on fetus and neonate

A review by Ding et al. (2014) examined two poor birth outcomes widely considered to be specifically linked to maternal anxiety during pregnancy (low birth weight and preterm birth) and confirmed the association across the eighteen included studies. The authors concluded that healthcare professionals should pay attention to the significance of this finding when considering mental health support for pregnant women. A further systematic review and meta-analysis produced similar findings, that there was an increased likelihood of preterm birth and low birth weight in babies born to mothers experiencing antenatal anxiety (Grigoriadis et al., 2018). A recent large prospective cohort study of 4408 women found that women who experienced generalised anxiety in pregnancy were more likely to give birth to a low birthweight infant than those with no anxiety (Gelaye et al., 2020). Uguz et al. (2019) found that the greatest chance of low birth weight and preterm birth occurred in women with comorbid anxiety and depression, as opposed to a sole diagnosis of anxiety or depression. A retrospective cohort study by Ciesielski et al. (2015) also noted an association between low birth weight and antenatal anxiety. However, this study included an assessment of epigenetic changes which enabled observation of a difference between active maternal disease and a history of maternal disease, with molecular changes only apparent in active disease. The authors therefore drew conclusions about perinatal anxiety as a potentially modifiable antenatal state with implications for management of the condition.

In a large retrospective cohort study, Dowse et al. (2020) found that babies born to women self-reporting anxiety during pregnancy were more likely to have birth complications (the nature of the birth complication was not reported), a neonatal unit admission and lower Apgar scores. Martini et al. (2010) also considered the effect of self-perceived distress on the fetus and neonate and found preterm birth and caesarean section birth to be associated. These are noteworthy findings as they both relate to maternal reports of self-perceived condition, indicating that relying on clinical diagnoses to determine the level of therapeutic need may miss a significant number of patients who would potentially benefit from additional treatment or support.

Creswell et al. (2011) studied the infants of mothers with social phobia. When these infants (aged 10 weeks) were shown angry and fearful emotional expressions, they had greater avoidance of the 'fear faces' compared to infants of non-anxious mothers or mothers with generalised anxiety disorder, suggesting that biased responses to emotional expression can occur from a very early age and may be more prevalent in infants of mothers with social phobia. In response to mixed evidence regarding the impact of maternal anxiety on newborn and infant interactions and bonding, Nath et al. (2019) explored both perceived and observed postpartum interactions, specifically sensitivity (maternal ability to respond to infant cues) in women with antenatal anxiety. The authors found that while there was no observable impact on mother-infant interaction, the participants self-perceived difficulties with bonding, although this effect was only seen in women with comorbid depression. In contrast Fallon et al. (2018) observed reduced breastfeeding initiation and duration, and lower breastfeeding enjoyment in anxious mothers. This finding was supported by Coo et al. (2020) in their prospective study involving 229 women, which highlighted an association between high levels of maternal anxiety and non-exclusive breastfeeding at 3 months. The authors observed that exclusive breastfeeding at 3 months predicted exclusive breastfeeding at 6 months, indicating that exclusive longer-term breastfeeding was more likely to be disrupted for women experiencing anxiety. Tietz et al. (2014) found that of 78 mother infant dyads, there was a significant association between postpartum anxiety and suboptimal bonding. However, in common with the findings of Nath et al. (2019), the authors note that subclinical depressive symptoms were also more likely to be present in the women experiencing poor bonding.

2.4.2 Impact on infant and older child

The repercussions for infants and older children of mothers experiencing perinatal anxiety can be physical, cognitive, developmental and behavioural. A high level of antenatal anxiety at a late gestation was found to increase the risk of bronchiolitis within the first year of life, suggested to be influenced by genetic polymorphisms in antioxidant defence and innate immunity genes (Lee at al., 2014). Greene et al. (2018) examined the impact of maternal anxiety during the neonatal admission of very low birth weight babies and found raised maternal anxiety to be associated with lower fine motor scores at 20 months corrected age. Glasheen et al. (2010) reviewed the impact of postnatal maternal anxiety on children, finding the strongest link with somatic symptoms (including colic and recurrent abdominal pain) and psychological outcomes (infant temperament), although overall the evidence was noted to have methodological inconsistencies and lack of control for confounding variables.

A later study by Barker et al. (2011) accounted for the impact of sociodemographic variables across 3298 mother-infant dyads and still found an association between ante- and postnatal maternal anxiety and depression and infant emotional and cognitive disorders. Glasheen et al. (2010) noted weaker associations with cognitive developmental outcomes compared to somatic symptoms and psychological outcomes. However, others have since evidenced adverse social and developmental sequelae resulting from anxiety in pregnancy and postpartum including negative impacts on relationship building, appropriate expression and regulation of emotion, exploration of environment and learning and behavioural disorders (Porter et al., 2019; Bendiksen, 2015; Korja et al., 2017). Stein et al. (2012) noted an association between postnatal anxiety and disturbed maternal cognitions which impacted negatively on mother-infant interactions and caused mothers to be less responsive to and engaged with their infants. Reck et al. (2018) observed mothers interacting with their 12-month-old infants and revealed lower language scores in infants of mothers with postnatal anxiety. The authors hypothesised that this would be related to maternal avoidance, although stressed that the complexity of pathways for infant development would make it tenuous to suggest the outcome solely results from the maternal-infant interaction.

Petzoldt et al. (2014) found that infants of mothers with an anxiety disorder, up to the age of 16 months, were more likely to cry excessively than infants of women without anxiety disorders and more likely to cry excessively than the infants of women with depressive disorders. Thiel et al. (2020) attempted to account for variation in type of anxiety presentation on infant temperament and found the strongest association with unsettled infants to be general antenatal anxiety and fear of childbirth. If this finding is further corroborated it has potentially significant implications for psychological care during pregnancy, since rates of tokophobia are estimated at 14% (O'Connell et al., 2017).

Given the challenges with controlling for comorbidity, and variations in condition over the course of the perinatal period, the MARI (Maternal Anxiety in Relation to Infant Development) study is a useful reference. This prospective longitudinal study with data collection at 7 points through pregnancy until 16 months postpartum indicated the peripartum as a period of vulnerability for persisting or recurring anxiety disorder (Martini et al., 2013; Martini et al., 2015). The MARI study differentiated between cohorts of women with no condition, just anxiety, just depression and comorbid anxiety and depression. Alongside maternal psychopathology and perinatal health the study examined infant outcomes thought to be antecedents to the later development of anxiety disorders. An association was found between anxious mothers and ‘difficult’ infants, displaying more tendency to cry or have feeding problems (Martini et al., 2017). An earlier study by Martini et al. (2010) noted associations

between Attention Deficit and Hyperactivity Disorder (ADHD) and conduct disorder in the offspring of women with anxiety diagnoses. Polte et al.'s (2019) study examined the development of 1336 two-year-olds and found an association between problems related to social-emotional behaviour and both ante- and postnatal anxiety, which supports the findings of the earlier MARI study.

Rees et al. (2019) recognised an issue with the evidence base around studies examining perinatal anxiety and child development outcomes, with a lack of cohesion across studies, and attempted to synthesise the literature in a systematic review. The authors included papers showing associations between antenatal and postnatal maternal anxiety and emotional problems for children aged 2-13, including increased incidence of offspring anxiety and social problems. Due to methodological variance and lack of controlling for confounding factors (such as co-morbid depression) in several papers, as well as doubt apparently cast on results dependent on who was reporting the anxiety (mother, father, teacher or child), the quality of several of the studies was impacted. It was therefore not possible to draw any firm conclusions and the authors concluded that while the evidence is suggestive of a link between perinatal anxiety and adverse childhood emotional outcomes, further research is needed.

2.4.3 Impact on mother/parents

For mothers the consequences of experiencing perinatal anxiety can impact significantly on their social, behavioural and cognitive function, and the need to understand the interplay between maternal and paternal experiences of anxiety and depression has been recognised. Women are disproportionately affected by anxiety disorders compared to men, and when these disorders are experienced by women they are overall more disabling than they are when experienced by men (measured by presence of comorbidities and days of missed work) (McLean et al., 2011).

Furber et al. (2009) interviewed 24 pregnant women self-reporting mild to moderate antenatal psychological distress. Even at this mild to moderate level, the stress the participants experienced, which related to past difficulties and current pregnancy worries, was enough to be significantly debilitating for some participants, causing changes in eating, lifestyle and work habits. It may be that the severity of condition was greater than reported (originating from the participants rather than clinical assessment), however it indicates that distress which is self-perceived as mild to moderate can have a deleterious effect on pregnant women. Highet et al. (2014) interviewed 26 women who self-reported experience of postnatal depression or anxiety in the five years leading up to the study. The

authors found a similar impact of anxiety on the participants who described excessive worry and impaired social functioning. Razurel et al. (2013) were also interested in levels of perceived distress, and attempted to evaluate the relationship between maternal stress, social support, coping strategies and maternal wellbeing. Their review indicated an association between perceived stress and postnatal depression, however the relationships could not be robustly assessed due to differences in the ways that perceived distress was evaluated in the studies. This study highlighted a need for further research to examine the role of social support.

Others have also suggested that postnatal depression can be a consequence of anxiety. In a systematic review and meta-analysis Grigoriadis et al. (2019) examined the relationship between anxiety and postnatal depression and found an association (persisting up to ten months post-birth) between antenatal anxiety and postnatal depression independent of the existence of antenatal depression, alongside lower odds of breastfeeding among anxious mothers. This finding regarding breastfeeding is in line with studies discussed above (Fallon et al., 2018; Coo et al., 2020), which also noted lower breastfeeding enjoyment and exclusivity among anxious mothers, suggesting that anxious mothers are at greater risk of the maternal benefits of breastfeeding not being conferred. Maternal distress is compounded by the negative psychological impact of a lack of successful breastfeeding, as different facets of anxiety and breastfeeding experience interact (Rivi et al., 2020). Dowse et al. (2020) also found an association between diagnosed anxiety disorder or self-perceived distress during pregnancy and postnatal depression. This study noted a relationship with preterm birth, as previously discussed, thereby suggesting not only an increased risk of postnatal depression for anxious or distressed mothers but also the potential additional maternal anxiety caused by neonatal admission and separation and the associated neonatal consequences as noted by Greene et al. (2018).

In contrast to the studies highlighting postnatal depression resulting from antenatal anxiety, Rousseau et al. (2021) recruited 149 pregnant women to investigate the relationship between antenatal trait-anxiety and posttraumatic stress following childbirth. The study found that antenatal trait anxiety was a significant risk factor for posttraumatic stress following childbirth. This suggests that women with antenatal anxiety may be more susceptible to developing posttraumatic stress (as well as postnatal depression), adding another layer of complexity to the overall picture of perinatal wellbeing, and that this may need to be accounted for by caregivers.

As noted above, a focus beyond the maternal experience is also present in the literature. Vismara et al. (2016) examined both parents to understand the evolution of parental anxiety and depression,

comparing fathers and mothers at three separate time points. The authors found that the presence of anxiety and of partner depression in either the mother or father influenced the persistence of both maternal and paternal postnatal depression. A systematic review by Philpott et al. (2019) examined the paternal experience of anxiety and found that fathers experienced a similar range of psychosocial risk factors for anxiety to mothers and that the trajectory for paternal anxiety was an increase towards the time of birth and a decrease post-birth. Fathers experiencing anxiety found that it impacted negatively on their physical and mental health and social functioning.

In-depth interviews conducted by Darwin et al. (2017) found that fathers expressed lack of validity around their own psychological challenges and valued their role in supporting their partner as they perceived this was central to maintaining the strength of their partnership to protect the family unit. Brandão et al. (2019) examined the relationship between parental anxiety and dyadic adjustment and found that fathers' anxiety symptoms were associated with their levels of antenatal attachment to the fetus and the relationship was partially mediated by their level of dyadic adjustment (the parental perception of relationship quality). The same was not found for maternal anxiety, however maternal depression was associated with reduced antenatal attachment, and this was mediated by levels of dyadic adjustment. Fathers' depressive symptoms were influenced by the level of maternal attachment. These studies highlight the importance of considering dyadic adjustment and the mental health of both parents in contributing to overall positive familial wellbeing.

Consistently we see that when attempting to understand the impact of perinatal anxiety, the picture is complex. Efforts have been made to account for some of the different dimensions and variables involved, but nevertheless the evidence indicates numerous poor outcomes associated with the condition. These studies point to the multifaceted nature of anxiety conditions, in terms of complex aetiology, comorbidity, and the role of perception which is as unique as each individual and is why an individualised approach to support and recovery is crucial. It is important to remember that poor parental mental health does not inevitably lead to poor mental health in offspring, and much can be done to work with families and across generations to improve outcomes (Reupert et al., 2015). In terms of public health concerns such as smoking and weight gain, pregnancy is often viewed as an opportunity to promote behaviour change and interventions (Olander et al., 2016). It is no less an opportunity to engage women in psychological support to aid recovery in such a way that impacts on their long-term mental health and that of their children. In relation to perinatal anxiety, it is key for healthcare professionals to understand what constitutes effective support, especially as this is supported by evidence pointing to perinatal anxiety as a modifiable state (Ciesielski et al., 2015).

Maternity care professionals are in a uniquely strong position to support recovery due to the frequency and intensity of their interactions with women and families (Thorsness et al., 2018).

2.5 Chapter summary

Understanding and managing mental health conditions effectively is critical due to the association between poor maternal mental health and the health and wellbeing of the fetus, infant and older child. If women are not supported to maintain stable mental health during the perinatal period, the deleterious impacts will continue to perpetuate an intergenerational cycle of adverse mental and physical conditions. Examining the literature around perinatal anxiety provides understanding of the aetiology and relevant psychosocial elements of this phenomenon, and the broader implications of related sequalae. Despite methodological inconsistencies and some weakness in quality across the literature there is no doubt that there is a determined will within the relevant research communities to find answers which account for the significance of perinatal anxiety, which while often comorbid with depression, should be treated as a distinct entity (Matthey et al., 2003).

It is striking within the perinatal anxiety literature, that while women experiencing the condition have been the subject of measurements and reporting, the evidence relies heavily on methods using predetermined language and parameters, with minimal attention to women's subjective, lived accounts. Several authors have noted a paucity of qualitative research describing women's experiences of suffering from perinatal anxiety and depression, with symptoms of anxiety most often described in terms of illness classification (Highet et al., 2014; Furber et al., 2009). Tools to identify and measure symptoms are one part of the evidence needed to provide effective care and support, however the woman's voice, critically positioned at the heart of the matter, is almost absent. It is possible to identify the antecedents, prevalence, severity and impact of perinatal anxiety, as represented within current evidence, without comprehending the meaning of the condition for those experiencing it. There is therefore an evidential gap regarding the complete lived experience of perinatal anxiety through pregnancy and the postpartum, which curtails understanding of how to effectively support women at all stages of their perinatal journey and is therefore a significant omission in the research.

This doctoral research addresses this gap using a longitudinal approach, examining the primary research question: "How do women experience anxiety during the perinatal period". This literature review has provided the rationale behind the research questions and outcomes for this study. The

next two chapters detail how the project was approached including the methodological standpoint, methods, and how ethical considerations and issues of trustworthiness were addressed.

CHAPTER 3: METHODOLOGY

This chapter presents the epistemological position of this work and explains the choice of methodology. Providing this rationale and considering critique of the approach enables exploration of the epistemological perspective to clarify the standpoint from which data collection and analysis is undertaken. This enables others to understand how the underpinning thinking for the work has developed. Following this, chapter 4 outlines the proposed methods for the study. The starting point for consideration of the study methodology is how to effectively address the research question, "How do women experience anxiety during the perinatal period?".

3.1 Methodological rationale

3.1.1 Epistemological premise

The need to give space to the open expression of women's experiences frames the proposed qualitative approach to this research. Qualitative research seeks to understand phenomena, and detailed comprehension of a particular situation which accounts for context and nuance, can be a strong basis for building theory and developing a more sophisticated level of learning (Green and Thorogood, 2018). This approach contrasts with measuring and labelling of symptoms, which Oiler (1982) notes contributes to classification and categorisation rather than description and therefore is ill fitting from a nursing or midwifery perspective which values a holistic approach. Meleis (2018) argues that rejection of the positivist paradigm is important and that a sole quantitative focus can impede the development of nursing theory and in so doing limit the progression of nursing science. The risk of nursing and midwifery research solely grounded in the positivist paradigm is that the meaning of living with a condition for patients is missed alongside the opportunity to learn about their needs holistically.

Exploration of individual experience and the meaning attributed to experience can be approached via a multitude of research methods and can be grounded in varied ontological principles, one of which may be phenomenology. Examples of methods used to study lived experience include narrative enquiry (Eastmond, 2007), reflective diary writing (Travers, 2011), and collective memory work engaging with a social constructionist paradigm (Johnson, 2018). Tomar and Stoffel (2014) demonstrated a convergence of methods, using a participatory action research method based on phenomenological principles. The aim of increasing understanding of how it feels to live with perinatal

anxiety informs the proposed philosophical paradigm for this study, phenomenology: the study of the ways individuals experience things and the meaning they derive from their experiences (Smith, 2018a). The proposed methodological approach to analysis will be Interpretative Phenomenological Analysis (IPA) (Smith et al., 2022). This is discussed in detail below, however to robustly establish my epistemological position it is first useful to consider the value placed on the concept of lived experience.

3.1.2 'Spreadsheets are people too" - The use and meaning of lived experience

An edition of the BBC's Moral Maze programme (BBC, 2020) opened with the idea that 'You can only really truly understand an issue and empathise with those involved if you have been through it' and went on to discuss the moral authority of lived experience. Contributors debated whether lived experience is essential for social justice; that those with lived experience should be privileged with more moral weight in the national argument, and whether those with no lived experience have a right to take a position at all. The counter argument raised concern about focusing on subjective experience and therefore prioritising the emotional over the rational, the subjective over the objective, thereby narrowing debate and politicising the term 'lived experience': using it to project authority in an argument. The point at which the arguments converged was the acceptance that understanding the richness of how people think takes different forms, whether first person narratives or spreadsheets of quantitative data, so called 'people too'. As human animals perhaps we are instinctively hard wired to accept personal experience as authority? And if so, maybe we do not scrutinise underlying agendas and motivations enough. In undertaking lived experience research, the scrutiny of data and the researcher's position, criticality and transparency within it are therefore key.

McIntosh and Wright (2019) acknowledge the potential for the use of the term 'lived experience' to be 'vacuous' or 'contradictory'; they explore lived experience as a concept and a research strategy and discuss the methodological and theoretical implications of this within social policy contexts. The authors argue that understanding lived experience contributes to discussion around the commonalities of the experience of different phenomena, thereby informing social policy. Of the bodies of work the authors recognise as key to social policy, phenomenology was identified as "the essential /reference point" (p. 450). This suggests that in building evidence to help shape perinatal mental health policy, phenomenology is a useful fit. The authors note that lived experience which has been influenced by public policy and practices offers a particular strength of moral authority, as is the case among people living with mental ill health.

The approach to this doctoral research question is borne of a personal conviction that knowledge of how the phenomenon of perinatal anxiety is experienced comes primarily from women with the condition: these women hold the authority. Other sources, including health and policy professionals in the field, contribute to the wider understanding of the phenomenon, but only those with experience can provide their unique insight. Therefore, phenomenology as a philosophy and a science provides a basis on which to develop this work. Dually positioned as a midwife and a researcher, how that knowledge is built will inevitably be influenced by these professional identities. This belief led to a methodology focusing on lived experience but with an interpretative rather than descriptive phenomenological stance, ultimately concluding Interpretative Phenomenological Analysis would support this epistemological position.

3.1.3 Phenomenology as philosophy and methodology

Edmund Husserl in the early 1900s described the philosophical idea of phenomenology as focusing on the experience of thinking and knowing, where experiences are intuitively grasped and their generalisable essence captured (Moran, 2000). Scientists observed the growth of the phenomenological philosophical movement and became interested in how consciousness and the meaningful consequences of human experience were understood, revealed through Husserl's emerging method of analysis of consciousness (Giorgi, 2017). In the years following Husserl's description of his phenomenology, those contemporaries identifying with the phenomenological method became increasingly distant from Husserl. This movement was fuelled by scepticism of the premise of eidetic reduction and the possibility of subjective transcendence; the development of phenomenology in philosophy began to result in an increasingly diverse range of intellectual application (Moran, 2000). One key diversion came from Martin Heidegger, a pupil of Husserl's who introduced the idea of an interpretative philosophy, leaning on the discipline of hermeneutics and attempting to understand phenomena within a certain context.

The hermeneutic phenomenologist does not seek to categorise the purely descriptive account of an individual's subjective experience. Rather they search for the meanings of the experience as implied by the narrative and the choices made due to these meanings, interpreting this in relation to "situated freedom" (Lopez and Willis, 2004: 729). This was Heidegger's idea that individuals are only free within their cultural, social and political context; Sartre understood situated freedom to be the existential reality of human beings and therefore the basis for all meaning (Lopez and Willis, 2004). The idea that meaning making occurs within the cultural, social and political context is a crucial aspect of the

phenomenological perspective according to Oiler (1982); they posited that reality is shaped by contact with the world and that subjectivity grounds reality, consequently context and individual perspective are inextricably linked when making sense of one's reality. An interpretative phenomenology is an appropriate epistemology to underpin this study into the lived experience of perinatal anxiety; a phenomenon which exists within the sociocultural and political arena of pregnancy and childbirth and is a deeply personal experience.

Examination of the individual within this context allows the meaning of the phenomenon to be uncovered. However, both phenomenology as a qualitative research method and Interpretative Phenomenological Analysis (IPA) as a phenomenological research method have been criticised. It is therefore important to unpick this criticism to proceed with confidence in using this method.

3.2 "The research equivalent of spin doctors?" (Paley, 2016: 145)? Critique of phenomenology as a qualitative research method

Paley (2016) provides an extensive critique of phenomenology as qualitative research (PQR), arguing for an alternative approach based on the flaws he finds across three key phenomenological research approaches, one of which is IPA. Paley's argument centres on three broad points in relation to PQR in general and specifically IPA: meaning attribution and theory, methodological distinctiveness and methodological validity, which are discussed below.

3.2.1 Meaning attribution and the use of extant theory

Paley (2016) notes that PQR is focused methodologically on how meaning is derived from the data, but that it is often unclear in published papers as to how the researcher has moved from the text to arrive at the meaning. He also questions whether meaning is truly resident in the text or is imported from outside. This is one of his major criticisms of IPA specifically – that the claim in IPA that meaning can be sought without introducing existing theory and researcher subjectivity into the meaning is untenable. Giorgi (2017) counters that the ways in which phenomenologists derive meaning can vary (a flexibility of approach with which Paley appears uncomfortable), meaning may be contained within the text but can sometimes be attributed to data from other sources. Paley (2016) describes that phenomenologists infer meaning from the text, Giorgi (2017:103) notes that:

"Phenomenologists do not 'infer' that meanings are in the data. They intuit the meanings that are correlated with intentional acts directed to objects and then critically evaluate and describe them."

Paley (2016) cites Smith's (1999) IPA paper on motherhood, highlighting the use of theory around self-identity being fed into the text rather than coming from the text. The examples that Paley gives to support his point seem robust: he pitches two extracts with an apparently tenuous link to Smith's theoretical statement "the symbiotic psychological relationship of self and other is facilitated and accentuated during the pregnancy by social occasions" (Paley, 2016:138). However, returning to Smith et al.'s (2009) explanation for this idea in context, we see that an additional two excerpts are used and that the logic behind the interpretation is clear. In this case Smith recognises women's accounts of their sense of self and relationships and connects to a theoretical framework in Meads' seminal work from the 1930s.

Paley states both that Smith's interpretation is not supported by the work of Meads and that the theory has been imported into Smith's reading of the data. The first point is not relevant to the critique of the methodology, it is simply Paley's alternate interpretation. Regarding the second point, Smith acknowledges that the addition of Mead is part of the second order analysis and that in this example the second order analysis has appeared sooner than is typical of IPA, that this study "pushes the I in IPA quite far" and that "the material is used in dialogue with a strong theoretical framework" (Smith et al., 2009:163). However, the authors also argue that nonetheless the approach follows the principles of IPA – inductive from first order analysis to second order analysis. Approaching the analysis from text alone, employing the double hermeneutic and reflexivity, and drawing on a theoretical framework, is a commitment to the key tenets of IPA's process of meaning making (Smith et al., 2022).

The transparency promoted by the reflexive process would guard against Paley's additional concern that Smith's (1999) study forms the basis for future IPA studies to be overly concerned with self and identity, and that this "agenda" means that IPA researchers focus on this theme and may "unwittingly attempt to elicit 'identity-friendly' material during the interview" (Paley, 2016:124). But one could argue that it would not be unreasonable if this were the case, given that this is phenomenological work using IPA. Indeed Smith et al. (2009) acknowledge that at the time of this study Jonathan Smith was becoming interested in the emergence in IPA studies of themes of self and identity, noting this is unsurprising if studying a topic with an existential focus. For Paley, Smith has a dependence on theory to facilitate meaning making. For Smith, there is a dynamic relationship between analysis and theory

and it is the connections the researcher makes between the findings and existing literature which help the reader see how the individual narrative illuminates the existing research. Smith's (1999) motherhood study demonstrates this dynamism and I question whether he should be criticised for presenting this example, given that he states his position explicitly? This transparency will help researchers to learn and the method to develop – Smith et al.'s (2009) text is intended as an introduction to the method and stresses its developmental status; Paley appears to mistake this evolutionary process for weakness.

Given that in Paley's (2016) examination of Paul Flowers' HIV interviews (see Smith et al., 2009) he states that respondents cannot be relied upon to be the authority on their own psychological states, and is unhappy with Flowers' reading of their narratives, one wonders who *is* permitted credibility in unpicking the meaning behind their descriptions. Paley argues that the respondent talking about psychological states only functions to accomplish social goals (going along with the interviewer, eliciting sympathy, fulfilling responsibility) rather than epistemological goals (describing internal goings-on). I disagree and would argue that in a conversation about a life experience there is a mix of these behaviours present and it seems paternalistic to suggest otherwise.

Paley further extends his discomfort with a PQR interviewer drawing out key words or significant statements by suggesting that using quantitative content analysis would ensure the genuinely significant ideas are captured by virtue of their frequency. Based on that logic, salience is measured in frequency and taken at face value, without ever attempting to develop a deeper understanding of meaning. This kind of data will tell the researcher 'what' but is unlikely to help them understand 'why', and therefore the opportunity to broaden understanding is limited. Neither method is flawless, or each method is equally flawed and equally useful – so why discount one approach so forcefully? Regarding meaning making, Paley's argument is weak and reveals his general positivist bias, his unwillingness to embrace the possibilities offered by phenomenology as a science and his poor understanding of the fact that the phenomenological scientific method is about discovery, not theorizing. The researcher adopting the phenomenological attitude to derive meaning is the key to this approach (Giorgi, 2017).

3.2.2 Methodological distinctiveness

Paley (2016) is also concerned with the methodological distinctiveness of PQR noting that methods using phenomenology, grounded theory and narrative enquiry have evolved to suit postgraduate

research. This has made it hard to distinguish between these hybrid methods which cross between meaning attribution, causal hypotheses and common themes. He argues that a need for publication productivity means that methodologists have superficially adopted philosophical ideas to justify a theoretical basis, which if based on experience negates the need to consider theory more broadly. Paley notes that IPA may specify that research questions focus on meaning rather than causation, but that this rarely plays out in the published papers. Paley advocates a sound methodological description which overtly quashes any doubt about whether what is reported is sound evidence or just what the researcher thought, and the avoidance of references to philosophy which he dismisses as "terminological garnish" (Paley, 2016:24).

Giorgi (2017) is more sympathetic to these naturally imperfect attempts to practice phenomenological science, for example by nurse researchers, who in most cases are unlikely to have a solid theoretical training in phenomenological philosophy; and are further likely to be challenged by the developmental nature of this new science. Giorgi's frustration at Paley's position is clear:

"Paley's reductionistic description of the motives behind phenomenologically-based qualitative research in nursing is a real disservice to the nursing profession." (Giorgi, 2017:107).

Although critical of Paley in this respect, Giorgi (2010) previously highlighted a similar view, noting that when research methods are based on philosophical underpinnings of phenomenology methodological variations can appear. This can impact the quality of the science, largely due to the lack of understanding of phenomenology as a science compared to phenomenology as a philosophy and the fact that as a science it is immature. The author notes this results in a combination of poor application of scientific principles alongside inconsistency with the phenomenological view.

Giorgi (2010) is also critical of IPA, questioning how closely aligned the method is with the philosophy, and that there is not enough explanation of how the method will be utilised, rather just description of how it is executed. Giorgi takes issue with the lack of prescriptive method, and the fact that this does not allow for replicability and scientific intersubjectivity. Giorgi's concerns are important, highlighting the challenge of the application of this philosophical tradition in scientific methodology and inviting IPA methodologists to be explicit and transparent in their method and thinking. However, as stressed by Smith and Eatough (2019), different approaches to IPA have been taken to advance the method conceptually and methodologically over the past 20 years; the application and distinctiveness of IPA continue to evolve.

3.2.3 Methodological validity – the nomothetic vs. the idiographic

The third focus of Paley's (2016) critique is around the validity of the IPA methodology. Sample sizes in IPA are small, and Paley takes issue with the notion of proving causation based on the experiences of a small group of people. The example is given of interviewing nurses who say what would be expected of them and therefore the methodology fails to add to the science. However, we have already seen that IPA does not set out to prove causation. One of the key features of IPA is its focus on the idiographic with a commitment to the particular through deep analysis of the detail of individual cases, and to understanding "how particular experiential phenomena (an event, process or relationship), have been understood from the perspective of particular people in a particular context" (Smith et al., 2009:29).

Smith et al. (2009) stress a sense of contradiction in the nomothetic approach – that the collection of empirical data removes the individual's relationship to the phenomenon. Grouping and measuring draws conclusions that, although generalisable in a statistical sense, cannot be an accurate representation of a general population precisely because the 'particular' has been lost in the process. Paley (2016) uses a paper based on the methods of Colaizzi and Giorgi (Tavakol et al., 2012) and reconstructs it to show how a model could be developed to explain an interesting phenomenon rather than just explore it. Because fundamentally Paley does not value the exploration of a phenomenon, he is drawn to quantifiable data. In the development of his model, he outlines criteria-based (from pre-existing theory), highly specific interview questions. He argues it is possible to carry out qualitative research in a way which is theory-laden and explanatory rather than exploratory. Paley's approach may have merit as a method, but this is not IPA, and misses the idiographic focus, thereby exposing the weakness in his proposed alternative phenomenological research method – it's like comparing apples and oranges.

Paley's (2016) summary about IPA is that meaning making is not possible without the help of imported theory, that the premise of a hermeneutic method to make inferences about the text is a fallacy and the lack of criteria in the method of IPA allows space for personal interests and biases to enter. Paley cannot reconcile this lack of criteria and in his view, the absence of perceived logical data means that each analyst will find in the data a reflection of themselves. Giorgi (2017: 141) sums up Paley's critique of PQR:

'The work of the phenomenological scientists involves the integration of a non-naturalistic philosophy with some of the procedures of positive science. Initially, the two seem to be worlds apart. But as opposed to what took place in physics, Paley ignores the successful baby steps, highlights the missteps and disparages the hard work of the pioneers in this tradition.'

3.2.4 Not out of the woods yet: is IPA phenomenological enough?

In addition to Paley's positivist critique of IPA, some phenomenologists are critical that the methodology fails to grasp pure phenomenological practices. Prior to Giorgi's (2017) critical response to Paley's stance on PQR, he had argued that IPA falls between the cracks of philosophical phenomenology and phenomenology as a theory of science, fulfilling the principles of neither effectively (Giorgi 2010). Max van Manen (2017) expressed similar concerns about the prevalent use of qualitative research labelled as phenomenological but which describes methods that in his view are not phenomenological, in part by virtue of their aim to generalise to other populations.

Van Manen (2017) posed questions to determine whether a qualitative method can be considered phenomenological. These included whether the questions and objectives are phenomenological and whether the work explicitly adheres to phenomenological scholarship including the thoughtfulness of the epoché, and with results that offer illuminating phenomenological insights (as opposed to unconvincing themes taken from reworded interview texts). Speaking of themes, van Manen (2017) described interpretative themes not as the research outcomes but instead a component of the reflective journey towards phenomenological enquiry and writing.

Highlighting IPA as an example in this critique, van Manen (2017:777) concluded that "not all qualitative research inspired by phenomenology is phenomenology" referencing the erroneous nomenclature of IPA when Jonathan Smith switched from psychological to phenomenological analysis. He further states that Smith's IPA asks research participants to reflect and make sense of their experiences with the researcher making sense of their responses, which van Manen argues is a psychological rather than phenomenological pursuit and that phenomenological meaning is not found in how individuals interpret their own experiences.

In response to van Manen's comments, Smith (2018b) counters with several points, including the author's misrepresentation of the IPA researcher as a therapist and the notion that participants as co-analysts is a common feature of IPA. Smith also evidences the use of phenomenological analysis in his

early papers to rebuff claims that he switched from psychological to phenomenological analysis to suit his desire for a phenomenological label for the method.

Regarding van Manen's assertions that the reflective state is not phenomenological, Smith (2018b:1956) argues individuals are self-reflective and the researcher "invites them to share this sense making, to act as a witness to its articulation and then, in turn, to make their own sense of it." Smith recognises that the reflective focus of IPA contrasts with van Manen's study of phenomenology which ascribes to pre-reflective meaning-making. Smith points to the writings of Husserl and Sartre describing the movement between pre-reflective and reflective states as part of experience and argues the reflective state is part of the phenomenon itself rather than a separate process.

Smith (2018b) also takes issue with van Manen's assertion that phenomenology should be approached in a prescriptive manner, given its complexity and the multiple ways phenomenological thinking has diverged. He does stress that for scientific transparency and validity researchers should be explicit about how their methodological choices have manifested and influenced their work, however "they cannot lay claim to a single definitive form of phenomenology because phenomenological philosophy is diverse." (Smith 2018b: 1956). Dowling (in Thomson et al. 2011:60) discusses the development of phenomenology as a research approach and notes that phenomenological psychology is a branch of psychology that is guided by philosophy, rather than being a "subfield of the phenomenological philosophy movement." Smith (2018b) concludes with the thought that good work can be both psychological and phenomenological, acknowledging that IPA can be done poorly and that the best IPA is "careful, insightful, surprising and leaves the reader feeling they have learned something important or powerful" (p. 1957).

Naturally van Manen (2018) responded to Smith, and the arguments and counterarguments about IPA's value as a scientific and phenomenological pursuit continue, demonstrating the challenges in finding consensus among the passion, expertise and nuanced positions of these stakeholders (Smith, 2010; Giorgi, 2011; van Manen, 2018; Zahavi, 2019; Barber, 2021). Nevertheless, this debate is mostly respectful, and the protagonists seem united in a common aim of moving the discussion and understanding of phenomenological qualitative research forward. So how does consideration of the methodologists' positions impact this doctoral work? I recognise my position, not as a philosophy academic but as a midwife clinical academic with much to learn, pursuing a scientific endeavour which aims for the generation of new knowledge in my chosen field of interest. Within this I take a pragmatic view. Acknowledging the criticisms of IPA, I understand from these arguments the importance of the

approach to IPA being robust, where the method is explicit and the desire to achieve the phenomenological attitude remains a firm commitment (Finlay, 2011).

3.2.5 Tain't What You Do (It's the Way That You Do It) – how to produce a quality piece of IPA work.

IPA has been used to study a range of biopsychosocial experiences during the perinatal period, including congenital heart disease, anorexia nervosa, alcohol consumption, obsessive compulsive disorder, and obesity (Chinello et al., 2019; Burton, 2020; Hocking et al., 2020; Flocco et al., 2020; Atkinson and McNamara, 2017; Birtwell et al., 2015). The range of studies using IPA indicates that researchers in the field set out believing that IPA will be a useful way to develop understanding of phenomena in the perinatal period, possibly due to how IPA is concerned with experience within a particular context or life event (Smith et al., 2022).

However, it is notable that some of these papers (Burton, 2020; Birtwell et al., 2015; Flocco et al., 2020) provide little or no detail about the philosophical underpinning of their studies and cite weaknesses in their small sample size and lack of generalisability. Chinello et al. (2019 p.599) go as far as to note that the small sample made cross group comparison for "definitive and quantitative results" impossible. These cited weaknesses are in fact not weaknesses of IPA, which as discussed, provides an idiographic focus and welcomes the use of the single case, with conclusions that can be drawn to apply in a more general sense (Smith et al., 2022). Therefore, the authors of these papers reveal a possible misunderstanding in the application of their method, which could cast doubt over the quality of their analysis; a more rigorous account of their method may have removed the need to apologise for a perceived small sample size. By contrast, Hocking et al. (2020) and Atkinson and McNamara (2017) provide a neat overview of the philosophical basis of phenomenology and how this is used within IPA, and their study limitations raise useful points about the nature of their samples and the meaning of this for their data, with no mention of sample size. These authors are clear that the justification for their use of IPA is because it facilitates study of the heterogenous, nuanced experiences examined with the ability to deepen understanding.

To support critical review of IPA work, Jonathan Smith and colleagues have offered guidance to assist with appraisal, initially through categorising quality in IPA papers from the body of work published between 1998 and 2008 (Smith, 2011a). Criteria were based on how closely the papers aligned with the theoretical principles of IPA, sampling approaches, the strength of the data and interpretation, transparency, coherence, depth, plausibility and interest. More recently Nizza et al. (2021) further

detailed how to craft a high-quality IPA paper, by focusing on papers regarded as exemplars and presenting four quality indicators: constructing a compelling, unfolding narrative; developing a vigorous experiential and/or existential account; close analytic reading of participants' words; and attending to convergence and divergence.

In keeping with this guidance, Larkin et al. (2006 p. 103) argue that students using IPA must focus on the quality of the interpretative work to avoid completing a purely descriptive exercise that doesn't engage with phenomenological theory, and that IPA is "easy to do badly and difficult to do well'. Hefferon and Gil-Rodriguez (2011) also note a tendency in IPA for heavily descriptive pieces of work, suggesting the methodology can be misunderstood as a form of thematic analysis, which results in poor quality IPA. Brocki and Wearden (2006) reviewed 52 articles using IPA in health, noting that in some cases the interpretative element was lacking, and were critical that authors are not always clear about their theoretical preconceptions or their position in interpretation, indicating the importance of attention to the reflexivity inherent in the process.

Lopez and Willis (2004) advise nurse researchers to choose a methodological approach that will substantially meet the aims of the research question in a meaningful way to further knowledge about the phenomenon under enquiry. IPA aims to be translational in its coherent and pragmatic efforts to build knowledge of phenomena, via analysis of third person data based on the insights of phenomenological philosophy (Smith et al., 2009). Understanding the meaning behind these lived experiences may illuminate the embodied, cognitive affective and existential domains of psychology:

"People are physical and psychological entities. They do things in the world, they reflect on what they do, and those actions have meaningful, existential consequences" (Smith et al., 2009:33).

In this way IPA is the right fit for an examination of the lived experience of perinatal anxiety, anxiety within the context of pregnancy, an embodied experience about which women reflect cognitively on existential issues and the anxiety provokes an affective response. The participants' and the researchers' foci of embodiment, cognitive affective and existential processes are typical of an IPA study and demonstrate the potential for IPA to offer a holistic phenomenological analysis in the study of perinatal anxiety (Smith et al., 2022).

McNamara (2005) notes the importance of nurse researchers responding to the critique of phenomenological research and demonstrates an attempt at conducting a study taking this critique

into account, showing that in the author's view this method has value in nursing science if methodological and philosophical integrity is maintained. The critique described above has provided valuable insight into the aspects of IPA which can be viewed as weaknesses, and how to strengthen a study to make it scientifically robust. These principles of transparency around the interplay between theory and meaning making; clarity of methodological process; commitment to a focus on highly detailed idiographic interpretative analysis and being explicit about the researcher's preconceptions and position are key. The aim of this is to provide a methodologically sound study which meets the criteria for a piece of high-quality IPA work (Nizza et al., 2021).

3.3 Longitudinal Interpretative Phenomenological Analysis (LIPA)

A longitudinal approach to IPA is an enhanced design which can meaningfully capture temporality and can be useful when researching a significant event such as becoming a parent (Smith et al., 2022). The investigation of lived experience should capture living through a situation and the subjective understanding of this over time, usually in response to an evolving situation (Neale and Holland, 2012). The longitudinal approach fits with studying lived experience within the context of this study due to the nature of the perinatal period being a time of significant life change. A review by Farr and Nizza (2019) of longitudinal designs using IPA indicated that this design can deepen understanding of the dynamic evolution of a phenomenon, allowing fuller comprehension of change. Indeed, longitudinal qualitative research is situated within the interpretivist tradition grounded in hermeneutic and phenomenological schools of thought (Neale, 2021). Longitudinal qualitative studies in healthcare can also be valuable for understanding how care provision which changes over time may influence patient experience (Calman et al., 2013). This is relevant for a perinatal study, conducted over a period during which professional healthcare input is initially intense during pregnancy and less so postnatally.

3.4 Chapter summary

This chapter has demonstrated that in addressing the question "How do women experience anxiety during the perinatal period?", a qualitative phenomenological approach is appropriate, as it supports the examination of lived experience. There are differing schools of thought around Interpretative Phenomenological Analysis, with an apparent consensus that it is easy to create poor IPA, which would mean a departure from the phenomenological lens. There is evidently a balance to be struck between philosophical phenomenological roots and psychological science to maintain methodological integrity. In choosing IPA, focus on this debate is maintained throughout the doctoral work which,

through the detail of the interpretative analysis and findings, transparent presentation, and reflexive research practice fulfils this aim, demonstrating the markers of high-quality IPA: constructing a compelling, unfolding narrative, developing a vigorous experiential and/or existential account, close analytic reading of participants' words and attending to convergence and divergence. The following chapter describes how the study was designed, including the approaches taken to methods of data collection and ethical considerations.

CHAPTER 4: STUDY AIMS, DESIGN AND METHODS

4.1 Aims and objectives

The primary research question addressed by the study was "How do women experience anxiety during the perinatal period?". Within this examination of lived experience there were two key aims:

1. To explore women's experiences of living with perinatal anxiety to gain a deeper understanding of the phenomenon of perinatal anxiety from the perspective of women suffering from the condition.

2. To contribute new knowledge and advance professional practice by broadening discussion on how midwives and other health professionals can most effectively support women with perinatal anxiety.

Gaining the detailed views of women experiencing perinatal anxiety via in-depth interviewing was the chosen method to achieve these aims. Completion of data analysis, related discussion and dissemination of findings intended to address the primary aim of improving understanding of the nature of perinatal anxiety. This process also informed practice recommendations regarding how women with the condition are best supported by midwives and other health professionals. The proposed methodology, Interpretative Phenomenological Analysis (IPA), with a longitudinal design, discussed in detail in chapter 3, was chosen due to its attention to the subjective examination of people's life experiences, especially when in the context of significant life events (Smith et al., 2022).

The interviews therefore sought to learn from participants' experience of perinatal anxiety aspects such as how it felt to experience the condition, how symptoms were managed, support structures, experiences of services, impact on life or daily functioning, wider impact on social function including within family/friendships/work and how perinatal anxiety impacted the experience of pregnancy and new motherhood (see appendix 2 for the full topic guide). The outcomes for the study were therefore:

- Improved understanding of the lived experience of perinatal anxiety.
- The ability to make recommendations regarding support and services taking the findings into account.

4.2 Patient and Public Involvement

Patient and Public Involvement (PPI) is essential to research in health and social care, and PPI input can be sought at various stages of the research process including in design and affirmation of the importance of the research question (NIHR, 2014). To ensure that the proposed study design and conduct was acceptable to participants, service users were consulted and asked to provide their views to shape the methods for recruitment and data collection.

In March 2020 I attended the social meet up of a local maternal mental health charity and spoke to ten women about the study to gain their opinions on the acceptability and design of the research. The group included two women with no mental health history, eight of the group had suffered from anxiety and two had had perinatal psychiatric admissions. The women were aware of my dual identity as a midwife and a researcher. Discussion with the women indicated they thought the research question was important, and that recruitment and conduct of the study via the means detailed below (including for example using interviews rather than focus groups) would be acceptable. For a full summary of this PPI activity see appendix 3. Two of the group agreed to review some study materials (Participant Information Sheet and study flyer), prior to submission for ethical approval.

4.3 Eligibility Criteria

Interview participants were women over the age of 16 who were pregnant or postnatal (less than one-year post-birth) and experienced any level of anxiety that they perceived impacted negatively on their daily life, either pre-existing (prior to conception) or of new onset. Extending the invitation to women aged 16-18 aimed not to exclude younger women and provide the opportunity for a wider range of experiences to be heard (Crane and Broome, 2017). Eligibility based on women's perceptions rather than diagnostic criteria was in keeping with the IPA ethos of valuing the subjective experience. This approach has been used by others: in their phenomenological examination of birth trauma Molloy et al. (2021) selected women who perceived their birth as traumatic as opposed to only approaching women with a clinical diagnosis of birth-related post-traumatic stress disorder.

Inclusion criteria

- Pregnant or postnatal (within one-year post-birth).
- Age >16 years.
- Nulliparous or multiparous.

- Any ethnicity.
- Any socio-economic grouping.
- Currently experiencing symptoms of anxiety which are the sole or partial reason for referral into the antenatal clinic or Perinatal Mental Health Team (PMHT)
- Due to give birth/gave birth within the Local Maternity and Neonatal System.
- May have concomitant mental/physical health diagnoses.

Exclusion criteria

- Infant more than one year of age.
- Maternity care delivered outside of the Local Maternity and Neonatal System.
- Pregnant but not yet booked with maternity services and pre-completion of dating scan.
- Lacks capacity to consent to participation.
- Not able to complete an interview conducted in English.

4.4 Sampling and recruitment

4.4.1 Sampling strategy

Purposive sampling of a deliberately homogenous group is an appropriate sampling strategy in IPA (Hefferon and Gil-Rodriguez, 2011). The sample was derived from the whole pregnant population giving birth within the Local Maternity and Neonatal System and was a homogenous group in terms of anxiety experience and gestation/age of baby, albeit with differences in parity and ethnicity (see table 2). Participants were identified by screening of patient lists and notes in clinics, by maternity and Perinatal Mental Health Team (PMHT) colleagues, who were part of the clinical team caring for the women. A study flyer was also shared via a local maternal mental health charity, however this did not result in the recruitment of any participants.

Women who met the eligibility criteria were approached with study information, initially by a member of the clinical team (midwives, doctors, mental health professionals) briefed on the study inclusion criteria. This individual introduced the study, provided a Participant Information Sheet and requested permission for a follow up contact from the Chief Investigator. The use of such gatekeepers can be helpful but also risks the introduction of bias and blocked access (Preston et al., 2016). The issues that concern healthcare professionals when recruiting patients with mental health concerns for research

include concern about their level of vulnerability, prioritising clinical tasks over research and a lack of confidence talking about research participation within a potentially sensitive consultation (Mason et al., 2007). Two screened potential participants did not receive study information as the consulting clinician did not prioritise sharing the information.

The key reason for the use of gatekeepers for this study was to avoid potential participants feeling under pressure to participate. Perhaps because I was part of the clinical team making the initial approach, blocking from clinical colleagues was not an issue. As Joseph et al. (2016) note, valuable recruitment strategies include using existing personal contacts and building respectful and trusting relationships with potential participants. My presence in the clinical space working with colleagues making the approach and available to recruit directly proved a robust system for recruitment. A Cochrane review examining strategies to help healthcare professionals recruit to research studies noted, whilst the number and quality of studies examining this was low, the strategy that appeared to be most impactful was the positioning of a healthcare professional with responsibility for recruitment in the patient area, again supporting the approach taken in this study (Preston et al., 2016).

Follow up contacts took place via telephone and in person in the hospital obstetrician-led antenatal clinic. Using several routes for recruitment aimed to increase the likelihood of reaching eligible participants. The hospital antenatal clinic and perinatal mental health service were accessed by women with identified mental health conditions so were appropriate settings in which to identify women with perinatal anxiety.

4.4.2 Sample

The initial aim was to recruit six women, a sample size which fitted with the chosen methodological approach. The key to IPA is the detailed examination of cases with the focus on quality rather than quantity; choosing a sample which is too large can make it problematic to achieve the commitments of the methodology (Smith et al., 2022). Giorgi (2017) notes there is genuine justification for small samples in the scientific phenomenological method as opposed to just being a convenient choice. It was anticipated that the participants would complete three interviews each and if lost to follow up, an additional participant would be recruited if practicable, dependent on timescales due to the longitudinal nature of the study. Nine women were approached and given study information, seven agreed to participate of whom two later withdrew (did not attend any scheduled interviews). The final sample size was five participants and all five completed three interviews each, resulting in 15 datasets.

Table 2: Participant demographics

Age	Ethnicity	Parity (at a/n contact)	Gestation at birth	AN interview gestation	EPN baby age	LPN baby age	Type of birth
34	Asian or Asian British: Indian	G1P0	39+3	34+3	10 weeks 2 days	34 weeks	SVB
36	White British	G7P4	39+2	37+6	9 weeks 6 days	42 weeks	SVB
27	White British	G1P0	37+2	36+2	11 weeks 4 days	38 weeks	Asst VB
34	White British	G2P1	37+2	35+0	8 weeks 6 days	34 weeks	SVB
24	White British	G4P0	39+1	32+4	13 weeks 3 days	34 weeks	SVB

4.5 Data collection

4.5.1 Interviews

In-depth interviews were chosen as the method of data collection to uncover the point of view of research participants, the meaning participants ascribed to a particular subject and to provide knowledge (Brinkmann and Kvale, 2015). Interviewing is a common and useful means of collecting data for analysis using IPA (Smith et al., 2022). As Green and Thorogood (2018) note, interview data must be regarded as part of a contextual account with meaning derived in terms of the reality for the interview participant and the theoretical aspects that may arise, as opposed to being representative of a broader reality. However, one of the aims of the depth of analysis in IPA is to be able to move from the single case to cross-case analysis and the ability to make more general claims (Smith et al., 2022).

How structured the phenomenological interview is will depend on the research question and methodology of the research, however Finlay (2011) advocates a spontaneous and fluid approach that allows the conversation to change direction as led by the participant or to allow more probing by the interviewer. Paley (2016) criticised as vague the open style of interviewing in IPA, which focuses on attentive listening and interview schedules as guides rather than a prescribed set of questions (Smith et al., 2022). However, a brief interview schedule with broad open questions allows the participant to take the lead on what is important to them as well as being advantageous in giving the participant control and shifting the power dynamic which can be present in the interview process (Hefferon and

Gil-Rodriguez, 2011; Foley and Valenzuela in Denzin and Lincoln, 2008). A topic schedule was used to facilitate the interviews (appendix 2) and was carefully studied in preparation for the first interview (Smith et al., 2022). In longitudinal IPA it is critical that the mode of interviewing effectively facilitates participants to give a detailed account of their thoughts over time (Farr and Nizza, 2019). The topic schedule remained the same through each interview, only adapted in relation to the timepoint (i.e. 'How has perinatal anxiety impacted on your experience of pregnancy/new motherhood?'). Maintaining the same schedule allowed the interviews to be led by the participant, avoiding assumptions about how experience may have altered over time (Farr and Nizza 2019).

4.5.2 Interview setting

Participants had a choice about how the interviews were conducted, although were limited to online or telephone due to the Covid-19 pandemic. After two participants initially consented to video interviews but then withdrew, I speculated this was because talking about emotional experiences may have felt too intense with visual interaction. The next participant was asked whether they would prefer the mode of interview to change from video to telephone and they said they would, therefore the remaining interviews were all conducted over the telephone. All the interviews were recorded using a handheld recording device; and the anonymised data was transcribed.

4.5.3 Consent and data storage

Consent to participate was sought prior to the interview taking place. Having been given the Participant Information Sheet (appendix 4) the participants had the opportunity to discuss the study and ask questions in person or over the phone. The participants completed an online Research Ethics Committee-approved consent form (appendix 5). During the consent process the participants were made aware that their involvement was entirely voluntary and that they could withdraw from the study at any time, including during the interview, without consequence.

Data was anonymised and analysed by myself, with advice and guidance from academic supervisors. Any identifying information (e.g. on consent forms) was stored on an encrypted hospital trust laptop and destroyed at the end of the study. All anonymised materials were stored on a secure university shared drive. The anonymised transcripts will be held for ten years as per university policy, prior to being destroyed.

4.5.4 Resources: costings

This was an unfunded study which formed part of a programme of doctoral study. The cost of conducting the interviews was met by myself (the use of a research-study dedicated mobile phone to avoid personal phone use).

4.6 Data analysis

4.6.1 Common processes of analysis

Data analysis in IPA is an inductive, iterative process which includes line by line analysis; identification of personal experiential statements and themes; attention to individual cases and across multiple cases; identification of group experiential themes; the crafting of an interpretative account and structure which demonstrates the relationship between themes; and the development of a narrative account using data extracts to evidence the commentary. The data is organised in such a way that the entire process can be traced and includes researcher reflexivity. The 'steps' involved are considered common processes rather than a prescriptive set of instructions (Smith et al., 2022). Nevertheless, there is a linear process which can be followed, in part to help the novice IPA researcher master the methodology and grow in confidence. For this study the process was as follows:

- Initial listening and re-listening to the interviews and reading and re-reading of the transcripts.
- Formulating three layers of annotations, first with a focus on what was being described and use of language before moving on to conceptual notes.
- Inclusion of reflexive annotations.
- Development of Personal Experiential Statements for each participant.
- A colour coding system was used to differentiate the layers of annotations and the development of the Personal Experiential Statements (appendix 6).
- Organising and clustering Personal Experiential Statements for each participant and developing Personal Experiential Themes supported by data from interview transcripts (appendix 7).
- Synthesis of Personal Experiential Themes and initial framing of Group Experiential Themes (appendix 8).

- Development of Group Experiential Themes through interrogation of interview data across the entire dataset for each timepoint; further reflexive annotations (appendix 8).
- Creation of narrative analytical account, validating Group Experiential Themes through supporting interview transcript data, presented in chapter 5.

As a progression from the original method of IPA, longitudinal IPA (LIPA) has raised questions regarding methodological approaches to identification of themes over time. Farr and Nizza (2019) identify two approaches to structuring themes, the first involves breaking down the entire findings into a set of themes and each theme describes a particular aspect of experience across multiple time points. The second approach develops themes around a single time point and details all aspects of the experience related to that stage in time. It is this 'themes tied to time points' approach that was taken in this study, for pragmatic reasons. The time constraints of the doctoral research programme and length of time between interviews, meant it was not possible to wait for the completion of all interviews before starting analysis. In part to take a view of the complete data over time, and in part because the data revealed notions of the experience of perinatal anxiety common over time, an additional step was added to the methodology. This adjunct to the process, which is unique to this doctoral work, was the development of 'Longitudinal Experiential Concepts'.

The Longitudinal Experiential Concepts were identified as the abstract experiential notions woven throughout all three interview time points, and common to all participants. These higher-level concepts were not directly underpinned by narrative quotes but were linked to and supported by the final Group Experiential Themes (chapter 5, table 8); they were viewed as the common threads underpinning the experience of anxiety across the perinatal continuum and are further discussed in section 5.6. Figure 2 shows how the different aspects of analysis fitted together, with the LECs emerging through the interpretative activity, and unfolding in tandem with the narrative account.

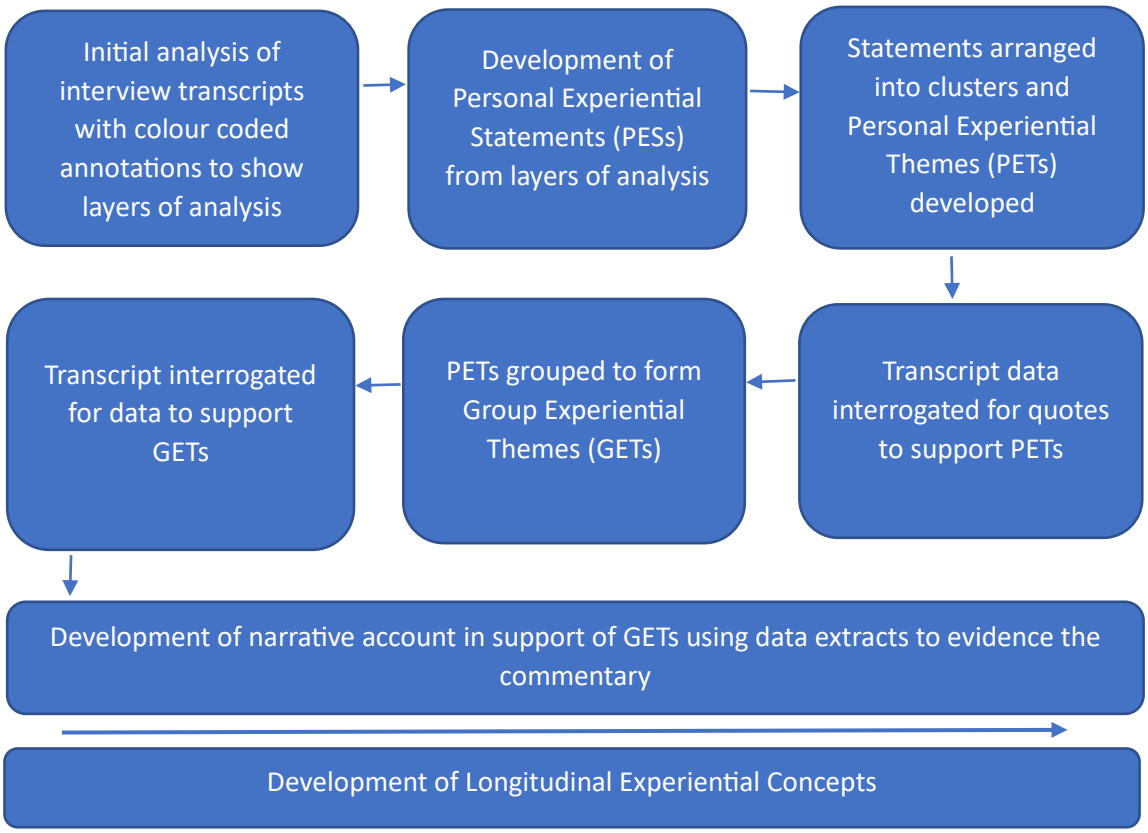

Figure 2: Flow chart to show stages of data analysis

Being guided by the original IPA 'steps' facilitated a structure to the analysis and the depth of insight which is characteristic of IPA, while reflexive annotations and diary-keeping enhanced deeper thinking. Smith et al. (2022) stress how IPA researchers move fluidly between several different ways of thinking about the data, and this was demonstrated through this process, culminating in the addition of the Longitudinal Experiential Concepts. The phenomenological attitude to analysis has been described as "a kind of dance between the reduction and reflexivity" (Finlay, 2011:74) and it is this, along with the key elements of the double hermeneutic, intersubjectivity and idiographic focus described below, which were essential to achieving a robust level of analysis.

4.6.2 Hermeneutics, intersubjectivity and idiography

Hermeneutics, intersubjectivity and an idiographic focus are three key principles inherent in the conceptual framework of IPA. According to Smith et al. (2022) use of the hermeneutic circle exemplifies the setting aside or bracketing of preconceptions. The researcher acknowledges preconceptions and moves to engage with the participant before returning to their original position irrevocably changed by the encounter. They then set aside any preconceived ideas before once again

returning to the participant. Smith et al. (2022:29) state that this "double hermeneutic" is key in the process of sense making, asking questions of the data and oneself.

Smith et al. (2022) further discuss the double hermeneutic in terms of interpretative positions (distinguished in the work of Ricoeur): hermeneutics of empathy vs. hermeneutics of questioning. The researcher seeks understanding both from standing in the participant's shoes (empathy) and alongside them puzzling over, or interpreting, their account (questioning). The authors note that effective IPA balances both aspects to develop understanding of how someone experiences a phenomenon alongside critical thinking and shedding light on the phenomenon. This includes first and foremost detailed interpretation of the textual layers, before importing any readings from outside of the text.

Another tenet of interpretation within phenomenological research is intersubjectivity: how the participant and researcher relate to one another and engage with the world, and how this influences interpretation (Lopez and Willis, 2004; Smith et al., 2022). Lopez and Willis (2004) note that nurse researchers must look beyond the interpretation and translate insights into real-life practical application including research, education and policy in order to maximise their contribution to health care knowledge. IPA therefore requires a combination of phenomenological insights (standing as close as possible to the participant's personal experience) and hermeneutic insights (acknowledging that interpretation is inevitable in formulating understanding). "Without the phenomenology there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen" (Smith et al., 2022:31).

One potential pitfall in IPA is noted by Hefferon and Gil-Rodriguez (2011), who warn against the common trap of over-identifying themes to comment on frequency. The authors note this is not the correct approach to the idiography which is inherent in IPA; a smaller number of themes is likely to represent a more thorough and robust analysis. The principle of less is more which holds with the methodology's idiographic focus extends to analysis – fewer participants, fewer questions in the interview schedule and fewer themes. This approach should facilitate greater depth of understanding, in contrast to a superficial analysis of larger numbers of individuals. Referencing Warnock (1987), Hefferon and Gil-Rodriguez (2011:758) note the "focus on the particular which can help illuminate the universal".

To address the methodological criticisms discussed earlier, the methods in this study built on the experience and guidance of those already working with IPA by using an open and brief interview schedule, ensuring attention to the depth of interpretative and analytical work, and choosing a small sample in keeping with the idiographic nature of IPA. Mindful of the criticism of those outside the field, and to address potential issues of imported external theory unduly leading the interpretative work (Paley, 2016), the study has been explicit about how the analysis dialogues with theory, supported by reflexive annotation and diary keeping (Smith et al., 2022).

4.7 Ethical considerations

The study was subject to the Health Research Authority (HRA) approvals process and local sponsor approval; no study activity took place outside of this framework and Research Ethics Committee approval was granted (21/EE/0104, see appendix 9).

4.7.1 Trustworthiness, reliability and validity

"Without rigour, research is worthless, becomes fiction and loses its utility" (Morse et al., 2002:14)

Rigour in qualitative research can be considered from both researcher and reader perspectives. Research should be methodologically sound and include measures to address trustworthiness within the design: the responsibility of the researcher. Readers should have access to robust methods of synthesising qualitative research to be able to judge its validity. Morse et al. (2002) discuss a shift in the discourse around reliability and validity in qualitative research from the onus being on the researcher to engage with strategies to address reliability and validity, to the reader being responsible for accessing methods to evaluate the validity of a study. The authors argue for the former and suggest that the criteria for trustworthiness proposed by Lincoln and Guba (1985) have been overshadowed by methods used to check back on evaluative criteria assessing the significance and impact of the research. Therefore, argue the authors, methods of rigour employed in the process of data collection have lost their credibility – shifting away from verification processes during data collection and analysis means that by the time the study is evaluated it is too late to address weaknesses. Porter (2007) discusses Rolfe's (2006) counter-position to Morse et al. (2002), which is that responsibility lies with the reader to appraise the research. Porter (2007) agrees that it is unrealistic for the responsibility for appraising validity to lie solely at the feet of the researcher: the reader must be able to make their

own assessment of quality and both elements work together to strengthen the production of rigorous qualitative research.

Porter's (2007) argument is sound – both having criteria by which to review qualitative work, and the researcher ensuring methodological rigour are equally important. Guidelines for reviewing qualitative research help ensure its legitimacy, improve scientific quality, facilitate synthesis and review and encourage development within researchers themselves and the methods used. In response to concerns around issues of quality control in qualitative research, Elliott et al. (1999) developed two sets of seven criteria with which to evaluate research, the second of which relates solely to qualitative studies and includes, for example, situating the sample and coherence. Cohen and Crabtree (2008) reviewed frameworks for validity in qualitative research and found the guidance to be broadly similar, summarised in seven criteria for good qualitative research including importance of the research, clarity of the research report and the use of rigorous methods.

Morse et al. (2002) argue that the key methodological consideration for researchers regarding rigour is in the processes built into data collection and analysis. In relation to IPA, Smith et al. (2009) initially drew on Yardley (2017) whose work on validity in qualitative research broadly centres on four dimensions: sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. The authors present an outline of the use of Yardley's (2000) criteria and how this relates within the context of IPA. For example, the researcher's sensitivity to the nature of the interaction between themselves and the participant during the interview; and coherence in producing a report that clearly fits with the principles of IPA, with the methodological choice clearly aligned with the research question and aims. Following publication of the first edition of their text on IPA, Smith recognised an increasing need for guidance specific to IPA and he and colleagues have produced papers to support this, as previously discussed (Smith, 2011; Nizza et al. 2021).

Due to my position as both midwife and researcher, it was particularly important to address issues of trustworthiness within this study. Building reflexive processes into the data collection and analysis, including use of a reflexive diary, helped with the process of bracketing and accounted for my position and thinking. Goldspink and Engward (2019 p. 292) describe a method for reflexive work within IPA, where another element of analysis is added, "attending to reflexive echoes". The authors argue this journaling practice, interwoven into the written analysis, promotes a deliberate and active reflexive focus during the move from description to interpretation, firmly positioning the researcher and adding to the trustworthiness of the work. Discussing bias in qualitative work, Galdas (2017) notes that the

issue is not whether it is possible for the researcher to remove themselves, rather how they ensure transparency and reflexivity in the data collection process. This reinforces the position of Morse et al. (2002): how best to ensure validity, and that the researcher has responsibility for attending to transparency in the conduct of their study.

The overriding reason for ensuring the trustworthiness and validity of a study is to ensure that it is ethically sound – that there is strong justification for the research question, that the methods chosen are the best possible to answer the research question and that it is conducted in such a way that it is scientifically robust. The ethical considerations for the conduct of this study are discussed below.

4.7.2 The ethics of examining lived experience

Russo (2016) cites a methodological and ethical imperative in looking beyond the third person narrative around mental health, the importance of speaking with people rather than about them. The author notes the need to establish the authority of the first-person narrative in mental health as a means of developing support systems based on authentic relationships. Ideally Russo notes, the narrator is also involved in analysis. Although IPA produces a third-person narrative, its commitment to the voice of the participant is in the detailed use of the text in creating the narrative account. This strong textual focus should enable the reader to draw their own conclusions about the interpretation of the text but remain able to clearly hear the voice of the participant, supported by effective first-person excerpts (Smith et al., 2022). IPA may not perfectly meet Russo's (2016) recommendation, but it does uphold the value of the owners of experiences being the primary voice.

"When we examine one part of a person and take that out of context, without knowing the person, it is as if we discredit the mystery of the living whole" (Merryfeather, 2014 p.61)

Holistic practice is central to midwifery. Seeing the whole woman is a fundamental principle of all facets of midwifery practice including clinical, education and research work, which does not accept that the only truth originates in empiricist academic perspectives while discounting the whole woman, in mind and body (Merryfeather, 2014). Therefore, the need to understand women's psychological experience of pregnancy and childbirth is equally as pressing as that of the physical. A recent systematic review of barriers to implementing mental health care, stressed the need for women to be at the centre of developing services, to make sure the approach in terms of flexibility, appropriate care and choice is in line with their individual needs, in all their complexity (Webb et al., 2021). This

research, in subject and design, is rooted in this holistic view – as a midwife, it would perhaps be unethical for it to be otherwise.

4.7.3 Ethical considerations for this study

The main ethical considerations for the conduct of this study related to confidentiality, anonymity, and the management of risk due to the nature of the subject matter and the time period over which the research took place being one of potential vulnerability. Defining a group as vulnerable in the context of research ethics can be problematic and lead to a lack of inclusivity. Ries and Thomson (2020) instead advocate a stance of universal vulnerability with research designed to account for this, as opposed to excluding groups of people on account of perceived vulnerability. Bracken-Roche et al. (2016) discuss the danger of excluding psychiatric patients from research is that the experiences of this group do not inform findings, which can lead to sub-optimal care if evidence does not exist to support their treatment. The authors suggest that ethics governance procedures imposed to protect these groups may inadvertently be limiting their representation in the scientific literature.

Van der Zande et al. (2017) argue that pregnant women are one such population which can be regarded as vulnerable. The authors' conceptual analysis using Hurst's (2008) definition of vulnerability concludes that pregnant women are only vulnerable insofar as a lack of scientific evidence representing the pregnant population exposes them to increased wrong. They argue that Research Ethics Committees should account for this when considering inclusion of pregnant women in clinical research. So, if the pregnant population is not by definition vulnerable, then deciding who is vulnerable requires a "context-specific consideration rather than a labelling approach" (Van der Zande et al., 2017 p.658). Hurst's (2008 p.191) definition of vulnerability is "an identifiably increased likelihood of incurring additional or greater wrong". If applied to the participants of this study, who were experiencing psychological vulnerability in pregnancy, it follows that the need was not to exclude them but to ensure that the research design did nothing to increase the chance of harm while supporting full participation.

4.7.4 Psychological safety

This study asked women to talk about their experiences of living with perinatal anxiety, and some of them experienced concomitant mental health conditions including diagnosed psychiatric disorders and physical ill health. There was therefore a risk that the content of the interview could raise difficult

emotions and it was vital to ensure that an appropriate support plan was in place should that happen. Several measures were taken to address this as previously described, including the option of pausing or terminating the interview and debrief and/or signposting should a participant become distressed or identify unmet psychological needs. The Covid-19 pandemic added another layer of significance to this approach; Townsend et al. (2020) recommend that for participation in mental health studies in the context of a global pandemic, it is especially important that researchers account for the impact of limited services for further support and factor in debriefing in case a participant becomes distressed. Even though the interviewing mostly took place at a time when the pandemic was under greater control, it was still important not to underestimate the fact that some participants had traumatic recent experiences related to Covid-19.

Assessment and management of risk

The main risk of taking part in the study was potential triggering of psychological challenges which the participant may not have been fully aware of or have support in place to manage. Although all the participants spoke with emotion about their experiences, sensitivity in the interviewing approach (for example not pressing them to expand on audibly difficult topics), meant none of them became overly distressed and required the termination of the interview or additional support measures. Plans to manage risk, regarding referral to support services, concerns about participant safety leading to an emergency referral or safeguarding referral, did not need to be actioned as no safety concerns arose.

Flexibility

There are external pressures on women at this stage of life, such as caring for other children or their new baby, or juggling work and family life. Therefore, the interviews were arranged at a time that most suited the participant, with flexibility when arrangements needed to change with short notice, which happened on several occasions. Flexibility is advised by the NIHR (2020) to facilitate a positive research experience for participants. Due to the pressures associated with the early weeks with a newborn, follow up postnatal contact was planned no earlier than 6 weeks post-birth and the first postnatal interview did not take place before the new baby had reached 2 months of age.

Benefit to participant and confidentiality

There was not any direct benefit to participants in taking part, however the key findings of the research are under peer review for publication, to inform the evidence regarding how best to meet the needs of women experiencing perinatal anxiety.

Data collected during the study was anonymised, and once transcripts of audio recordings had been checked, the original recordings were destroyed. Participants were asked to maintain the confidentiality of other individuals mentioned, those with either a personal or professional relationship with them. When the participants inadvertently identified specific details about individuals with whom they had interacted, the transcript was redacted accordingly. The involvement of the participants themselves remained confidential among the researchers and clinicians approaching women regarding participation.

4.8 Chapter summary

This study sought primarily to improve understanding of how anxiety over the perinatal period is experienced as there is a lack of current evidence examining this. These insights inform the practice of health professionals caring for women in pregnancy and the transition to motherhood. The approach taken, interviews and analysis using longitudinal IPA, was specifically chosen to position the experience and voice of the woman at the centre. The analysis sought to maintain close attention to the women's stories whilst being explicit about how meaning was derived including researcher position and with the import of extant theory. Chapter 5 details the findings of this analysis.

CHAPTER 5: FINDINGS AND ANALYSIS

5.0 Introduction

The five study participants (pseudonymised in this thesis) were each interviewed three times, once during pregnancy and twice postnatally. The fifteen interview transcripts were analysed according to the principles of Interpretative Phenomenological Analysis, as described in chapter 4. Once the initial phase of analysis was complete, narrative accounts were structured, and these form the bulk of this chapter. The narrative accounts are presented in three sections, antenatal, early postnatal and late postnatal. The narrative accounts support the Group Experiential Themes (GETs), which in turn underpin a novel methodological step, the creation of Longitudinal Experiential Concepts (LECs). These lay the foundation for further examination through the detailed discussion in chapter 6.

Understanding participant characteristics

Although not known prior to the interviews taking place, the doctoral data analysis revealed that the participants in the study all experienced at least one antecedent and consequence of perinatal anxiety (Folliard et al., 2020). Although inclusion in the study was deliberately framed around self-identification of anxiety symptoms in pregnancy, this finding confirms that the presentation of the participants is in line with the conceptual understanding of perinatal anxiety in terms of antecedents and consequences and provides some context to the background of their narratives (table 3).

Table 3: Participant experiences of perinatal anxiety antecedents and consequences

Antecedents and consequences of perinatal anxiety	**Observations of participant history from interview data**
A trigger or triggers from the biopsychosocial spectrum, either as a single factor or combination of factors *(Antecedent)*	Adverse childhood experiences (Gabi, Sam) History of diagnosed psychiatric disorder (Meena, Gabi, Lucy) History of domestic abuse (Gabi) History of sexual trauma (Gabi, Kate) History of perinatal loss (Lucy) Physical health condition (Gabi, Kate) Pregnancy complications (Kate, Sam) Relationship difficulties (partner or family) (Meena)
Events arising from the experience of perinatal anxiety which have short, medium or long-term sequelae for the fetus, infant, child or mother, which may be of a biological, psychological or social nature *(Consequence)*	Impaired social functioning (Meena, Gabi, Kate, Sam, Lucy) Emotional withdrawal (Meena, Sam, Lucy) Agoraphobia (Gabi, Lucy) Low mood/depression (Meena, Sam, Lucy) Lack of sleep (Sam) Compromised bonding and attachment (Lucy) Intrusive thoughts (Lucy) Hypervigilance (Gabi, Lucy) Infant avoidance (Lucy)

5.1 Summary of Group Experiential Themes

Table 4 shows the finalised Group Experiential Themes and subthemes. The development of Longitudinal Experiential Concepts was an additional analytical step, as discussed in chapter 4, added to represent the emergence of higher-level concepts related to the experience of perinatal anxiety over time. The formulation of the Longitudinal Experiential Concepts and how they are underpinned by the GETs is detailed in section 5.6.

Table 4: Summary of Group Experiential Themes (GETs) and subthemes

ANTENATAL GETs	EARLY POSTNATAL GETs	LATE POSTNATAL GETs
THE ANXIOUS MOTHER Otherness Burdens	BABY AS EXTERNAL FOCUS Comfort Distraction Optimism New worries	MOVING ON Coping Acceptance Resolutions
TRANSFORMATION Fighting with self Temporal collisions	RETURNING TO ONESELF Finding the way back Looking forward	SHIFTING SANDS This too shall pass Omnipresent
SETS OF EARS Reflecting and self-understanding Feeling heard Safety net	THE EMOTIONAL UNKNOWN Relief and overwhelm State of flux	
THE ANXIOUS PREGNANCY Lonely and unmagical Grasping psychological safety		

5.2 Antenatal experiences

Table 5: Antenatal Group Experiential Themes (GETs) and subthemes

GROUP EXPERIENTIAL THEME	**SUBTHEMES**
THE ANXIOUS MOTHER	Otherness Burdens
TRANSFORMATION	Fighting with self Temporal collisions
SETS OF EARS	Reflecting and self-understanding Feeling heard Safety net
THE ANXIOUS PREGNANCY	Lonely and unmagical Grasping psychological safety

5.2.1. The anxious mother

The anxious mother theme arose from how the participants described the experience of being anxious during pregnancy and how their status as the anxious mother set them apart from others, both within their close social relationships and the wider context of societal expectations. This brought a sense of otherness to their stories. The participants also described how the status of mother when combined with anxiety brought an added sense of responsibility which through their negative portrayals was conveyed as a burden common to them all.

Otherness

A clear theme across the participants' accounts was a sense of otherness, how being pregnant and anxious rendered their experiences not *normal*, that they were somehow set apart. This theme was strongest for Gabi, Kate and Lucy although was also touched on by Meena and Sam. Gabi described the feeling of observing other people in a waiting room and reflected what she suggested was a hidden struggle which set her apart:

"I could look as normal as they come and yet I have this every day." (Gabi, AN)

For Gabi, her sense of not being able to behave as others did partly related to her fear of attending maternity appointments and that her inability to do so made her out of the ordinary. Her reference to the concessions her family made to help her manage these occasions added to the sense that making these demands of them was extraordinary behaviour. The strength of feeling was demonstrated as she stated she would not have attended appointments alone:

"I wouldn't have gone to these appointments on my own. There would be occasions where my mum can't come with me so he's had time off work, if I had just been normal I could have just gone by myself." (Gabi, AN)

Lucy also referred to perceived normalcy relating to the social experience of pregnancy and how she interacted with her peers. She expressed a sense of loss as she described sadness and lack of excitement as her anxiety restricted the routine social experience of pregnancy:

"It's really I guess saddening to not be able to do all of the things that you want to do during pregnancy. Like you want to be able to go out with your friends and go baby shopping and for it to be really exciting and go out for little coffee dates and just the normal sorts of things during pregnancy, and it just holds you back." (Lucy, AN)

Kate also described a hindered social experience as she restricted her contacts due to worries about the Covid-19 pandemic, for example missing out on a leaving work celebration. She also expressed a wish to know that her pregnancy was *like every other*, indicating a similar desire to Gabi and Lucy, to fit within the demographic of a 'normal' pregnancy:

"Yeah I think at this stage of pregnancy well we've had the scans and everything and they measure the weight and movements; I think it's all a big reassurance that it's like every other pregnancy." (Kate, AN)

Meena's feeling of otherness related to a sense of whether her anxiety meant she should legitimately occupy the pregnant space, whether she was behaving irresponsibly in pursuing a pregnancy at a time when she was experiencing heightened anxiety. The hesitancy in her speech implied a sense of uncertainty around possible rule breaking, which again played into the perception of social norms and acceptable behaviours:

"Yep so um there have been times where... I have thought to myself, erm, probably I shouldn't be carrying now." (Meena, AN)

This hint at illegitimacy was also expressed by Gabi, who in describing how she managed when her husband or mother were unable to attend appointments with her, referred to making an *excuse* for not attending appointments which was *lame*. This suggested that she sensed her fears were overblown or invalid, that being anxious was not a good enough reason for not attending:

"I can't go into appointments on my own, I have to have someone there, if not I make some lame excuse that I can't get there or whatever." (Gabi, AN)

Gabi was concerned about how she presented to others, how she may have been perceived. This concern about how one presents externally was shared with Lucy, who explained that trying to fit with

how others expected her to behave and not reveal the impact of her anxiety meant she was not being genuine:

"Other people are excited for you and just want to buy things for the baby and actually you are putting on a bit of a fake side of 'ooh I'm so excited blah blah blah', but actually it's just a constant worry about everything." (Lucy, AN)

Fear of other peoples' perceptions was also a feature of Kate's narrative as she described feeling highly anxious early in pregnancy when she contemplated sharing the news with others, which implied a worry about being judged for her choices:

"I think it was the initial shock more than anything of oh my god I'm pregnant, how do I sort of handle this kind of thing, sort of, how do I tell people, what are people gonna think?" (Kate, AN)

Concerns about external presentation, judgment, and a need to adopt alternative realities brought a sense of conflict to the stories which built a feeling of the participants being set apart. Meena noticed that when her anxiety escalated significantly it stopped her from being able to connect with others who may have offered support, which further added to a sense of isolation:

"Other times I can reach to that panic attack level, you know like extreme level where no matter what anybody says erm, I'm not receptive to that." (Meena, AN)

Gabi was also familiar with the experience of anxiety on an extreme level and was explicit about how this meant she was not like people who were anxious in a way she regarded as understandable, for example anxiety about starting a new job. Gabi perceived that her anxiety was not on a level which was simply an expected response to everyday situations:

"There's anxious and then there's completely anxious. And people get anxious every day when they start a new job but I feel like my anxiousness is a hundred times higher and that's without starting a job." (Gabi, AN)

The experience of these highly anxious states which separated the participants from other pregnant women, altered expected pregnancy behaviours and controlled social functioning, was neatly described by Lucy:

"I think a lot of women do put it out there that it's the most amazing, magical time and every day you should be grateful and not complain about how you're feeling. Stuff like that and I think when you've had a really difficult experience where the pregnancy isn't that easy, it should be a little bit more normalised I guess that it's really OK to not enjoy it." (Lucy, AN)

Anxiety hindered the participants' social experience of pregnancy, and this caused them to feel as though they were set apart from other women. Gabi touched on how this felt as a mother, encouraging herself to *come on mum* and put on a *brave face* to attend her son's appointment, suggesting that for her anxiety in pregnancy did not just set you apart as a pregnant woman, but also as a mother:

"So I got out the car and I was like 'come on then mum' and I put on my brave face, but my husband did make sure that he parked straight in front of the A&E so we just stood at the window. We weren't sitting down like everyone else normally would sit down I was just stood by the window just watching the car…" (Gabi, AN)

A deep-rooted responsibility weighing on the participants to fulfil the perceived maternal role was a theme that echoed across the narratives, bringing a second facet to the anxious mother theme.

Burdens

The participants' perceptions of being a pregnant woman with anxiety were portrayed negatively, with all participants describing experiences which were conveyed as weighty, hence the focus of this subtheme being burdens. Meena directly referenced the worry she felt for her unborn child in having an anxious mother:

"I've read that you know that mothers with anxiety or depression or mental health issues, er.. (their) children can develop problems with, you know, in their life like ADHD and stuff like that yeah so you know it certainly has er, erm worried me. It still worries me, I'm not gonna lie." (Meena, AN)

The status of being the person to determine the future wellness of the unborn child was echoed by Gabi. The sense that this will be influenced by what has happened in utero, which she may be solely responsible for, was heightened by reference to the moment she *comes out*, suggesting that the

baby's emotional state at birth was already determined and therefore emphasising this was all on Gabi's shoulders:

"When I'm pregnant it's me and only me that can protect her. So yeah, I think being pregnant makes it a little bit worse because everything I'm doing and everything of how I feel I just didn't want it to impact her. I don't want her to come out and be a worried baby, I want her to come out and be a happy baby, do you know what I mean?" (Gabi, AN)

Kate also described her responsibility for protecting the baby, *wrapping up in cotton wool*, ensuring that the pregnancy is progressing healthily. The repetition of *best you can* gave a sense of her encouraging herself to keep trying to do her best while at the same time being kind to herself in recognising this will be *her* best effort:

"You want to do everything best you can to protect it and make sure everything is going ok, best you can before she's born. Make sure everything is ready and you keep on top of things. It's like wrapping someone up in cotton wool. I know they say you shouldn't do it but it is something that it does definitely." (Kate, AN)

Doing her best was a sentiment shared by Meena, in terms of the motivation to reduce her anxiety and protect the baby:

"I don't know how [anxiety] would affect the baby, um and that was what I was worried about. Frankly that was one of the reasons why I tried to er, er do my best to kind of, er… I know it's easier said than done but kind of not get anxious as much as I can." (Meena, AN)

The burdens described by the participants were not just directed towards protection of the unborn baby. Lucy's fears about loss were partly around how she would respond to others in the event of an adverse pregnancy outcome. Her anxiety was heightened because her confidence in the pregnancy was low compared to those around her, which also added to a sense of her being on the outside:

"And even though people were saying oh I know this will be OK and they will be the one but I was like how, how do you know? By people saying that it was like I knew that it wouldn't be okay and how do you then go to those people and tell them something bad has happened? And say well actually you were wrong…" (Lucy, AN)

Sam's maternal burden also extended beyond her pregnancy and the responsibility for the unborn baby, highlighting a sense of needing to protect her daughter and close family from potential loss. The emotion she verbalised using the language of *failure* indicated the extent to which this weighed on her as a mother: she was not just responsible for keeping the pregnancy and the baby alive, but also the hopes and dreams of her close family network:

"My… I'm going to get emotional now… my biggest worry was having to tell my four-year-old that she wouldn't be getting the brother or sister that she'd been told she'd be having. How do I explain to a four year old that the baby died? I just lay there replaying the conversation in my head that I'd have to have and feeling like I'd failed her as a mum, because I didn't fight hard enough to get the support I needed…(tearful)… even though I was doing everything I physically could. And you know and having to see my husband lose a child and my in-laws lose a grandchild, it just felt like it was all on me to keep this pregnancy and this baby alive." (Sam, AN)

Gabi was also audibly emotional when describing the responsibility she felt for her husband's wellbeing and how her anxiety had a detrimental impact on him. She was at fault for putting this additional pressure on him, with the idea that she was causing him to be overworked:

"I feel like my anxiety for my husband has dragged him down. It's hard for him because I feel like I can't just go to Asda if we need something so he'll go (tearful). So I feel like I'm overworking him, he'll work all day and then he'll come home and if we need a shop he'll go or we'll try and go, but yeah I think I put a lot on him." (Gabi, AN)

A sense of responsibility for their unborn babies and their partners and families underpinned this subtheme, with negative connotations rendering the pregnancy experiences of the anxious mother burdensome.

5.2.2 Transformation

This theme related to how the participants viewed themselves within their experience, most specifically highlighting incongruence between the person they were prior to and during pregnancy as determined by their anxious state, thus providing a sense that a transformation was occurring. This was expressed as a disconnect with their sense of self, partly in terms of the relationship between mind and body, characterised by reference to them battling with themselves. Further this theme was

expanded in terms of temporality, as the participants made sense of their transformations through reflections on the past, present and future. Within their discourse there was a sense of these temporal perceptions colliding which gave a sense of disorientation within their lived experience.

Fighting with self

For some of the participants the experience of anxiety in pregnancy became a battle with themselves which related explicitly to the mind-body dynamic. Describing the timing of the onset of heightened anxiety, the early stage of pregnancy was when Kate first started to feel she was not herself:

"So I had three months of morning sickness to start with, erm which was a little bit daunting because, er, you just really want to look after baby, you just want to be yourself, you don't want to be being sick all the time, so that was kind of playing on my mind a little bit." (Kate, AN)

Craving a different experience of pregnancy was also referenced by Lucy who described being engaged in a fight with herself, giving an indication that the stakes were especially high when there was no guarantee of experiencing pregnancy again in the future. There was conflict in how Lucy wanted to feel and behave as the anxiety caused her to shut down, alongside pressure related to the uncertainty surrounding future pregnancy:

"So I think you're just fighting with yourself trying to do things because you don't know if you'll experience it again but at the same time your head is just shutdown. It's like you can't do this, you just need to stay in the house. Something will happen if you go out and it's just quite difficult I guess." (Lucy, AN)

For Lucy the ability to physically leave the house was determined by whether her mind would allow her to do so. Later she described seeing herself as someone who wanted to leave the house, and therefore her self was disconnected from her body with physical action in thrall to her anxious mind:

"…again like fighting with yourself, I want to go out but is my brain and body going to allow that kind of thing. Am I gonna step out the door and then panic and then want to be back at home?" (Lucy, AN)

Gabi also reflected on how her anxiety limited her physically, also with a sense of engaging in a struggle (*trying*) to be less anxious so she could attend appointments, which contrasted with her behaviour

outside of pregnancy (where she would happily not attend appointments with no internal conflict arising). This indicated that the struggle arising for Gabi was rooted in the drive to maintain a healthy pregnancy:

"… through the pregnancy I then notice I try not to be so anxious where, if I wasn't pregnant and I had an appointment I'd think balls to that and I'd cancel it, I'd just think I can't physically do it today." (Gabi, AN)

Meena similarly described an internal battle, noting that her ability to gain control over the anxiety was variable, and she also hinted at a sense of resignation or acceptance of this being how she was:

"I try to fight it and it can be quite good sometimes but not so great sometimes and in a way I've, I've, erm I've learnt to live with it." (Meena, AN)

For other participants any acceptance of the anxiety as a part of themselves seemed more immediately profound within the context of their current pregnancy, leading to a sense of helplessness as shutting down became a feature. Sam recognised a clear connection between her anxiety, a sense of defeat and lack of being able to function:

"Didn't talk to anyone, my friends did invite me out for lunch and stuff, I didn't do that, didn't have a baby shower, didn't want to plan anything because I didn't think I was gonna get to full term. My sister was really excited for me to have a baby shower and I was like why? What's the point? Might as well plan a funeral because I'm not going to get there. I was just defeated." (Sam, AN)

Gabi also referenced eventually 'breaking' and giving in to the anxiety, again a sense of being overcome by it despite her best efforts:

"But I think yeah being pregnant… you don't want to be overanxious because you don't want them to sense your worry, so you don't want to think too much into anything because you don't want to stress the baby. So, you keep as level a head as you can but then you have the odd moment when you break but then you just sob and then think I need to stop because they can sense your sadness. You try and just knock it on the head as much as you can but sometimes you just can't help but break." (Gabi, AN)

The result of such levels of anxiety leading to a loss of function was in part responsible for building on the sense of disconnect between the participants and who they really were: they could not be the well and functioning pregnant women they wanted to be. For Lucy the point at which anxiety caused her to stop behaving in a spontaneous way and embracing life was abrupt and signalled a change in who she was:

"I used to love just getting up and going out and I was definitely more spontaneous than I am now and I would just be let's go here, let's go there, let's go out and enjoy the day. Whereas now it has to be planned and if I have a bit of an off feeling about it, it won't happen… I suddenly switched one day." (Lucy, AN)

Kate also noticed a sudden change in her level of anxiety which shifted her view of herself, with the realisation that she was far removed from the person she had been following an admission to hospital, her reference to being hit suggestive of an attack:

"That was when the anxiety hit, going through all the scans I had to go through and him not being able to be there and being sick and not being very well and I was like this just isn't me. That's when it really hit" (Kate, AN)

Meena on the other hand recognised that suicidal tendencies were a part of her makeup, however during pregnancy noted that due to the anxiety these were on a different level, the worst she had ever experienced:

"Due to the anxiety I had, I had suicidal tendencies as well, erm, that part of me my worst, worst ever during my pregnancy but erm ever since then I still have had quite a few lows." (Meena, AN)

The gravity of the anxious feelings was also described by Sam, who began to question the validity of her perceptions about her pregnancy which in turn threw in to doubt her own rationality:

"I felt like I was going crazy. I started to believe them, like maybe I'm not, maybe this is all in my head, maybe I am just being a hypochondriac and maybe… and then you think I can't think like that because if I am right I'm putting my child's life at risk… I was laying awake for hours playing through the conversation, questioning myself, like am I actually going insane right now? And is what everyone is telling me right, or is what I know I'm feeling, what I know is right?." (Sam, AN)

For Lucy the impact of the anxiety on her behaviour was so stark that she didn't view herself as someone who was actually experiencing being pregnant:

"And go out more and experience actually being pregnant instead of hiding in the house quite a lot. Yeah so it just puts a little bit of a downer on it experience wise because who knows if you are ever going to experience pregnancy again?" (Lucy, AN)

Anxious not to lose the battle and find herself in that *low place*, Meena described keeping herself busy, suggesting if her mind was occupied away from worrying then she would be victor in the fight:

"I'm trying my best to distract myself, just so that I don't want to give in and be in that low place again." (Meena, AN)

The participants' stories featured internal battles with themselves, the flavour of which varied, however the essence of these remained: how the conflict caused by experiencing anxiety in pregnancy served to make them feel that they had been transformed from the women they once were or wished to be.

Temporal collisions

This subtheme was particularly strongly expressed by Lucy and was a feature for both Kate and Gabi. These participants tended to reflect on their current anxious states and made sense of this in terms of time, thinking back, projecting forward or both. Their descriptions gave a sense of their perceived transformation, with the significance of time and where they currently sat within a journey which was unfolding. For Lucy this meant thinking back to her own happy childhood while considering her motivations for recovery from anxiety and what this meant for her unborn baby's future:

"It's definitely all around the baby. I had a really lovely childhood of constantly going to parks and theme parks and the zoo and swimming and all of that and it's like I cannot have my children not experiencing that because I can't leave the house… It's definitely that motivation to get up and get out, I would hate it if I was just keeping the baby in the house because I needed to stay in the house." (Lucy, AN)

Kate's past experiences also played into the future she imagined for her baby, however for her the worries were around the baby being free from physical ailments, which she found reassurance over following her fetal anomaly scan:

"…when I was born I was born with a diaphragmatic hernia and one of my biggest fears during pregnancy, and I've got scoliosis as well, was that baby is going to have the same. So that played a big part on my pregnancy as well, and so luckily she's healthy and she hasn't got anything that I had or I've got so I'm quite lucky in that respect." (Kate, AN)

Lucy focused heavily on current, day to day experiences, giving a sense of the constancy of living with anxiety and the unpredictability of the condition**:**

"You know at the moment again sort of day to day, sometimes I can go out and be out all day and not take any of my meds, you know like my lorazepam, and then sometimes I try to go out without it but then we'll be in the car and I get anxious and have to take it. And then sometimes I just wake up and think I need to take a lorazepam because I'm just full of anxiety." (Lucy, AN)

In considering her future Lucy imagined further uncertainties to come (her past imaginings of having a baby did not reassure her), unable to predict how her future experience of anxiety would compare to the present:

"I've always thought about having a baby but then it's like Oh my God it is actually happening. What's going to happen after it's here, is everything going to be okay? Am I going to be a good mum? Just everything goes through your head. But during the actual months of being pregnant it's am I prepared, have I got everything, am I buying too much, am I buying enough?" (Lucy, AN)

A focus on the future was also significant for Gabi, who colourfully described how she viewed the aim of psychological therapies in terms of time:

"I did contact the Wellbeing [service] and they said is it counselling you want to conquer your past or is it a cognitive behavioural therapy you want to conquer and challenge your future. So I said it's the challenging the future I need. I said the past, to me the past is dead and I try not to let that get to me now." (Gabi, AN)

When Kate considered her future, she provided a feeling of hope and optimism around the baby's arrival, along with a sense that she would gain psychological strength from the baby:

"But yeah I think knowing that she's, I'll be bringing this person in kind of gives me like a little bit of light, that I've got to be strong for her if you know what I mean." (Kate, AN)

For Lucy any optimism was tinged with worry over regrets when looking back at how her anxiety had limited her experience of pregnancy and whether she would think she should have done more to manage her symptoms and behaviours:

"And then you're like thinking when I'm not pregnant am I going to look back and wish that I had done more? (Lucy, AN)

Gabi again sounded determined that she had no intention of looking back once the baby arrived:

"My aim of the game is to concentrate on my future. To concentrate on getting out of the house, letting my kids live a little, taking them to places they want to go without me worrying." (Gabi, AN)

For Lucy, Gabi and Kate, their experiences were meaningful within the context of time, with their perceptions shaped by what had gone before and what was to come as well as their present, and how their personal transformations played into their sense making. It is worth noting that Meena and Sam did not engage in the same reflecting back and forward in terms of their past and potential future experiences of anxiety. For Sam this may have been because she did not identify experiencing anxiety outside of pregnancy and was certain that once the baby arrived she would no longer experience anxiety. Meena was less forthcoming around what lay at the root of her anxiety and so her discourse was very much focused on her current experience.

5.2.3 Sets of ears

The title for this theme came from a comment from Meena, who described the input from the perinatal mental health team as giving her a 'set of ears to listen to myself'. Descriptions of different support functions were present through all the participants' stories, and the combined elements of support started to emerge as distinct sets of ears, operating in different ways but together creating a multifaceted safety net of support. Listening was a key characteristic of how these sets of ears were

helpful to the participants (or detrimental when not being listened to), and the subthemes that developed came from the emergence of the different functions of these listening relationships, whatever the source of them may have been. The functions became the subthemes of 'reflecting and self-understanding' and 'feeling heard'. The third subtheme, 'safety net', reflects the sense that when these sets of ears combined this provided powerful reassurance which met a spectrum of need and therefore gave an overall sense of the participants being psychologically held. Where the intermeshing of the sets of ears was not apparent, there were gaps in the safety felt by the participants.

Reflecting and self-understanding

Meena's reflection on the sets of ears demonstrated the function of the professional support she received in facilitating self-reflection which helped her to make sense of her feelings. There was a strong sense of Meena feeling empowered through this process as she discovered her agency and started to work out how to manage her anxiety:

"With the perinatal mental health team and the crisis team it gave me… erm, it gave me a set of ears to listen to myself or listen to my worries or the reasons for my anxiety, erm… and eventually the negative thoughts and suicidal tendencies whatsoever uh… and it kind of made me understand what was really causing the problem and what I can do to help myself rather than sit there and worry." (Meena, AN)

For Gabi the desire to have a greater understanding of her mental health was a conscious decision which led to her completion of a mental health awareness course. It was striking that this decision did not only help Gabi, evidenced by her awareness that there were only odd days when she felt she was not in touch with overcoming anxiety, but also how her ability to understand and help others added to the sense of empowerment she gained from this:

"I do try to challenge myself… in lockdown I needed to try and understand myself and others more, so I did do the mental health awareness level 2 course to try and help myself but also to see the signs in others and try and help them… Erm and since then you know I have the odd day where I feel I should have done better, I should have set myself another challenge and I haven't." (Gabi, AN)

A consistent set of ears through Lucy's pregnancy was the therapeutic support from the Wellbeing service, with whom she worked on overcoming her pregnancy agoraphobia. For her the function was twofold, allowing her greater self-awareness and the ability to function in a practical sense:

"Having different techniques about how to relax a bit more and to focus on myself a bit more, also understanding the feelings that I feel when I'm anxious, has definitely helped to get me out and to get back to a bit more normality in life I guess." (Lucy, AN)

As well as sets of ears coming from professional sources, Kate described the value she saw in being able to speak to someone on more of a peer-support basis, someone who would have a shared experience with her and that the value of that common experience would provide her with the ability for reflection based on their insights:

"Initially I thought it would be nice to talk to someone, not who has been through what I've been through, but kind of in the same sort of – someone who I could reflect off who has been through what I have been through." (Kate, AN)

Sam was the only participant whose experience of pregnancy was overwhelmingly defined by how little support she had, and she described how she also would have valued the opportunity to connect with someone who really understood how she was feeling. The expression of this conviction was strengthened by her positioning people without that shared experience outside of the realm of support she would be reassured by - as though it was worse to speak to someone who thinks they understand and doesn't than to speak to no-one at all:

"And it's really hard to speak to them because I haven't got anyone who has been through obstetric cholestasis. No-one understands what it's like to literally want to rip your skin off because it's itching, they're like oh yeah I itched in pregnancy, I'm like you didn't itch in pregnancy, you might have had a little scratch one day. I'm like itching for five days straight, I've literally got welts on my skin where I've itched it so hard and nobody understands, nobody understands that when you're sitting there at 3 o'clock in the morning and there's nothing you can do to stop the itching." (Sam, AN)

The other set of ears which was relevant to participants was from partners, family and friends. Lucy recognised that the support her partner was able to provide was limited by the fact that he didn't have

any shared understanding of how it felt to experience anxiety, and again that it was perhaps easier not to talk about how you are feeling than to try and explain to someone who can't understand:

"It's quite difficult because he doesn't necessarily suffer with anxiety and things so I guess it's quite difficult for him to understand why on a certain day I'm acting the way I'm acting or feeling the way that I'm feeling because of the anxiety. And trying to explain that to somebody that doesn't suffer from it or hasn't experienced it is really difficult." (Lucy, AN)

With a contrasting experience which confirmed the esteem in which shared understanding was held, Gabi valued the fact that her mum's experience of anxiety meant she was trusted as a voice of authority, her mum reflecting her own experiences as Gabi tried to make sense of how to manage life. As Gabi and her mum talked about Gabi's anxiety she listened to her mum's advice:

"Well my mum used to have panic attacks and anxiety as well because of my dad for many years. So you know when I got to that point she was like well you need to try this, and you need to try and push yourself and you need to try and challenge yourself, so each day to me is a challenge anyway." (Gabi, AN)

Feeling heard

The connection with shared experience was one way in which the participants as a group felt that they would genuinely be heard. A sense of feeling heard and the validation that provided, as well as the opposite if you were not heard, was common among Meena, Kate and Sam. Kate felt this from a midwife whom she considered the first person to really listen to her mental health concerns, and she described how this made her feel cared for. This suggested that it was not only those with shared experience that could provide this level of validation; perhaps it was reassuring to feel heard by a healthcare professional:

"That actually made me feel like someone cared, I mean not like cared as in like was listening to me, do you know what I mean? … it was nice to have that little bit of support from somebody that actually understood and listened to what I needed to say." (Kate, AN)

Sam similarly found that the midwives listening to her resulted in an improvement in her stress levels and this positively impacted her ability to function. The power of being heard was demonstrated by

her awareness that this not only reduced her psychological symptoms but enabled an improvement in her physical wellbeing as her appetite returned:

"Probably end of August/beginning of September, was when like I started being able to eat a little bit better. But again that's when the specialist midwives got involved so that took some of the stress off me because somebody started listening." (Sam, AN)

Meena's experience of being heard by healthcare professionals was positive, however she had a different experience with her partner. His lack of interest in or validation for how she was feeling was painful for her as evidenced by her connection between that and the escalation of her crisis:

"My partner could have been a bit more supportive – that's the only thing I would say would have changed it dramatically, I wouldn't have gone into such a low point otherwise." (Meena, AN)

Prior to the point that midwives listened to her Sam described the significant impact of not being heard in common with Meena, also with the resulting negative feelings around feeling unvalued:

"Literally defeated. I thought why, why am I trying to have a second child? I just felt like I'd been written off. She's obviously not going to make it so…that's the only way I can describe it is that nobody thought I was going to make it. So they thought we'll just keep palming her off since eventually she won't be on our books. Nobody treated me like I was having a baby." (Sam, AN)

By contrast once the midwives and subsequently medical team started listening, Sam described an interaction which was less autocratic and provided her with autonomy which led her to feel a sense of agency and respect:

"…she was the first consultant I had spoken to who had sat down and said what do you want and let me say what I needed and then she said what they could do and we came to a working compromise. I wasn't being dictated to, I felt listened to…" (Sam, AN)

For Sam feeling heard was a turning point in how she felt in the time leading up to birth. She was finally able to express legitimacy in her existence, rather than feeling invisible:

"I feel like I am on someone's radar. There's a date booked, something planned in. People are aware I'm coming in and having a baby and I am going to have that one-on-one care because it's planned." (Sam, AN)

Safety net

The ways in which the varied sets of ears were present for the group gave a sense of support being multifaceted. Where there was effective support both from personal and professional relationships, it led to a sense of feeling robustly held. Lucy's and Gabi's accounts did not reference a lack of support across any of the personal or professional sources, so have not demonstrated this theme. However, for the others, where one aspect of support was lacking this led to greater anxiety and disconnection and this came across from Meena, Kate and Sam. Meena described effective access and support from professional teams and her family and friends:

"I have had regular antenatal appointments with my midwife and she has been supportive and in fact she is the one who referred me to the… perinatal mental health team in the first place… I haven't contacted the GPs to be honest so I naturally haven't received any support from that side…And I've also got support from my friends as well so those other things in addition to my family, yep." (Meena, AN)

"And the support of Wellbeing, in terms of tackling my OCD, is helping… I can call when I need anyone, in terms of professional help or if I want to access I've got all the numbers that have been given to me whether that's from the perinatal team or whether that's from crisis or Wellbeing." (Meena, AN)

However as also referenced above, the minimal support from Meena's partner was problematic and the lack of care she felt from him was distressing:

"I think with my partner it's a bit different… at times he is not that supportive, he dismisses me, which is one of the concerns I still have." (Meena, AN)

In contrast to Meena, Kate felt that the level of professional support from midwives was limited as she struggled to have midwifery contact during her second trimester:

"I felt there was a lack of support and I felt kind of like I was doing it all by myself. Although there was like my partner, but like you know outside of the home there wasn't anybody." (Kate, AN)

The support Kate later had from the Wellbeing service was valued in terms of the contact it provided her, which she recognised as having a different support function from that of family and friends. For Kate this seemed to be about distance - the close support she valued from her mum and partner and the distance she needed from the therapist:

"I kind of carried on with it purely because it's somebody to talk to at the end of the day… It's somebody different to family, friends and although you can talk about pregnancy or talk about whatever you like, it's that extra person." (Kate, AN)

"Someone who doesn't quite judge you for who you are and they just talk to you openly and they don't know an awful lot about you they're happy just to… and that's been quite reassuring." (Kate, AN)

And when Kate felt unsupported by professionals during a hospital admission, she explicitly stated needing her partner to be present to pick up her unmet support needs:

"I just kept saying to them I just want to see my partner, my partner can help me, is there a way of seeing my partner and actually having some time with him because I just felt really restricted and isolated." (Kate, AN)

Kate highlighted different functions of support, and how she leant in to one when another was missing. For Kate there was enough of what she needed overall to mean she could maintain her mental state. Sam also relied on her partner for emotional support in the absence of support from professionals:

"I've taken a lot of my stress out on my husband because he has been the only one here to listen to me. There's been no-one else to talk my problems to and all my frustrations when I've come out of appointments that he hasn't been allowed in have been vented at him." (Sam, AN)

Unfortunately for Sam the overall picture of professional support was so lacking that she experienced a significant decline in mental health despite good partner support:

"I just felt like, obviously I know the child is always going to mean more to us than anybody else, but I just felt like no-one even cared. I was just another number." (Sam, AN)

The way in which Meena, Kate and Sam articulated the different facets of support gave a picture of a need for a support structure which was comprehensive across all relevant personal and professional relationships. If one strand of this network was weak this could be mitigated by the strength of others, however this was not guaranteed and the result could be a debilitating increase in anxiety.

5.2.4 The anxious pregnancy

This theme was distinct from that of the first theme, The Anxious Mother, in that it did not pertain to the woman's *status as mother* and the psychological manifestations of that state. Rather this was about how it felt to experience an anxious pregnancy. This theme quite clearly contained experiences falling under one subtheme 'lonely and unmagical', and a second subtheme, 'grasping psychological safety' which was about the ways in which the participants used different methods to reach a restful state of mind.

Lonely and unmagical

Meena, Kate, Sam and Lucy described their feelings around their pregnancies in negative terms, and how anxiety had consumed them to an extent which meant that they felt overwhelmed by uncertainty and fear. Meena described how her worries about the effect of her anxiety on the baby had made the pregnancy difficult:

"Erm.. so it's… it's… in one word it's not easy at all. Of course erm… well at least in my case, I've been worried about how the anxiety that I have got in my perinatal period is gonna affect the baby … yeah it's definitely not easy, erm.. and I'm, I'm trying my best to do whatever I can erm.. to not be so anxious." (Meena, AN)

The baby provided a focus for Meena to try and look to the future but her language suggested that she was barely managing to get through each day:

"I think there have been days where I, what's the word, I've lost my appetite, I've lost any interest in anything for that matter. The baby is the only reason I have eaten any meals on many of those days. And baby is the reason why I am still trying to get up and face the world." (Meena, AN)

Meena articulated a build-up of emotion internally which created mounting pressure that she sensed was only getting worse prior to an intervention by the crisis team:

"Until then [the crisis referral] I think I kept everything in my mind, all that pressure build up was only making me even more worse than helping me in any way, shape or form." (Meena, AN)

The distress Meena felt at her emotional state caused her to become angry and withdrawn as she struggled to express her inner turmoil. The description of the wall conjured a picture of Meena isolated, unable to be reached by others:

"So it's either like erm I'm expressing my anger or I am being completely like a wall, I've got a wall around me." (Meena, AN)

The uncontrolled anxiety Meena experienced led her to feel low and there was a sense of her being overwhelmed as she struggled to understand why she was so tearful:

"I think it's made me feel a lot lower, down in terms of you know like low mood and erm.. crying, sometimes I know why I'm crying but sometimes I don't if you know what I mean." (Meena, AN)

Kate also experienced being overwhelmed by the anxiety, and she described the adjustment to the pregnancy, as she too experienced her mood becoming low as a result of the anxiety:

"That's when it hit me that oh my god, I'm carrying this child and I don't know what I'm doing, this is my first time, all these different feelings going through my head and in my body and it just kind of just set me off on like a kind of a low, like er, what do you call… a low cycle" (Kate, AN)

Kate's struggle with anxiety was ongoing but was most tested when she experienced an unexpected hospital stay. Her description suggested that the uncertainty around the length of hospital stay brought her a level of great discomfort:

"Oh it was horrible. It was basically like I was able to manage it because I was told it would be an overnight stay and at that point I thought I can deal with that, I've done an overnight stay in hospital before and it wasn't nice but it's manageable. But then when it extended and it was more than just that and that was when the anxiety hit." (Kate, AN)

The experience of the unexpectedly prolonged hospital stay and how this triggered a state of high alert for Kate was mirrored in her description of leaving the house in the light of concerns about the Covid-19 pandemic:

"Yes I want to be safe from covid and that's probably made my anxiety a little bit worse because every time I go out I'm like oh my god, have I got hand sanitiser, have I got a mask, I'm forever testing… so it's sort of like yeah a lot of anxiety around covid and going out and about." (Kate, AN)

The idea of there being multiple different experiences which could trigger an increase in anxiety was also touched on by Sam, who found that the focus of her anxiety shifted over the course of pregnancy:

"With my condition my anxiety has gone down a lot. I still have a lot of anxiety coming up to the birth but that's based on my previous birth experience and there's not much I can do about that." (Sam, AN)

Sam described a similar experience of the negative impact on functioning which Meena also felt, when she noticed the impact that anxiety had on her appetite, and recognised this shift away from something in life that used to give her pleasure but she could no longer enjoy:

"It is definitely stress and anxiety and yeah just not wanting… I've got no desire… whatever I eat I don't enjoy, I'm eating because I have to eat, I've lost all pleasure in food. But I love cooking and now I'm just like urgh I'll just put a kiev in the oven." (Sam, AN)

This also gave an indication of the anxiety becoming so overwhelming that it eventually caused a low mood which was also the experience for Meena and Kate. The power of Sam's language around feeling numb highlighted the debilitating effect of the anxiety, causing her to stop feeling anything:

"The only way I can describe it is I was numb… Because, because I had no fight left in me… I wasn't eating, I was just literally laying on the sofa, I didn't get dressed for days, didn't function." (Sam, AN)

The detrimental impact of anxiety during her pregnancy also manifested to shape Sam's perspective on the whole of her pregnancy, which had been a time of suffering:

"This pregnancy is where I've really, really suffered um like lost sleep, felt ill through anxiety." (Sam, AN)

The experience caused Sam not only to think negatively about how she felt day to day, but also stopped her from being able to have any optimism about her future, as she described how she responded to friends giving her baby items prior to the birth. She was unwilling to allow herself to connect with the possibility of a positive pregnancy outcome, which added to the sense of negativity surrounding the experience:

"People have been donating clothes to me and I've been like yeah thanks and then just chucked them in the spare room and closed the door… I didn't want to get my hopes up, didn't want to set my home up for a baby for my daughter that might not come home." (Sam, AN)

The fear of a poor pregnancy outcome was shared by Lucy who was also unwilling to engage in thinking positively about the future and the symbolism of material items. Sam expressed this in terms of protecting her older daughter; for Lucy this was about protecting herself from added emotional pain in the event of perinatal loss:

"You know we also didn't want to buy anything because I thought if we buy something then that's just going to jinx it and as soon as I buy it that's it, I've got that in my house and something bad is going to happen. And I'm then going to have to come home and see that baby item and break down over it. So it was really difficult to find the right time even to just buy that first item." (Lucy, AN)

In common with Meena, Kate and Sam, Lucy also experienced a change in behaviour which negatively impacted her ability to function:

"If I was to leave the house it would just be the worst thing in the world. I physically couldn't, if I got closer to the front door I would just start panicking, I wouldn't really know where I was and everything

was just heightened and that really just isolated me. It put me in a position of, well, because that has happened a few times now when I have tried to go out I won't try to go out, I will just stay in the house so that I don't have to feel those feelings." (Lucy, AN)

Lucy's description of this being the worst thing in the world was an indication of the strength of her feeling and the level of fear, which she also indicated when describing pushing herself to make a trip away from home which triggered a breakdown:

"But yeah we got there and I had some lorazepam in the car and was actually thinking maybe this will be really good for me, I'm out of the house and I have to be away from my house. Maybe that will spark something in me to want to go out more and things. But I actually just spent the whole two weeks in bed. I don't know what happened…" (Lucy, AN)

To add to the negativity of Lucy's feelings there was also a sense of self-criticism about the behaviour that her anxiety triggered, as she described when feeling she over-reacted about the baby's movements:

"But yeah so I think there were some times when I didn't feel the baby move for a little while and I was like is everything OK? So then I'd be on the phone to the midwife just saying I just need to check if everything is alright, and then I'd get off the phone and I would feel something and I'd think oh God I'm just being overcautious or dramatic…" (Lucy, AN)

Lucy recognised that her anxieties caused her to think negatively, and expressed how those negative thoughts distanced her from people who were trying to encourage her to think in a positive way:

"It was quite difficult because people were trying to be nice and supportive and get me not to feel as negative but when you've been through three miscarriages in a row it's quite impossible to think that it's going to go in a positive way." (Lucy, AN)

The impact of the negative manifestations of anxiety was felt throughout the narratives of Meena, Kate, Sam and Lucy, and the manifold impacts of the anxiety caused a thread of sadness to run through their stories, as summarised by Sam:

"Lonely. It has just been a very, very lonely, unmagical time." (Sam, AN)

The one participant who was an exception within this theme was Gabi, and it is possible to make some presumptions about why that may be. The experiences described by the other four participants were different from Gabi's, in that Gabi had no sense of a failing in the level of personal or professional support she received. She also was the most experienced mother, pregnant with her fifth child. Her agoraphobic anxieties were a hindrance to her but there was no sense that she was fighting with herself about leaving home. Lucy was another participant with agoraphobic worries but staying at home was at odds with what she wanted to do. Whereas Gabi was her happiest at home, despite her awareness of a motivation to go out for the sake of her children. So, from Gabi's data we understand that her pregnancy was anxious and stressful, but not that it was lonely or unmagical. This may be because her support needs were broadly met, providing her with the safety net she needed, and her pregnancy did not carry the same level of uncertainty as for those who had experienced pregnancy loss or complications.

Grasping psychological safety

This subtheme centred around the efforts that the group made to maintain some level of control over their psychological state. The references to the actions the participants took provided a sense that they were all striving for something which would make them feel better, and that feeling better resulted from feeling psychologically unthreatened. This was touched on first by Gabi, who clearly recognised that the kind of safety that concerned her was that of psychological safety, as she described the feeling she had from being at home:

"I think it's just my safe place, I'm there, my kids are there. I can lock the door and let no-one in. I'm just safe." (Gabi, AN)

The strength of this feeling was cemented by her later description of the decision to birth at home against medical advice:

"I got to the point where I didn't really leave the house and home birth was more preferable.... I knew I was safer at home." (Gabi, AN)

Lucy also considered home to be her psychologically safe place, as she described the reassurance she experienced as soon as she was in that space, which she regarded as protected from the potential negative experiences of the outside world:

"If I'm feeling anxious or panicky I know that as soon as I step through the front door I'm fine. It's a safety kind of thing, it's like no one else is here this is my space. I'm comfortable here and I know nothing bad is going to happen." (Lucy, AN)

The predictability of home provided psychological reassurance for Gabi and Lucy, with the uncertainty that came with venturing away from home removed. Responding to uncertainty was a key part of Kate's experience, and she recognised that the uncertainty through pregnancy had caused it to be an anxious time. As the birth approached, she perceived less uncertainty from her pregnant state and therefore a reduction in her anxiety:

"I think the biggest thing that sets off my anxiety is the big unknown, I don't deal with change very well, so that's part and parcel of, unfortunately, being pregnant it's a big change, so that in itself I struggled with. But then you kind of get used to it and now I've actually, now she's almost going to be here it kind of takes that edge off things." (Kate, AN)

Kate's sense of the uncertainty of pregnancy reducing contrasted with her earlier experience where she felt overwhelmed by her anxiety when not receiving an expected phone call from the midwives:

"I was given a date and like when they were going to ring. And then when they didn't ring I was like, oh, ok what do I do now sort of thing. And I kept asking like my mum what do I do, because I didn't know what to do, you know you don't want to go and pester somebody if they're not supposed to ring or whatever, you don't want to go chasing it up but then at the same time you want to find out what's going on sort of thing." (Kate, AN)

Kate took some control over the situation by ringing the midwives, but not before she has questioned the situation, herself and sought reassurance from her mother. Gabi expressed a similar response to the uncertainty around how to engage with health services:

"I think it's the not knowing and not knowing how they do things now and the rules around birthing now and having a problem with anxiety." (Gabi, AN)

Sam's efforts to grasp psychological safety began before pregnancy, as she reached out for support that would enable her to enter pregnancy with the risks of additional anxiety already accounted for:

"I didn't go into my second pregnancy blind. It took me 4.5 years of research to convince myself I could do this again. I had even spoken to a consultant to alleviate any stress before we even conceived, and they set out a plan of what would happen, and it didn't happen." (Sam, AN)

For Sam the effects of the plan she had made not being followed and her complete lack of agency during pregnancy were devastating. She described one way in which she felt she could have been supported to manage the unknown, which involved her understanding all the various eventualities, again to remove uncertainty:

"I wish someone had sat down and said ok in an ideal world what would the birth look like. Ok, that's what you'd like but we need to make you aware that these are the things that could happen and this is what would happen in that situation." (Sam, AN)

Sam recognised what would have helped reassure her despite the unpredictability of her circumstances, however could not find this resolution from caregivers. Lucy's attempt at removing uncertainty was more successful as she successfully accessed additional monitoring to reassure her that the pregnancy was progressing:

"We paid a silly amount of money so that every month we could have a scan and I was constantly Googling whether my symptoms were right." (Lucy, AN)

Lucy, Sam, Kate and Gabi all strived to protect their psychological safety in some way, and this was borne of a fear of life's unknowns. The sense that this was an avoidance of psychological threat came from the fact that they worried less explicitly about the physical impact of what could happen, and more about the emotional – whether related to feelings of loss, loneliness, fear of not coping or failing their children. The actions taken to achieve psychological safety were in themselves unpredictable, hence the sense of grasping for something which is not quite within reach. As Lucy described, despite her best efforts to overcome her fear and organise herself for the arrival of the baby there is:

"*… still that heightened anxiety of the what ifs." (Lucy, AN)*

5.3 Early postnatal experiences

Table 6: Early postnatal Group Experiential Themes (GETs) and subthemes

GROUP EXPERIENTIAL THEME	SUBTHEMES
BABY AS EXTERNAL FOCUS	Comfort Distraction Optimism New worries
RETURNING TO ONESELF	Finding the way back Looking forward
THE EMOTIONAL UNKNOWN	Relief and overwhelm State of flux

5.3.1 Baby as external focus

The theme of baby as an external focus arose as all the participants naturally reflected on the monumental shift in how their lives felt following the birth, and with the baby as an overt physical presence in their lives. This theme centres around the meaning of the baby's physical presence, as there seemed to be significance placed on the tangibility of the baby compared to when in utero. The emotional response the baby inspires is mixed, sometimes comfort and optimism, at others the reality of living with anxiety during this early postnatal period centres on new worries for which the baby is a trigger, although simultaneously provides a welcome distraction from anxious thoughts. This range of emotions forms the four subthemes: comfort, distraction, optimism and new worries.

Comfort

For Meena, the arrival of the baby brought a tangible presence which was powerful, there was a sense of awe in her language. The wonderment in her tone and the instant sense of connection with the baby she described sounded comforting:

"Surreal is the word. Erm, I know I had a baby but it's amazing to see her out. And you know like I said when I first saw her, even though, you know, you had a baby, you always wonder how she would be and everything. It's not... it feels like magic or something you know you can actually see her out and how she adapts. And, you know, she knows you're mum already and she wants to be with you and have a cuddle and everything straight away." (Meena, EPN)

The comfort Meena conveyed in the close connection she described was echoed by Gabi's description of the closeness in the family including how her older children interacted with the baby. The image of Gabi observing her older daughter and warmly reflecting on the growth of her family also intimated feelings of comfort:

"Since she has been here, my daughter is besotted with her and it's lovely to sit there and watch her hanging over and playing and it makes me think I know I've done something right…they spend so much time with her and it's lovely to see. So if anything her being here has brought us all closer and around each other more so that has been quite nice." (Gabi, EPN)

Kate also described seeing her daughter from across the room which reminded her that she was no longer alone (as she was in pregnancy) and this made things easier for her, including helping to set her back on course if she was having a difficult moment. The level of comfort she felt from her daughter was reinforced by her gentle language ('melt it away') and the help this provided when she had 'a little blip', suggested the therapeutic power of the baby's presence:

"I think because I've got that extra body in the house whereas before being pregnant I was practically by myself during the day, whereas now I'm not, I've got Mia with me, I find it easier. Sometimes I can be having a little blip but I look across at her and it helps... what's the word I'm trying to use... helps melt it away…" (Kate, EPN)

The comfort that Sam found in the baby's physical presence came from the control that she regained after the birth. She expressed recapturing her agency as a mother once the baby was an external physical being, and the lightness in her description of her anxiety lifting, 'a breeze', in stark contrast to her experience during pregnancy, highlighted the comfort she felt:

"We got him here, he's now my baby, he wasn't my baby that was at risk of stillbirth or at risk of premature labour or any of the complications with obstetric cholestasis. He had jaundice but I expected that because my daughter had jaundice. But everything else was in my control, he was my baby and nobody could tell me anything else. He was the other side of my stomach." (Sam, EPN)

"So being ill and him being ill that was hard, but apart from that it has been a breeze." (Sam, EPN)

Compared to the rest of the group, Lucy had a very different experience of the early weeks after her baby's birth because she did not feel comfort from the presence of the baby. This was possibly made harder by her awareness that this was at odds with how other people feel and what she was expecting:

"You know, I don't know how to explain it, but you know everyone says when you give birth and they put the baby on your chest and you just have this overwhelming love and everything, it wasn't like that." (Lucy, EPN)

Rather than feeling comforted, following an escalation of severe anxiety Lucy found herself in the grip of a mental health crisis. It was striking that her description of how she felt by the time her baby was three weeks of age directly contrasted with any sense of comfort; instead she portrayed turmoil as overwhelming intrusive thoughts about harming the baby prevented her from being close to him:

"I just ended up being, not that I didn't want to be involved with him, I just couldn't, my whole feelings and stuff had shut off. I think out of fear of hurting him. I just didn't want to be in the same room as him, didn't want to go near him." (Lucy, EPN)

Support from mental health crisis and perinatal teams helped Lucy to recover and at the time of the interview she had only recently started to feel able to connect with the baby. It was in this description of these nascent feelings of connectedness that she conveyed a sense of comfort in their bond:

"Beforehand I didn't feel like he was mine, I didn't really have any bond with him, I wasn't really bothered if he was there or not. And then afterwards I was like... Yeah, I really do love him!" (Lucy, EPN)

Lucy's audible surprise at her strength of feeling mirrors that of Meena and Kate (the other two first time mothers in the group), as we witness their shared experience of the newness of this connection, the *magic* and the *melting away* of fear.

Distraction

As well as offering comfort, the physical presence of the baby naturally offered distraction. While the diversions were described in terms of the occupation of caring, the emotions inherent within the experience for Meena, Gabi and Kate conveyed joy, reassurance and companionship. Meena welcomed what she viewed as a positive mental focus:

"I think my mind is more occupied with what's really giving me the joy now, as opposed to me having that time of emptiness when I'm just sitting there worrying about hundreds of things." (Meena, EPN)

Gabi echoed this shift in internalised worry about herself to a preoccupation with the baby which forced a different mindset:

"I've got reassurance with Emmy now, I get to play with her or whichever one of them. So I've constantly got something to occupy me if you know what I mean. So you don't necessarily, you ain't got time to think of yourself." (Gabi, EPN)

Kate's narrative also related the busy activities of providing care, alongside the companionship that the baby brought and a sense that less was unknown now the baby had arrived, which reiterated the significance of the baby's physical presence in terms of anxiety and uncertainty. The unborn baby did not provide the same focus:

"Having Mia here I'm obviously not as lonely anymore, there is another person." (Kate, EPN)

"There's nappies to change, feeding to do, bathing to do, playing and having cuddles, whereas through pregnancy it was not knowing. (Kate, EPN)

This subtheme held different meaning for Lucy, who due to her difficult experience in the early weeks following birth, did not describe positive emotions linked to the baby as a distraction. However, this was not because distraction was not present or impotent. Indeed, it was the distraction of the first busy few weeks of settling into life at home and seeing visitors that suppressed difficult emotions which later came to the fore:

"I think those first two weeks were so busy, I didn't really get a chance to think too much about it, and then I think when that settled down is when I had more time to think and realise that actually I don't like this baby sitting next to me." (Lucy, EPN)

Lucy's worries around feeling disconnected from the baby escalated once there was less external distraction and ultimately led to crisis. This suggested that the meaning of distraction in her case was about suppressing worries. Perhaps because distraction was not an experience positively connected to the baby in the way it had been for the others, it was not enjoyable or sustainable and ultimately made way for catastrophic intrusive thoughts to surface. This gives a sense of the psychological protection that the connection to the baby brings and stresses the importance of early mother-infant attachments being forged.

This subtheme of distraction was not present for Sam, which may be because Sam was the only participant who described a complete resolution of anxiety once the baby had arrived.

Optimism

Sam was also the only participant who did not give an overt sense of optimism around the resolution of anxiety following the arrival of the baby, and this again is perhaps because she always expected a swift resolution of her anxiety post-birth. For the rest of the group the arrival of the baby signalled a positive change in their anxiety levels and behaviours, with an optimistic view of the future. Meena clearly described this new start:

"I think because she was such a fresh sense to our lives to be honest, so I think we are trying to probably enjoy the best that we can make the most of it and try to spend the time with her and everything." (Meena, EPN)

Kate similarly described a life-affirming new beginning with the shift in her mental state following the baby's arrival. She alluded to resolution of the uncertainty which characterised her anxiety in pregnancy as of particular importance:

"It's been a lot more positive. Obviously in pregnancy you don't know, you can feel everything going on but you don't know quite what's going on. But once she is here, she's with us, it's a whole different ball game. It's a whole new lease of life if you know what I mean." (Kate, EPN)

Gabi's statement about the improvement in her anxiety was clear; the fact that she referenced the anxiety as something which held the potential for work and further recovery added to the feeling that she was looking forward with a positive frame of mind:

"I would say it has definitely improved. Yeah. There are still little bits that need a little bit of work on and are a bit rough around the edges but all in all I would say yeah, I am a lot better." (Gabi, EPN)

As we have seen, Lucy had a different experience of anxiety in the early weeks post-birth. For her the level of disconnection from the baby made this a dark time. However, when challenged to be in a situation that might make her miss her baby, she recognised a shift in her feelings which allowed her to think differently about their relationship with a hint of hope:

"It was like this sudden kind of, oh I do have feelings towards him. And I think it was the perinatal team told my partner and I to go out without him for dinner or something, to see if it would make me miss him, and whether I would have those feelings of missing him and wanting to be with him and worrying about him and stuff. And I was like oh I don't care, I'm just going to go out and enjoy myself. I'm not going to think about him and all of that. Literally I was like as soon as we started driving off, I was like oh I really miss him." (Lucy, EPN)

New worries

Except for Lucy, among the participants there was an overall sense of a rapid lessening of anxiety once the baby had arrived. However, it was also possible to see that a new set of worries replaced the pregnancy anxieties. This was evident for Gabi in her description of how she felt about leaving the house, as she perceived some improvement yet recognised the focus of her anxieties had shifted to the baby:

"I had anxiety with leaving the house, going out, that side of things, which that has somewhat got a bit better to be honest. Because I feel like I'm not going out the door on my own and worrying about me, I'm going out the door and worrying about her. So it's taking my mind off me, which is making my own anxiety better in a way but the anxiety has moved to her." (Gabi, EPN)

For Gabi the natural replacement for her pregnancy worries became the practicalities of baby care, which added another layer to the meaning that distraction held in altering the experience of anxiety. Gabi was worried about the baby, and this distracted her:

"I dunno, I think before I was feeling like I had to protect myself, which was then making me think of my problems and anxiety and worries, where now I'm worried have I got enough nappies, have I brought enough milk (laughs), I don't know, now I'm constantly worrying about her and have I got everything she needs." (Gabi, EPN)

Gabi's description conveyed the potential for multiple worry foci, which may have played into Kate's perception of the enormity of managing this new life with her baby, which she described almost as a shock as she contemplated what she faced:

"…when she had arrived, things got a little bit real." (Kate, EPN)

Kate's narrative focused on worries related to how she would cope with the new baby. She sounded daunted about the prospect of managing with the new baby, highlighted in her description of feeling abandoned when she had less midwifery support postnatally than she was expecting:

"I find the midwives' line really difficult because the midwives they came out on the day after we came home and then the day after that to weigh her and then two days after that I had another midwife come out and that was it, and all I had the next time was a phone call. And then after that I was like okay, it almost felt like now you're just left to your own devices to do it." (Kate, EPN)

The shock Kate hinted at, of facing this new role and responsibility for the baby, was also intimated by Lucy, as she described a sudden and unexpected shift in perception of the reality she was facing and how she was not prepared for what it would entail:

"When I was pregnant I had all of these worries about him but he wasn't physically here so I couldn't really like do anything about it if that makes sense? And then as soon as he arrived it was like an 'oh crap' moment, I have a baby what do I do." (Lucy, EPN)

In common with Gabi, Lucy's anxiety prior to her mental health crisis was also focused on the care of the baby and his needs:

"I would say my anxiety was more towards actually having a baby there. Is he OK, have I fed him all right is too hot or too cold, is he comfortable? All of that sort of stuff, and then just randomly one night it was really horrible." (Lucy, EPN)

Lucy clearly saw a deterioration in her anxiety once the baby had been born. As her anxious thoughts escalated this manifested as a fear of the unknown and potential negative events, a position which is contrary to that of the other women who gave a sense that their babies' arrival meant that less was unknown:

"God it has been horrible. Anxiety in itself, then when you put a baby into the mix, it's like something you can't fully describe without feeling it, the amount of stuff that runs through your head, it's all the things that are negative about what could go wrong." (Lucy, EPN)

When recovering from the crisis Lucy noted a shift again in her anxiety, an apparent switch from internalised, intangible yet terrifying worry, to worry directed externally. This meant a new focus on the safety and wellbeing of the baby as she also perceived threats from the surrounding environment:

"My anxiety kind of like changed over the weeks, when we got into a better place of me spending more time with him and stuff, that was like a worry of, is he OK, if he cries have I done something wrong? Have I accidentally put too many scoops in his milk or something like that? And especially when we are out, obviously massive anxiety anyway, but the additional anxiety of I have to make sure he feeds alright, have I got this this and this with me? Make sure I get him out of the car OK, and then when you're walking around and stuff, I can't take my eyes off him for one second, if I turn around is somebody going to run off with him or something?" (Lucy, EPN)

Meena was less vocal about worries around organising herself and the baby. This may have been because at this stage her parents were staying with her so she had constant support with baby care from her mother. She did however continue to feel the same worry as she did in pregnancy about not passing on her anxiety condition to her daughter:

"Um, the only thing I was ever concerned about was about her picking up my habits of OCD." (Meena, EPN)

Clearly at this stage of their postnatal journey, anxieties existed for Meena, Gabi, Kate and Lucy. Undoubtedly however the baby as an external focus brought affirmation and occupational reward, positive emotions which were profoundly described by the participants. However, there was still a persistent undercurrent of worry for Meena, Gabi and Kate, directed towards regular daily life with a new baby. Lucy's postnatal anxiety was altogether catastrophic, as intrusive thoughts stopped her in her tracks and she found she had to rebuild. The primary worry focus for Lucy was the lack of connection with her baby, which set her apart from the others and gave some indication of the significance of the maternal-infant bond in navigating the early postnatal weeks while experiencing anxiety.

5.3.2 Returning to oneself

This theme centres around the idea of the participants coming back to who they were before pregnancy. It encompasses a range of feelings about the ways in which Meena, Gabi, Kate and Sam reconnected with themselves and regained some stability as they described experiencing their anxiety over these early postnatal weeks. Several of the antenatal interview themes carried the idea of the participants' sense of self changing through a transformative experience. This idea of returning to oneself highlights continuing transformation and is partly characterised by the ways in which the participants look to the future. Therefore, the subthemes that emerged were 'Finding the way back' and 'Looking forward' as the participants described these changes and improvements in their anxiety. Lucy was an exception because at this stage she had not experienced transformations of self which felt positive (in fact the opposite), and her narrative served to highlight a lack of returning to herself.

Finding the way back

Meena found that since the baby's arrival, a renewed sense of stability within her relationship with her partner had changed her experience and allowed her anxiety to reduce:

"Obviously the relationship issues we had were the thing that were causing a problem before. But now things have just changed for the better." (Meena, EPN)

For Meena the reduction in anxiety at this point was in powerful contrast to her experience of pregnancy, pointing to the extremes of emotion she had lived with. She explicitly referenced her experience during pregnancy, suggesting that since the birth she had returned to how she felt prior to pregnancy. She described her anxiety as:

"…the best that it can be as far as I've ever felt by my experience. Because my experience during pregnancy, it was one of the lowest." (Meena, EPN)

The sense that Gabi gave of how her anxiety had shifted postnatally came from the verbalising of her thought processes around worries about her daughter which illustrated a change in the level of rationality she could access. She articulated that despite the presence of an anxious response to her daughter's behaviour (*panicking*), she could rationalise why she was concerned and bring those thoughts under control. This was counter to her experience in pregnancy when she would find herself engaged in uncontrollable worry which she perceived as irrational (*things that are never going to happen*):

"…but then I think well then she's going to be running, she might fall and hurt herself so then I start panicking about things like that, way before it is even here. So I'm just constantly thinking, but I find I'm thinking now more well you're gonna think that because you don't want her to fall and hurt herself. I feel like I'm thinking more on a normal level now rather than thinking things that are probably never gonna happen." (Gabi, EPN)

Gabi's ability to talk herself round and actively challenge her thought process was further demonstrated when she described using this skill. A calm strength emerged from Gabi's narrative as she mastered her thinking. Further, describing this in the context of having *a right to be here*, gave a

sense of legitimacy and somehow emerging to be seen, which contrasted with her time in pregnancy when she was largely hidden due to her wish to stay in the house:

"You know, that helps me out as well because it gives me a reminder when I do start thinking well actually I've got a right to be here as much as anybody else, I'm just being stupid, you know I change the subject in my own head." (Gabi, EPN)

Kate similarly noticed a shift in how she felt now the baby had arrived, and used a comparison in common with Meena, back to a time before pregnancy:

"A little bit like [the anxiety levels] were before pregnancy." (Kate, EPN)

Kate attributed the shift that she experienced partly to the relief that the baby had arrived safely, but also to a return to the physical health she was in prior to pregnancy. For Kate this demonstrated that her return to self was not just a psychological experience but also bodily:

"I think because knowing that she's here safely, and that my breathing has got back to some sort of normality, that kind of helps." (Kate, EPN)

Kate talked several times about the importance of routine and demonstrated insight into how this helped her manage the anxiety. A routine with the baby made her feel like her old self, partly by facilitating time to herself. This need to know what to expect was evident in her concerns around the uncertainty of the timing of her midwifery appointments both in pregnancy and following birth. Within Kate's description she was categorical about the importance of the routine and gave a sense that once she had achieved this ordered existence she felt more like herself:

"So having a routine has helped my anxiety. Not having a routine does not help my anxiety at all. So knowing what I'm doing and when I'm doing it is easier for me. So most of the time we have a routine where by lunchtime she has fed and is ready to go down for a sleep so I can then do what I want to do. So yeah not having a routine, that was hard, that was hard going. Because you just didn't know what to expect and what to expect when because each day was different…" (Kate, EPN)

It was Sam's description of her husband's perspective that demonstrated her return to herself as she detailed the difference between how he viewed her during pregnancy compared to how she felt after the birth:

"Well [my partner] was there at most appointments and he was saying to the consultant she is literally a shell of a person, borderline hitting depression - and that didn't make any difference. But yeah he said that he thinks I'm still not fully back to normal, but he knows I've got this worry in my head about becoming pregnant, but I know how I feel in myself and apart from that I feel like me again." (Sam, EPN)

It was interesting that Sam described this using her husband's view, as though there was somehow more validity in his verification of just how far removed from herself she had been in pregnancy. This was possibly a consequence of Sam's loss of confidence in anybody listening to her which was a highly significant feature of her pregnancy anxiety. Sam painted the contrast between pregnancy and post-birth in terms of being a mother; when she was not heard in pregnancy she did not exist as a mother. This echoed Gabi's experiences of emerging postnatally as somebody who has a right to be here, no longer hidden from view – both women exist again:

"…that's the only way I can describe it, people didn't treat me like a mum so I didn't feel like I was a mum." (Sam, EPN)

Sam also mirrored the experience described by Kate regarding routine: that once control was restored and uncertainty diminished you were able to be yourself, whether that was through the freedom to do what you want to do (Kate's perspective) or just to *be a mum*:

"…all the anxiety I was having was related to the care I was getting for my baby and my labour. So once I wasn't worrying about those, I know how to be a mum. It was all the stuff that's not in my control that was making me anxious." (Sam, EPN)

For Meena, Gabi, Kate and Sam we saw that since the arrival of the baby, although they may have found their anxiety was triggered, their experience of dealing with it differed. Greater containment came from different sources including a stable relationship, the ability to rationalise worries, routine and regaining agency, and these sources of containment characterised a shift in the anxiety experience

in the early postnatal period. The change in their relationship with anxiety altered their sense of self, as they found space to return to the person they were prior to pregnancy.

Lucy' narrative diverged as she had experienced a mental health crisis in the weeks after her son was born which meant that she provided no sense of a positive shift towards psychological containment as her anxiety escalated uncontrollably:

"I just ended up being, not that I didn't want to be involved with him, I just couldn't, my whole feelings and stuff had shut off. I think out of fear of hurting him. I just didn't want to be in the same room as him, didn't want to go near him." (Lucy, EPN)

For Lucy this was worse than her experience of pregnancy anxiety and was characterised by worries over how she would be perceived and how uncontrolled the experience was. As she reached new depths, she retreated not only physically from her baby but also asked her partner not to reveal who she was (or had become) to his mother:

"Yeah, and I was anxious about… if people knew what they would then think of me, whether he was going to be taken from me, and then every bad scenario came into my head. I told my partner not to tell his mum what was going on because I just didn't want to be judged or branded like a bad mum from something that I had no control over." (Lucy, EPN)

So, for Lucy, rather than seeing a postnatal shift back to her previous self, we saw that she moved even further away from herself with her *whole feelings shut off* and *no control*. This suggests that a rapid postnatal return to self is not a given and in fact the distance from oneself can widen. Lucy's reasons for this were directly related to a lack of connection with her baby, which was not the experience of the other participants. The connection with the baby may therefore be the key to returning to oneself.

Looking forward

As they reflected on their postnatal experiences all the participants considered the future. The positivity and confidence expressed by Meena, Gabi and Kate further cemented the sense of them feeling more certain of themselves. For Meena this came across in her description of how she felt

about her mother leaving, and while she was emotional about this, she was confident that she would manage with the level of support being less immediate:

"Yes, I know I'm going to miss her, even not considering all the help she has done, I will miss her, everything that she has done as her daughter… It's a bit sooner than what we wanted but I know I can always give her a call. She's around at the end of the phone for me to talk and everything." (Meena, EPN)

Gabi also sounded confident about the future, a confidence she had partly gained from her increased understanding of mental health and the perspective this had given her, which she appeared to be reassured by:

"Well I did do the mental health awareness course with all the anxiety and different things like that and that was more of a learning curve for myself and to be able to see it coming in others when they're depressed or whatever, um, so I dunno sometimes little things are in there that you realise, you know, you're overthinking for nothing and worrying over nothing." (Gabi, EPN)

Part of this experience for Gabi which added to the positivity was about the relational aspect of identifying a common experience with others and their mental wellbeing, being able to *see it coming in others*. Relational aspects were also key in Kate's thoughts about the future, as she described a new perspective she had for the future of her wider family relationships, which had previously felt beyond repair:

"So I just thought well she's here now it's up to you, I'm going to make new memories with her, it's up to you whether you're involved. It's hard because she's going to grow up not knowing who some of these people are. And I want to introduce her to as many people as possible so that she doesn't feel left out, so that she doesn't think hang on a minute who is that person when we come to family gatherings." (Kate, EPN)

The perspective gained from Sam about her future was less about what might be different, but rather about never being in a position where she might once again feel how she did in pregnancy. As she considered an irreversible procedure to avoid a further pregnancy, she was categorical about the future being one in which she would not want anything to change, certain as she was that the status quo should now be maintained:

"I can't put myself mentally through it again. I said the same after the last one, and I can't do it again, I have to be here for the two children that I've got. And it wasn't like it was a one off, it happened both times." (Sam, EPN)

For Sam this added to the sense of a return to the person she was prior to pregnancy, and this was strengthened by how emphatically she described her determination not to move away from being that person again. Lucy's perspective on the future echoed Sam's fears about again living through an anxious pregnancy. The difference for Lucy was that she did not necessarily consider her family complete. Nevertheless, still very much caught up in the anguish of her recent experience, Lucy's worries about the future were clear and challenged her ability to look forward with positivity:

"I think the only thing is that it makes you think more about any future babies. I think with the anxiety and, I know that not everybody experiences postnatal depression in the way that I did, but all of it together with the anxiety it makes you... Like before you have a baby you're like yeah I'll have three babies and it'll be amazing but actually it kind of sinks in that I'm not sure if that is 100% for me. We would want another one but then what if that all happens again and what if it's worse? It just heightens all of the future anxieties." (Lucy, EPN)

Although Sam and Lucy did not reflect forward with positivity in the way the other participants did, their thoughts about the future revealed a level of insight and self-awareness that intimated a strength in their sense of self, a strength which had not been present for either of them during pregnancy.

5.3.3 The emotional unknown

This theme arose from a sense the participants gave of conflicted emotions during the early postnatal weeks, meaning that the feeling of uncertainty which had prevailed during pregnancy persisted. The emotions expressed were mixed and at times quite polarised, apparent in the first subtheme as both relief and overwhelm. Alongside these slightly disorienting contradictory emotions, there is further uncertainty around the fluctuation of their emotional state, and this emerged as the second subtheme, state of flux. Here the emotions described are not always related to the baby, which was seen in the first superordinate theme, but rather how the participants felt within themselves and a sense of internalised emotion.

Relief and overwhelm

Meena expressed the realisation that her OCD symptoms had diminished since the arrival of the baby, and this knowledge enabled her to look forward with positivity. Her tone was optimistic as she considered how things might have been (had the OCD persisted at the same level) and conveyed a sense of relief:

"I think I was more worried about her catching up with my OCD habit but now that I've seen my OCD has gone down it's a positive high, giving me that positive encouragement to look forward to the future and everything." (Meena, EPN)

Meena described how worried she had been during pregnancy that her emotional state would be worse when the baby arrived (negatively impacted by the presence of the baby), and so the fact that this had not transpired further cemented her relief:

"During pregnancy I was terrified, I was terrified for how things were going to be when I had Nell. If it would be, with the way things were in my pregnancy, way way worse having Nell around." (Meena, EPN)

Kate also spoke of relief at the arrival of the baby and that the baby's physical presence, how she could evidence their wellness by having sight of them, was reassuring:

"You feel them wriggling around and you just assume they're okay, but you don't really know until they come out. There's only so much a scan can show and so until they come out you don't really know." (Kate, EPN)

Sam's experience of being able to touch the baby and the relief that came with this was instant. She found the relief to be so great that it overshadowed the pain of medical complications she experienced at the end of her birth. The language she used to convey the relief was powerful and gave a real sense of healing with immediate resolution of all her fears:

"It was different the moment he was put on my chest. It was just relief. I didn't even realise how much pain I was in with my placenta for like half an hour. It was just when they said OK your placenta has

still not come that I realised actually I was in a lot of pain. It was surreal, the second he was here and I heard him cry everything just went away." (Sam, EPN)

Sam's relief was largely due to a sense of regaining the power and autonomy she lacked during pregnancy, and comparing her feelings at the birth she described how disconnected she had felt as a mother until that point:

"I just remember crying as soon as he was on me, it wasn't happiness it was just pure relief that it was over and that this is a bit that I know I can do, and no one else has an opinion because he's my child now. That's all I kept thinking during my labour, was as soon as he's out everything becomes your decision. It's not their rules anymore… Once he's born it's my choice… whereas before none of it was my choice. I was just the person carrying him." (Sam, EPN)

In common with Sam, Kate and Meena, Gabi also found her anxiety was relieved by the baby's arrival. Being able to see and touch her baby provided Gabi with reassurance which removed the pressure of 'having' to worry as she could check the baby and immediately resolve her anxiety. This instantaneous gratification was not accessible to her during pregnancy:

"Erm, you just haven't got to worry how I was before because I can see her. And not only can I see her I can check her and attend to her. Where before I couldn't… you know, is she alright? There have been times where she has overslept and it sounds awful but I have poked her and woke her up to see if she's alright." (Gabi, EPN)

There was however in Gabi's narrative more of a sense of this relief being mixed with a feeling of overwhelm, present in her anxious waking of the baby to check she was ok. So, where the presence of the baby gave relief, it also meant Gabi could fulfil her need to seek that constant feedback, which conveyed the continuing presence of significant anxiety:

"I looked over and was panicking because I was watching for her to breathe but she was in such a deep sleep that her breathing was really shallow. So I moved her fingers and her fingers were really limp and I was like oh my God I hope she's alright. So I poked her, not obviously hard but enough to wake her up and move. And within that she had gone back to sleep and so I was like oh she's fine and so walked away again. But I'm constantly up checking her, even though she's not making a noise, she's just sleeping but I'm constantly up checking." (Gabi, EPN)

Here we see the high state of alert that was present in Gabi's antenatal narrative continue postnatally. This was evident when she described contracting Covid-19 and how her anxiety quickly rocketed:

"I was freaking out when I got it, I was like oh my God I'm going to pass it to her. What do I do, do I stick her on a bottle and get somebody else to feed her? So I started to read up on it and I was sending myself insane thinking 'God it's here now what do I do?', um, and then I read up and it said provided you put all measures in place, wear a mask, sanitise your hands, do this this and this, as long as you did then she'll be fine. So I done all that, I was doubly masking myself, I could hardly breathe and I wouldn't look at her, I wouldn't directly talk to her. I would literally feed her, sort her out and put her away from me. She had to be like six foot away from me or something." (Gabi, EPN)

Kate also described feeling overwhelmed, but for her this manifested in worry about her partner returning to work and being alone and how she would manage with the baby. She described arranging for a friend to be with her:

"…Luckily I managed to ask my friend to come round, cause I was like Oh my God how am I going to cope. The night before he went back to work, I kind of freaked out a little bit-you're going back to work, I will now be by myself, that kind of thing. But luckily my friend came over and she kind of helped out." (Kate, EPN)

Kate's sense of being overwhelmed also came across when she described how it felt when the baby was crying and she and her partner were finding it hard to soothe her. The feeling of not knowing what to do and the uncertainty around this created pressure; Kate's repetitive language sounded panicked:

"…it puts me on edge, because I don't know what to do. And my partner, he doesn't like it when she's crying so much and just wants to soothe her, but he can also get quite stressed out with her crying. There's me trying to stay calm and then he's not getting cross with her, he's getting cross with himself. Which then in a way sets me off in the fact that I don't know what to do, what else can I do?" (Kate, EPN)

For Sam the overwhelming feelings were to do with her abject fear of becoming pregnant again, which caused her to consider seeking a hysterectomy, such was her terror at the prospect of experiencing the psychological anguish of another pregnancy:

"And that's what I want, I know it's going to come with its own health complications, I know it will put me into an early menopause, but that's what I want - I would rather deal with that than the thought of being pregnant again. Because I can't do it." (Sam, EPN)

It was Lucy who gave the richest description of these conflicting emotions, although for her there was initially little sense of relief that the baby had arrived, as her mental health deteriorated rapidly. She described in detail how overwhelmed she felt and how this prevented her from being physically present with the baby:

"… it wasn't that I just didn't want to be around him and didn't want to be involved, it was that I physically couldn't. The emotion just wasn't there." (Lucy, EPN)

The fact that Lucy was unable to even be in the same room as her son starkly highlighted the significant consequence of the degree of overwhelm she felt. The rapid and catastrophic escalation in Lucy's anxiety was also characterised by conflicted emotion, between intrusive thoughts of hurting the baby and the instinct to keep him safe:

"…it was like I was sat there and I was just trying to think about something else to distract myself, but it kept getting worse and worse. I could just feel myself like in a way pushing my hand down, to like, no don't do anything." (Lucy, EPN)

As Lucy began to recover from this episode, although she still described the negative impact of her anxiety in overwhelming terms, being constantly *switched on*, it was also a relief for her that she felt what she regarded as normal protective instincts towards the baby:

"I would say that even though it's horrible to be switched on and aware of people around, it's tiring like constantly watching other people and making sure he's alright, but it's also quite reassuring that I have that worry about him, if that makes sense? Instead of like being Oh yeah he's alright, someone can wander off with him and I'm not very bothered… I think I would prefer that over not having any worries towards him." (Lucy, EPN)

The participants revealed at times polarised and contradictory emotions in these early weeks, and it is this mixed picture of emotion which gives rise to both relief and overwhelm that provides the sense

of the emotional unknown, as they continue an emotive journey which proves labile and unpredictable.

State of flux

As well as emotion leaping between relief and overwhelm, the participants all provided descriptions of anxiety being in a constant state of flux. This gave a further quality of the anxiety's unpredictability, with the only certainty being its omnipresence. Meena found that developing Covid-19 instantly caused anxiety, and the language she used of the *shooting up* of her anxiety hinted at a lack of control:

"But after that I got covid myself so that kind of affected my OCD quite badly so again my anxiety shot up but after that it was good, there was no… in fact my OCD has gone down." (Meena, EPN)

Simultaneously Meena expressed the joy that she felt because of the anxiety being overall reduced, in the knowledge that the anxiety could vary between extremes which although improved, had not disappeared:

"I'm less anxious and it's more joyful. It's just all going well, touch wood, and hopefully it stays like that. The only difference is that the anxiety was from one extreme to the other, it was worse during my pregnancy. It's nowhere near perfect, but it's definitely better." (Meena, EPN)

Gabi also found that although overall her anxiety had reduced somewhat since the arrival of the baby, it still had the capacity to re-emerge in certain triggering situations, such as attending appointments:

"…as a whole, um, normally I'm on and off the toilet, if I know I have to go somewhere I'm on and off the toilet. And I still have an occasion like yesterday I had the doctors because we had our six to eight week review, slightly late, erm and I was needing the toilet then but I managed it." (Gabi, EPN)

Gabi recognised that this changeable state of anxiety had existed throughout her life, and that she was living with it in a way that felt far more manageable than when she, and her now adult children, were younger:

"… when they were younger I had so much going on with my life at that time as well… so I was mentally in a different place back then whereas now I am definitely more stable. So I can deal with it better and I've got over a lot of things, where before I hadn't I was still living in the past if you like, with the crap I'd gone through. I was still in that place yet still trying not to be in that place if that makes sense? Where now I'm a completely different person to who I was back then, mentally." (Gabi, *EPN)*

Gabi's view of her current experience within the context of her whole life supported the idea of an anxiety omnipresent but fluctuating. For Kate the changeability in her anxiety was triggered by uncertainty around what to expect, for example when the visits from the midwife would happen:

"I am somebody who likes to plan in advance so if I'm going to have somebody turn up I need to know what time in advance if you know what I mean. Or at least have a phone call to say we're coming out to see you, we'll be there at this time just so I know. But this one didn't which kind of threw me." (Kate, EPN)

Although Sam expressed a return to feeling free of anxiety after the baby's birth, she still showed that she did not feel confident about the level of control she would have over anxiety in the future. She hints at an awareness of anxiety as a fluctuating state which could change at any point, hence she felt her only option for control was to categorically rule out any future pregnancy:

"The only minor negative emotion that I have had is that I know I'm going to have a battle to get the contraception I want, I know I'm going to have to wait and wait and wait for that. Apart from that, I'm back to me." (Sam, EPN)

For Sam becoming pregnant again would mean an impact on her psychological wellbeing which would present an existential threat. Viewing it in this way demonstrated the strength of Sam's feelings and validated the desperation that she had felt. If anxiety was on a spectrum, she could not again contemplate being at the sharp end:

"We have talked about it (a vasectomy), but it's still a one in 100 chance of it not working and me getting pregnant from that, and I couldn't abort a baby for my health needs. I don't ever want to be in a position where I have to make that decision… I want [my womb] out and I don't want any risk of me ever having to fall pregnant again. I don't want to go through it because I wouldn't survive it." (Sam, EPN)

Lucy was also cognizant of her anxiety fluctuating, and described how she approached the decision to go to a baby group: discovering how her anxiety felt on a day-by-day basis and responding accordingly:

"…I will just see what I'm like on the day, if I'm too anxious and things like that. I just thought I'm going to give it a go, I will take my lorazepam and my mum came with me." (Lucy, EPN)

For Lucy the anxiety continued to be changeable and unpredictable:

"…sometimes now I'll go out like to my mums or something, and I won't have to take any lorazepam and yeah if my partner has a really busy day and I just feel like popping out or something I just get Charlie ready and we just pop out for a coffee or something, or go round friends and sometimes it's easier than others. I don't know, I just wake up a little bit more anxious some days than others, so I'll take a lorazapam or something…" (Lucy, EPN)

Perhaps the most profound mood change for Lucy was the one she described when she first became unwell postnatally with intrusive thoughts around hurting her baby, which gave a sense of just how dramatic and sudden a new wave of anxiety could be:

"Yeah, it was so random, we were literally just eating dinner, watching TV, and I just spaced out. It was like, yeah, that was all that was in my thoughts." (Lucy, EPN)

In Lucy's summary of the early postnatal weeks the level of distress she felt was plain:

"People talk about intrusive thoughts, postnatal depression and stuff and I obviously was aware of it because of my history with mental health and stuff, but I didn't think it was quite like that. I thought it was something that was just, I don't know... a little bit more down, baby blues and things like that but it was 100% the worst thing I've ever had to go through." (Lucy, EPN)

The variations in anxiety the participants felt ranged from levels that allowed them to function to complete dysfunction. Witnessing their description of these extremes added to the validity of the subtheme of state of flux and how this characteristic of anxiety is inherent within the theme of the emotional unknown.

5.4 Late postnatal experiences

Table 7: Late postnatal Group Experiential Themes (GETs) and subthemes

GROUP EXPERIENTIAL THEME	SUBTHEMES
MOVING ON	Coping Acceptance Resolutions
SHIFTING SANDS	This too shall pass Omnipresent

5.4.1 Moving on

This theme is characterised by the participants thinking back over the past 16 months of their lives. Their language conveys a new confidence, the emergence of which gives a sense of forward motion as we begin to understand that the participants, having adapted to this life change, are moving on. This is evidenced by the descriptions of how they have coped with, accepted and gained some degree of resolution to their anxiety, concepts which form the subthemes and pertain to the experiences of Meena, Gabi, Kate and Lucy.

Coping

In Meena's description of how she developed a unique coping strategy for containing her anxiety she illustrated how she had taken control of difficult emotions, and her reliance on herself to contain her feelings conveyed independence and strength. It was notable that the development of a self-made grounding technique centred on the baby, suggesting that the comfort derived from the baby (a theme in the early postnatal interviews) remained:

"But since having the baby it has been a lot lot better, even though like I say I have good days and bad days, when I do have bad days I have this new kind of plan or technique where I say the baby's name 10 times and look at her and concentrate on her instead of the source of the anxiety." (Meena, LPN)

Gabi also hinted at a greater sense of control over her anxiety, indicating the ability to decide on her response. Her will to gain control over an anxious situation was evidenced in her language, the force of the anxiety against her determination not to capitulate:

"I also know that a lot of it is in my head and because I know it is in my head I try and rise above it. But other times it will come into force more and I will think I'm just not doing that." (Gabi, LPN)

Although Gabi seemed to be taking greater control over her anxiety, she recognised that a risk of losing this was still present, as she described a recent period during which she had not left the house. This self-talk, where Gabi instructed herself to face a challenge was present in all Gabi's interviews, and suggested that this mind over matter approach to coping was a long-standing behaviour for her:

"In the last few weeks I have turned into a bit of a recluse. So I started thinking I need to get out and do some things. I was having a panic, like, I haven't been out for a few weeks how am I going to be. So I thought I need to deal with this now… I just went to this appointment because it was planned and that, I just got my head around it and went. I'm hoping that just nipped me back into reality and that I can go and do something rather than just sit about." (Gabi, LPN)

Kate's means of coping were strongly focused on how much her daily life with the baby allowed her to have time to herself, and this also came across in the focus on routine she described during the early postnatal interview. Her account of grabbing time for her coffee and breakfast when the baby was asleep suggested her favouring this as a solitary experience, some space just for her:

"Yeah, because I like to have breakfast and everything when she's asleep and I can grab a cup of coffee and have breakfast." (Kate, LPN)

While Kate was enjoying seeing her baby develop, she also recognised that this presented a potential limitation on her freedom, which again stressed how Kate valued time for herself to feel emotionally well as this enabled her to cope:

"It's a great change don't get me wrong, it's nice to know she can move around and do things. But on the flipside, it's not good because obviously I don't get time to myself." (Kate, LPN)

Lucy also referenced the need for time apart from the baby to enable her to attend to her own needs:

"Just simply asking for a bit of help, can you feed him you know? Once a day can you make the bottle, can you put the washing on? Just simple things to give you 10 or 20 minutes to make yourself some food or make the bed, it really does make a difference." (Lucy, LPN)

Another facet of Lucy's coping was apparent through her description of an increased level of self-awareness and understanding of her condition, through which she conveyed a sense of strength and empowerment as her personal narrative around her illness became clearer to her:

"Yeah, I think now it makes a lot more sense to me; I've looked into it a lot more and done a lot of my own research around it. And I've spoken more with the perinatal team and with doctors and things and it definitely is sort of like reassuring that a lot of women do go through it. It's a bit reassuring that it's not just me and it's not something I'm intentionally doing. You know hurting him or wanting to run away from him, it's just a chemical imbalance that I can't control. And I just needed some help with that." (Lucy, LPN)

Acceptance

This comment from Lucy hints at an acceptance which has been facilitated through greater understanding of her experience. A mindset of acceptance was also present for Meena and Gabi. Meena described the ongoing fluctuation in her anxiety, and sounded philosophical in her tone:

"It's definitely better, if I had to rate it now I would say it is less than five to be honest. It's quite an improvement, and I understand it can never be -zero - that is just how life is. It's brought me to a stage or a phase where I can go on with my day-to-day life easily." (Meena, LPN)

Meena was not suggesting that her life would be free of anxiety, but she conveyed a manageable rhythm now. Referencing her experience of anxiety in pregnancy suggested since the birth there had been a shift in the degree of negative impact caused by the anxiety:

"There are episodes or days when it would go up or down, like you would expect but it didn't necessarily have the bad effect to the same extent as before I had the baby. So yes, good days and bad days but definitely not the worst like it was in my pregnancy." (Meena, LPN)

Gabi also described some perspective from looking back at her anxiety during pregnancy, and articulated a similar wisdom of hindsight as Meena, when she considered how she might respond in an imagined conversation with her pregnant self:

"Umm…basically not to worry. I think a lot of my thing is I was just paranoid, and I was a thinker, and when you think you overthink – when you overthink you go to the extreme. I think, personally, just don't think into it too much. Everything will be fine and your body usually lets you know if it's not fine so you know, listen to your body as well." (Gabi, LPN)

It was interesting that here Gabi highlighted a level of innate trust in her body which she had not described before; previous mention of her physicality was largely focused on anxiety-related bowel problems, and the lack of control she felt over her body. So the faith in herself seen here augmented the feeling of acceptance - just being how she was. This was further reflected as she described anxiety as inherent within her:

"I think I've gotten to grips, that this is how this is just built in now, I have some days that are better than others." (Gabi, LPN)

Throughout her interviews Gabi conveyed hard-won insights in the context of a lifetime of exposure to significant traumatic events. Her perspective lent her wisdom and the ability to accept her life as someone with anxiety. Here she gave a conciliatory tone and a sense of being within a community of people with anxieties, which further added to a tone of peace and acceptance:

"I suppose we all fear different things. We all speculate and think into things but I'm just the worst for it I suppose." (Gabi, LPN)

Much of Lucy's psychological distress since the baby's birth had related to her feelings towards him, which was evident in her earlier postnatal interview, and was at the heart of a second time of crisis when her baby was 4 months of age. Despite the huge distress she experienced, and that the time of crisis was in recent memory when interviewed for a final time, she nevertheless hinted at an acceptance of how things were in the way she described her ability to rationalise her thoughts. Lucy echoed the sense of being able to bring herself back to 'reality', which was a sentiment previously expressed by Gabi:

"I think I'm a little bit more rational about things, I do have things that pop up in my head and stuff and I think I can't think about that right now it's just not reality. I can only think about the moment and the next couple of months at the max." (Lucy, LPN)

Ultimately acceptance for Lucy was most inferred when she articulated self-compassion, permitting herself to know that she did love her baby from the beginning, there were just uncontrolled thoughts that challenged her. This added to the sense of Lucy creating her own narrative around her experience, the ownership of which conveyed strength:

"I didn't get any smiles from him obviously because he was a newborn, and I was just there thinking I don't know if I like this. But now he's so interactive and he's fun to be with, I wake up in the morning and go into his room and he's just there talking to himself, giggling and stuff, and I think maybe I was just not enjoying that first few months… I'm not really sure if there was like a particular moment when I thought I do really like him, or I do love him. In a way I think… I don't know, I've obviously loved him from the beginning I just struggled with my own thoughts." (Lucy, LPN)

Resolutions

There was a clear changeability in the experience of anxiety over time, from pregnancy and through to this late postnatal point, which is further demonstrated in the second superordinate theme, 'Shifting sands'. Related to the notion of moving on, Meena, Gabi and Sam shed light on the culmination not of a single complete resolution as anxiety persisted in various forms, but in resolutions presented in multiple ways as circumstances changed. For Meena at the early postnatal interview, this was primarily to do with the arrival of the baby; at this late postnatal stage she described how the shift in her social picture with the return to work had helped her:

"…it was really nice to have that kind of break after you are set in your own routine with a newborn which can be quite monotonous. My husband has gone back to work and I will be going back to work from the 1st of September, so things are looking positive. In terms of the anxiety and everything, it is a lot reduced… I think the combination of the holiday or going back to work and not being stuck inside has helped." (Meena, LPN)

This shift felt positive for Meena, something she welcomed as a change and recognised directly impacted her anxiety. Gabi noted the change in her anxiety at this point compared to pregnancy, and put this down to no longer experiencing the consequences of pregnancy hormones:

"I think overall I was so worried about what if something happened and the pregnancy didn't make it to the end. Just stupid stuff that I probably shouldn't have worried about, I think my hormones were probably all over the place." (Gabi, LPN)

For Sam, we had previously seen detail of the psychological torment she had experienced during pregnancy, and she had been categorical around the causes of this. Reflecting on her anxiety at this later stage the experience of pregnancy predominated, with the unwavering assertion that her anxiety overwhelmingly resolved once the pregnancy was over:

"Oh yeah it was instant, yeah it was instant. I knew that the obstetric cholestasis would go away once I had given birth… I know that's a fact, I've been through it before, what I need is to get through to giving birth. I knew as soon as he was here it would go away, and I knew I would love him as soon as he was here. But I didn't want to love a baby that I thought wouldn't be here, I thought it would be harder to lose him." (Sam, LPN)

Compared to the other participants who described the ongoing presence of anxiety during the months after birth, Sam articulated less postnatal changeability in anxiety because as she described, the relief at birth was absolute. However, it is Sam's reference to her feelings when she shifted out of that anxious state which adds some insight into the ability of all the participants to move on from disabling anxiety. This was largely to do with, whether through a shift in biological, social or psychological state, reconnecting with themselves:

"The only way I can describe it is that now I am me and before I was just looking at me. I felt like I wasn't there, I was just seeing myself disappear." (Sam, LPN)

For Lucy there was a less clear sense of resolution at this stage, likely due to the recency of her second episode of crisis at the time of interview. For Lucy however a hint of resolution came from her description of being more open about her difficulties; a sense of hope around resolution stemmed from her confident description of the safety plan that was in place. Her comment was striking as she gave a sense that this plan offered a secure place from which to recover:

"But yeah I think I just got in my head way too much, just thinking I couldn't do it, I couldn't carry on feeling that way towards Charlie. I think I was just guilty and, yeah, didn't ask for any help and I should have done. But yeah I think since then we've got a good, I think what the social worker calls a safety plan. So if anything was to start going downhill we sort of know where everyone is, what the plan is. So yeah, I've definitely opened up a lot more to people, like I just tell Dan if it's not a good day.. not if it's not a good day… but if it's a bit on the iffy side, and he helps out a little bit more and things like that." (Lucy, LPN)

Lucy – a counterpoint

Overall, Lucy's narrative presented a counterpoint to the experiences of her fellow participants. Although some degree of coping, acceptance and resolution was present within her narrative as noted above, she articulated at length experiences which were contrary to these notions and the ways in which her experience was different set her apart from the other participants, hence her Personal Experiential Themes of 'Internalising' and 'Chaos', with a subtheme of 'Guilt'. The comfort, joy and optimism described by the other participants during the early postnatal interviews were emotions still not easily accessible to Lucy. The following highlighted how Lucy was an outlier and illuminated a different view of the experience of perinatal anxiety at this point post-birth.

Lucy described her experiences at this time as internalised and heavy with guilt. In the depths of her recent psychological crisis there was a chaos which pervaded her attempts to make sense of her feelings. Lucy initially hid her true feelings, in part motivated by her perception that other people would expect her to cope. She did so for a period before it became unmanageable:

"I think I masked it a little bit, everyone just expects you to get on with it, just put it aside and all of that and I think I really tried to just sort of brush it under the carpet and move on. But I think it was just taking over a little bit more than what I thought it would and I think as the weeks went on and the crisis team left, and the perinatal team support went down a little bit, I just started thinking in my head I can't do it." (Lucy, LPN)

It appeared Lucy had a degree of superficial resolve which cracked as she became aware that she was not going to be able to manage without ongoing professional support. The realisation that she could not cope was starkly demonstrated in her description of her intrusive thoughts leading to an attempt to harm herself:

“I was sat downstairs with Dan and it was going through my head I want to hurt him, I just want to do it, I feel like I just really need to do something to him, but I couldn't say anything. And I know that Dan knew something was up because he kept saying are you OK, you look upset? And I just kept saying no, no I'm fine, obviously was completely the opposite, and I think then I just freaked myself out as well. I just didn't really know what to say or who to say it to or anything. So I just got in the car, thought that'll be alright I'll just chill out and have some time on my own, didn't really think the rest of it was going to happen.” (Lucy, LPN)

Even when offered the opportunity to disclose these dark feelings to her partner, Lucy was not able to. This gave a sense of the way in which she was moving towards the climax of her despair – on the night of the crisis feeling that resolution was too far out of reach. Again, Lucy disguised how she really felt and here there was a feeling of guilt and confusion that she could feel this way about a baby that should have been a pleasure. Lucy also returned to a theme present in her antenatal interviews, that of comparison with others:

“Yeah, really bad intrusive thoughts, and really the urge to do something and at the time I just felt a bit stupid not wanting to say to anyone that I wanted to hurt Charlie. You sit there and think well why on earth would you want to do that, he's such a good baby, he’s so chilled, he doesn't cry or anything, he sleeps really well. And when you talk to other mums who have babies who scream all night and don't want to be put down or anything, I’d think god I've got such an easy baby but I'm still having all of these horrible thoughts and things towards him. What's wrong? You know. I thought I was going crazy.” (Lucy, LPN)

This internalising of emotions was explicitly described by Lucy as she recognised a shift in the direction of her feelings, although the intrusive thoughts related to harming her baby, her distress was ultimately focused on herself:

“It's weird because the feelings weren’t what I was feeling about Charlie but more towards myself. I said to Dan that evening, I was just going to get some food or something, it was quite late probably 11 o'clock and I just sort of thought I was going to go for a bit of a drive, just have a bit of a chill. And then I was in the car and just started having sort of a massive panic attack and I didn't really know what I was doing. I don't really remember even doing it which is good because it wasn't really very nice. I remember the crash itself, but not actually going towards anything, yeah it was just a bit of a mess.” (Lucy, LPN)

Lucy's inability to cope was driven by external pressures, which seemed to force this internalising. Worry about how she would be perceived partly driving her actions, juxtaposed with a sense that she knew this wasn't really who she was: that taking her own life was not something that was truly within her make up:

"I still don't really think that I would have ever been capable of doing something like that. They said, crisis and perinatal team said I just totally dissociated and had no idea what I was doing. I don't remember. And it was just as simple as just talking to someone, but I didn't want to let anyone down or disappoint anyone or be branded that 'bad mum' because I didn't want to spend time with him. And to have that judgement." (Lucy, LPN)

The guilt Lucy expressed revealed something about her inability to find the acceptance that the other participants had discovered at this stage. She could not accept that she was good enough for her baby and simultaneously could not accept continuing to have such detachment from him: these were chaotic thoughts. The urge to free herself from her internal dialogue was perhaps the thing that ultimately overwhelmed her:

"I don't know what it is but I didn't have those feelings towards Charlie, I didn't like him, didn't like being with him or around him, things like that. And I didn't like interacting with him and I think it just sort of spiralled from those thoughts, like obviously I'm just not cut out for it, can't do it, and I just felt really awful and guilty over it because I thought he doesn't deserve that, he hasn't done anything and I think yeah then I just sort of got inside my head and just didn't really know what to do, and for some reason thought that was the answer." (Lucy, LPN)

Despite the horror of Lucy's experience, she commented on how hindsight had helped her think differently and this was a hint within her narrative that resolution may yet be possible. For Lucy it was not that the prospect of resolution did not exist, but at this point she was perhaps early in a process of truly feeling this, highlighted by her expression not being convincingly affirmative with the inclusion of *necessarily* and *I guess*:

"I think I was like oh my god I'm such a horrible person, people want babies all the time and can't have them and I've been able to have one and I don't want him. And I think I felt so awful I just got in my head and thought well you shouldn't be here, you don't want to live like this. But now looking back on

that, it was just something going on in my head that I needed help with, obviously. It wasn't anything that I could necessarily control, it was just unfortunate that it happened I guess." (Lucy, LPN)

Lucy's experience and the ways in which it was contrary to the experiences of the others, indicates the nature of perinatal anxiety is not just that it ameliorates following birth, or after the early postnatal weeks, or that it assumes a more predictable form over time. So, while notions of 'Moving On' may be experienced for some, for others the worst may be yet to come. Nothing is certain even towards this midpoint of early infancy. The process that Lucy described when her son was eight months of age aligned with the antenatal experience of other participants, especially Meena and Sam, demonstrated in the subordinate antenatal group experiential themes 'Burdens' and 'Lonely and unmagical'. There is no linear or predictable process to perinatal anxiety, as demonstrated in the final theme, 'Shifting sands'.

5.4.2 Shifting sands

This theme centred on the participants' perceptions of the experience of perinatal anxiety over time. At this late postnatal stage, they reflected on the pregnancy and articulated a different kind of anxiety experience, in the case of Meena, Gabi, Kate and Sam, one which had improved. As we have seen, Lucy's narrative highlighted a counter experience which supports the notion of movement and unpredictability inherent in this theme.

Shifting sands is characterised by the idea of anxiety having a persistent presence but with constant fluctuation in severity. The subthemes reflect this notion. 'This too shall pass', a mantra I frequently heard as a new parent, was taken directly from Meena and in these four words sums up anxiety as a changeable experience bound up in time. 'This' being the present moment, 'too' referencing experiences that have gone before, 'shall' as a nod to the future, and 'pass' something fluid that will later inhabit the past. The second subtheme, omnipresence, has emerged from the participants who unanimously referenced the constant presence in their lives that anxiety had been, is and would continue to be.

This too shall pass

Meena's comment and the origin of this subtheme's title, arose as she reflected on what she would say to her former pregnant self, and she articulated this in terms of the natural ebb and flow which defined her experience of perinatal anxiety:

"I would probably say 'this too shall pass'. Because I think looking back to me it felt is this it, is this is the end - but it's not, it's just an emotion which comes and goes. I have good days and bad days, and so that is what I would tell myself." (Meena, LPN)

Meena attributed the fluctuation of perinatal anxiety to a combination of factors including physical and social changes: hormonal responses and alterations in her work and personal life. This description augmented the sense that anxiety is not static, but responds to the natural rhythms of life:

"I think in pregnancy it can be a combination of factors like hormones, me getting worse OCD, the OCD was higher - I mean not initially but being at home on maternity leave it went up slightly. And the relationship issue for me." (Meena, LPN)

Sam's anxiety with its existential focus on herself and her unborn baby, was bound up in her responsibility as a mother, with anxiety shifting once she regained control over that status after the baby's birth:

"But my, what's the word… I wasn't worried about me as a person but I was worried about me as a mother. I had another child, so I was having to survive for that child while trying to make sure that this child survived." (Sam, LPN)

The arrival of the baby delivered a return for Sam back to herself and her reference to the time before she was pregnant illustrated this move back to a non-anxious state which at the time of the interview remained with her:

"Life has been easy, I'm back to the person I was before I was pregnant – it sounds stupid but it was just pregnancy." (Sam, LPN)

Gabi also spoke of a positive uptick in emotion, she described the baby mediating her anxiety and bringing her into the moment, providing a sense that the anxiety had passed:

"So yeah things have been really good to be fair… she has definitely been a highlight to my life in the day, with having the others at school and being here on my own and having the time to think and dwell on things, I don't have time to think anymore!" (Gabi, LPN)

Despite the improvement that the baby had brought, Gabi's vulnerability to the whims of anxiety was nevertheless evident with the potential for her emotions to be rapidly altered:

"…when my anxiety kicks in, I'm normally on my own and then I panic. Whereas when I am with her I find my anxiety kicks in then I can distract myself by playing with her." (Gabi, LPN)

Being in the present moment also came across as a positive aspect of Kate's experience at this stage, as she aspired to let go of future worries. She described the shifting nature of anxiety as an awareness that she would not always be on solid ground:

"I keep telling myself what happens in the future happens in the future, I need to live in the here and now. Some things you can plan ahead and other things you can't, some things you can't plan at all. So yeah, we just sit in the here and now and when the future comes the future comes." (Kate, LPN)

The letting go of future worries appeared aspirational as Kate described effortful behaviour in changing her mindset *(keep telling myself)*. There was still work for Kate to do to truly be in the moment, as her pragmatic tone belied her comments made about multiple directions of worry:

"So pregnancy anxiety was based around not knowing what was going to happen when she arrived. Knowing what she's like now it's a whole different ball game if you know what I mean. When you're pregnant the 'what ifs' come out, 'what if this', 'what if that'… whereas now she's here I can see what she's doing, and I think that's where the anxiety kicks in because I can see a lot more of what she is able to do. And I'm like should you be doing this now? Why aren't you doing this and why aren't you doing that? That sort of anxiety runs through my head." (Kate, LPN)

The efforts described by Kate were similar to Gabi's comments about controlling the anxiety from kicking back in. In common with Kate, Gabi also considered the future, with an awareness of the

potential for positive change, and even if this was not going to be fully possible for herself, it could be for her children. This suggested another element of the changeability of anxiety in a cross-generational context; how although anxiety may exist in Gabi the same experience for her children and grandchildren would not be a foregone conclusion:

"But at the same time I've watched the other kids, and they've not been to places because of my anxiety, and I don't want that for her as well… I don't want history to repeat itself when they have kids that it will be the same. So I have been trying to push myself more with different things that we have done." (Gabi, LPN)

Gabi used strong temporal imagery reflecting on the idea of history repeating itself in the future lives of her children. The uncertainty about this illuminated an unpredictability inherent in the future experiences of anxiety within her family that contributed to the notion of a fluctuating phenomenon. Kate's description of her anxiety in pregnancy was also focused on future worries, concern around pregnancy-related events that had not yet happened which gave a sense of the uncertainty of anxiety being about the future as well as the present:

"Pregnancy was still definitely the worst time. Not knowing what was going to happen, when it was going to happen. Because obviously everything I went through during pregnancy was towards the end at least quite stressful. So yeah it was definitely the not knowing that caused it a lot more. I am not an individual that can deal with the unknown very easily, I like to know well in advance if there is going to be any change, or if anything is going to happen, I am not one for last minute. I really struggle with that." (Kate, LPN)

Sam also expressed fear of the unknown outcome of pregnancy, profoundly articulating the inner working of her mind, which made it possible to feel her torment as she grappled with which child to prioritise, how to love, how much to give of herself. Her anxiety was bound up in time and uncertainty:

"Um… so every ounce of mental energy I had was fighting to get me through this pregnancy to make sure I was going back to the child I had. Because I couldn't love him yet because of the risk of him not being here, and I didn't know him, not like I know my daughter." (Sam, LPN)

Lucy echoed this same focus on her child which moved the gaze away from herself. Thinking about her son's future she described struggling with how to move beyond her experiences, as she tried to make amends for past thoughts and behaviours. Through her present actions she tried to heal the anxieties of the past and control future worried preoccupations:

"Is he going to be nasty or angry? Has everything that has happened gonna subconsciously affect him? Have I you know sort of... I know, well, I know he's a baby and they're not gonna know of everything that has happened, but when it was happening I was thinking oh god he's got the vibe from me that I don't like him. He's going to grow up knowing that when he was a baby I didn't want to be around him, things like that - is he going to grow up to not like me? Always going to be a horrible child because of how I was in the first six months with him? And I think at first I used to over… I know they say you can't spoil a baby with like love and stuff but I think I was trying to make up for the first few months of not wanting to be with him." (Lucy, LPN)

A calmer perspective emerged from Lucy when asked about her general view of anxiety at the time. She provided a notion of changeability using imagery of the natural world: waves which pass and the grey cloud which threatens, images which lent themselves to metaphor for the shifting yet omnipresent nature of anxiety:

"I think it comes and goes in waves, some days are really good and I'll have either just really low anxiety or like nothing at all, and I'm like oh wow that's amazing. And then like the next day it would just be like everything is bothering me or I can't really explain on that day what it is that makes me feel anxious and like there's a bit of a grey cloud over me and I'm making more of a big deal of things." (Lucy, LPN)

Towards the end of the interview, Lucy looked back over the time that she had been involved in the research study and concluded with comments that really gave a sense of the distortion of time, no longer related to calendar dates but a perception which adopted an entirely new meaning over this perinatal period:

"I think over the time that we've been talking it's weird to see the differences in how anxiety can change. Like even though it seems a long period of time realistically it's actually a short period of time. And I think going from the anxiety that I had before pregnancy and then during pregnancy and after pregnancy it's just really weird to see how it can change so quickly. I guess it can even change daily, my anxieties and what's going on and everything." (Lucy, LPN)

Omnipresent

The constancy of anxiety, whether low or high level, was a common experience for all the participants. Meena had expressed an improvement in her emotional state but referenced the anxiety which existed before pregnancy; the additional perinatal dimension created what she found to be a powerful emotional experience for her, as indicated by the sense of tipping into something out of control:

"So the pregnancy itself I wouldn't say is the sole reason behind the anxiety, but like I said maybe the hormonal changes, the tiredness et cetera, made it tip over the edge." (Meena, LPN)

The omnipresence for Gabi can be seen when we think back to her pregnancy narrative where she wished for a glass stomach to be able to see the unborn baby. This expressed a need for vigilance and monitoring which we discovered had not resolved once the baby had arrived. This notion was strengthened by the fact that as Gabi reflected on pregnancy she perhaps forgot the anxiety which had not been relieved by rubbing her belly at the time:

"Yeah, you know where she is to keep her safe, and you're doing what you're doing to keep her safe [in pregnancy]. Whereas obviously she's out now and you're paranoid, well I'm paranoid, of who touches her… So it's just constant now because she's here and she's in front of you… it's like if she's here I can see she's ok. But at the same time I am a little bit more fearful because she is completely there - I can't just rub my belly and know she's alright, I have to keep an eye on her all the time." (Gabi, LPN)

The ongoing psychological challenge that anxiety presented for Gabi was highlighted in her description of a recent experience of not wanting to leave the house. She explained how the baby, as well as providing a positive distraction from the anxiety described above, also presented a reason for avoidance of the outside world:

"Every day I think I don't want to go out I don't want to do this. I've got a friend and I'm at no. 24 and she's at no. 14 and I haven't seen her for a month and a half. So yeah I have been quite bad with not going out, I think it's either too hot for her and I don't want to get her burnt and even in the shade it's too hot. And now it is raining, So what do you do?! [laughs]" (Gabi, LPN)

Kate described the experience of worrying what might happen now her baby was mobile, and not wanting to leave the room even briefly, which in common with Gabi, gave an impression of the intensity and persistence of the experience, that she still felt limited in the most minor of activities:

"It has been heightened at times because she is a lot more mobile than she was. So you are cautious of, say like, what's she doing, what has she got out on the floor. I can't leave her just for like 5 minutes to go and grab a cup of tea or go to the toilet." (Kate, LPN)

Although Sam was the one participant who was categorical in her denial of any anxiety following birth, there were points in her late postnatal narrative which hinted that she was not entirely without anxiety. Although for her not debilitating in any way, anxiety was still present in impacting her decisions about the future, evidenced by her wish to have a hysterectomy to prevent future pregnancy. While this may have been more an indication of the degree of pregnancy-related trauma she had felt, it also hinted at a level of needing control over the future focusing on a means of achieving this that could be regarded as extreme. When Sam considered whether she would have gone ahead with her pregnancy had she known how distressing it would be, this persistent anxiety is further illuminated:

"I don't know, and this sounds horrible because I love him to pieces, but I don't know if I knew then how it was going to be whether I would have gone through with it. Obviously I wouldn't change having him now, but I don't know whether I would want to put myself and my family through it. It's horrible to say, knowing what the end result was, but I wouldn't have known what the end result was." (Sam, LPN)

Although Sam knew that the outcome of her pregnancy had been positive, she didn't trust that catastrophic anxiety would not be waiting for her if she were to choose to conceive again:

"I think before the pregnancy I would prepare myself to be ready for the fight." (Sam, LPN)

This sense of the unpredictable and lack of ability to trust the emotional state was also described by Lucy, who was tripped up by thinking that things had improved as she moved past the first postnatal crisis and thought she was recovering before realising that the anxious thoughts had never fully diminished:

"So after we finished the baby massage we went on to sensory classes. Things seemed to be getting better and then I started getting all of those bad thoughts and feelings and sort of distancing again away from Charlie and I didn't really tell anyone because I didn't want there to be a whole thing about it." (Lucy, LPN)

The two subthemes of 'This too shall pass' and 'omnipresence' are juxtaposed, anxiety is constant yet always in flux. They are also inherently connected, giving rise to a simultaneously concrete and fluid, and therefore disorientating and at times bewildering, experience. Examining perinatal anxiety over time has given credence to the concept that the sands shift. Looking back over 16 months, through pregnancy until 8 months post-birth, acknowledges transformational elements, but illuminates a circular rather than linear psychological process. The only constant is the existence of anxiety, in the conscious or subconscious, waiting to emerge again, for the sands to shift.

5.5 Diving for pearls

Smith (2011b) uses a metaphorical gem to describe the moments in qualitative analytical work when notably resonant data shines through, overtly or subtly, and enhances the analysis. Gems could be a word, a sentence, a passage, a single powerful case, but are pivotal analytic touchpoints for the researcher facilitating greater insight to the individual and group experience. Smith (2011b, p.14) presents a spectrum of gems, those that are easily apparent in meaning to both researcher and participant, "shining"; those that are "suggestive" and require effort to be seen and understood; and those that are "secret", the researcher needs to look very closely to reveal their significance and the participant is not aware of their existence. The gems of particular significance in the doctoral study data related to Lucy and Meena and were the key to unlocking a deeper level of insight into the experience.

The emergence of Lucy's story as a counterpoint to the other participants was stark. As the fifth of the early postnatal interviews to be completed, her experience was immediately evidently very different from the others, standing out by the way in which she described her emotions with one utterance especially resonant:

"my whole feelings and stuff had shut off. I think out of fear of hurting him. I just didn't want to be in the same room as him, didn't want to go near him." (Lucy, EPN)

This example of a gem illustrated something about the experience that was clear to Lucy, she understood an emotional shift which had cut her off from the baby and could rationalise the reason for this – being scared she would hurt him. As a listener, this passage and the way in which Lucy describes the physical shutting away of herself provided a clue as to the potency of feeling, with no half measures, unable to share a physical space with the baby. Paradoxically, shutting herself away because she didn't want to hurt him (out of care for him) indicates a confused questioning of her feelings towards the baby. A gem provided by Meena also resonated on initial hearing due to language conveying positive strength of feeling for her baby:

"… it feels like magic or something you know you can actually see her out and how she adapts. And, you know, she knows you're mum already and she wants to be with you and have a cuddle and everything straight away." (Meena, EPN)

The bodily closeness clearly welcomed by Meena, the gentle tone referring to a cuddle, is in stark contrast with the physical barriers Lucy employs. Meena implies something innate – the baby *knows* that she is mum, there is a dialogue with the baby as she *wants* to be with Meena and the fact that this happens *straight away* suggests an urgency to this magical, magnetic connection between the two. By contrast, Lucy's innate feelings are to do with harm towards the baby and distance from him, evoking the antithesis of mothering which perhaps lay at the root of her distress. She does not describe what her baby wants emotionally, she just knows she cannot trust herself to be with him.

These examples shone brightly because of how experience was expressed, and through their contrast provided insights which enabled an understanding that something at the core of the experience of perinatal anxiety was tied to maternal expression and responses (Smith 2011b).

5.6 Longitudinal Experiential Concepts and model to demonstrate the lived experience of perinatal anxiety

As previously mentioned, a novel addition to the process of IPA was adopted during the study, the development of Longitudinal Experiential Concepts (LECs). The LECs emerged from a gradual recognition during the analytical process that there were characteristics of the experience which were common over the entire perinatal continuum but were more abstract than those represented in the Group Experiential Themes. This related to notions of how mothers see their worlds (Maternal eyes), transformation (Transforming existence), and the multifaceted emotional experience of perinatal

anxiety (Emotional kaleidoscope). The LECs were represented at each time point (table 8) and facilitated a model for the lived experience of anxiety over the perinatal continuum (figure 3).

Table 8: Longitudinal Experiential Concepts and Group Experiential Themes of the lived experience of perinatal anxiety:

MATERNAL EYES	**TRANSFORMING EXISTENCE**	**EMOTIONAL KALEIDOSCOPE**
THE ANXIOUS MOTHER (AN) Otherness Burdens	TRANSFORMATION (AN) Fighting with self Temporal collisions Reflecting and self-understanding	SETS OF EARS (AN) Feeling heard Safety net
BABY AS EXTERNAL FOCUS (EPN) Distraction New worries	RETURNING TO ONESELF (EPN) Finding the way back Looking forward	THE ANXIOUS PREGNANCY (AN) Lonely and unmagical Grasping psychological safety
Omnipresent (LPN)	MOVING ON (LPN) Coping Acceptance Resolutions	THE EMOTIONAL UNKNOWN (EPN) Relief and overwhelm Comfort Optimism State of flux
		SHIFTING SANDS (LPN) This too shall pass

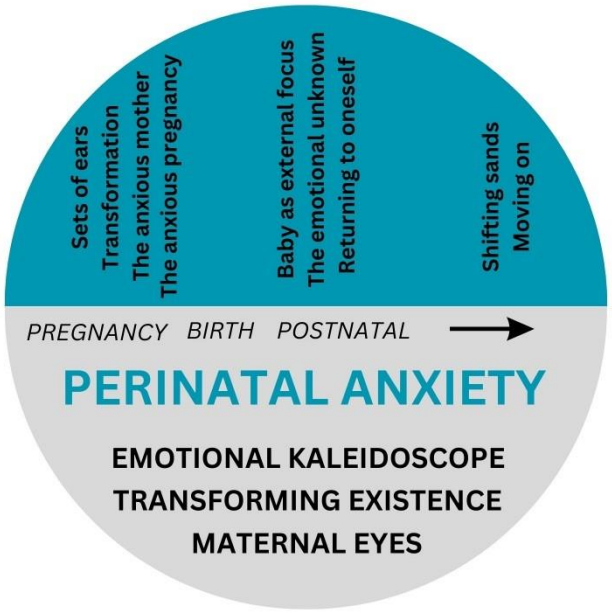

Figure 3: The lived experience of anxiety over the perinatal continuum

5.7 Chapter summary

This chapter has presented a narrative analytical account to demonstrate how the interview data supports the Group Experiential Themes. This has taken a 'themes by time point' approach (Farr and Nizza 2019), and a view of the continuum of the lived experience of perinatal anxiety has been demonstrated through a novel model to represent the phenomenon from a temporal perspective, within which Longitudinal Experiential Concepts speak to the core common threads of the experience (figure 3). The next chapter moves to the extant literature, positioning the findings alongside published evidence, presenting the novel insights generated from this doctoral work and providing the foundation for implications for clinical practice, education and research which have emerged, and will be outlined in the concluding chapter.

CHAPTER 6: DISCUSSION

6.0 Introduction: approach to this discussion chapter

This chapter considers in greater depth the findings from this doctoral study research including convergence and divergence with the wider background literature within and beyond a foundational conceptual understanding (Folliard et al., 2020). The discussion will demonstrate how synthesis of the doctoral study findings alongside the extant literature adds original insight into the lived experience of perinatal anxiety, offering a novel detailed, idiographic perspective and addressing the original research aims:

- To explore women's experiences of living with perinatal anxiety to gain a deeper understanding of the phenomenon of perinatal anxiety from the perspective of women suffering from the condition.
- To contribute new knowledge and advance professional practice by broadening discussion on how midwives and other health professionals can most effectively support women with perinatal anxiety.

The analysis of the findings in the previous chapter generated a conceptual model for the lived experience of perinatal anxiety (figure 3). The analysis and model provide a unique representation of the lived experience of perinatal anxiety, building on the findings of the literature review and concept analysis, discussed in chapter 2. Table 9 summarises the attributes forming the theoretical definition of perinatal anxiety (Folliard et al., 2020) and elements within these doctoral research findings which converge and strengthen ideas previously discussed, and those which diverge. This representation of convergence and divergence alongside the theoretical attributes will be used to structure a synthesis of the doctoral findings positioned within the wider extant literature and will highlight novel aspects of the phenomenon of the lived experience of perinatal anxiety identified in this work.

The chapter will close with a summary of how this doctoral study has added to the understanding of the lived experience of perinatal anxiety. This is prior to the concluding chapter, which considers how the use of Longitudinal Interpretative Phenomenological Analysis (LIPA) has addressed these research questions, the implications for practice, education and research, limitations within the work and aspects of reflexivity.

Table 9: Concept analysis attribute convergence and divergence with Group Experiential Themes

CONCEPT ANALYSIS FINDINGS	**DOCTORAL RESEARCH INTERVIEWS FINDING**
CONCEPT ANALYSIS ATTRIBUTE CONVERGENCE WITH GROUP EXPERIENTIAL THEMES/SUBTHEMES	
Psychological challenge bound up in the transition to motherhood *(Attribute)*	The anxious mother (GET) *Otherness; Burdens* Transformation (GET) *Fighting with self; Temporal collisions; Reflecting and self-understanding* Returning to oneself (GET) *Finding the way back; Looking forward*
Not unique from general anxiety in its somatic or mental presentation, often with a focus on perinatal concerns *(Attribute)*	The anxious pregnancy (GET) *Lonely and unmagical; Grasping psychological safety* Baby as external focus (GET) *Distraction; New worries* The emotional unknown (GET) *Relief and overwhelm; State of flux* *Omnipresent*
CONCEPT ANALYSIS ATTRIBUTE DIVERGENCE WITH GROUP EXPERIENTIAL THEMES/SUBTHEMES	
An unfamiliar concept to health professionals	No parallel
No parallel	Moving on (GET) *Coping; Acceptance; Resolutions* Sets of ears (GET) *Feeling heard; Safety net* Shifting sands (GET) *This too shall pass*

6.1 Convergence between the doctoral research findings and extant literature

Convergence between the Group Experiential Themes (GETs) and background literature was seen across the attributes of perinatal anxiety regarding the psychological challenge and transition to motherhood, and the presentation of perinatal anxiety in line with general anxiety but with a focus on perinatal concerns. This discussion will highlight how the doctoral findings explicate, support or shed different light on the pre-existing literature and in doing so will enhance understanding of perinatal anxiety.

6.1.1 Perinatal anxiety is a psychological challenge bound up in the transition to motherhood

Psychological challenge: worry, distress, stress or anxiety?

The doctoral study data offers detail about the nature of the psychological challenge of perinatal anxiety, specifically around varying levels of perceived psychological challenge associated with perinatal anxiety. A level of worry was regarded by the women in this doctoral study as a normal response to pregnancy and new motherhood, but they also identified a more extreme anxious experience, setting them apart from others. Within the experience of being an anxious pregnant woman was an inherent sense of otherness. This was especially apparent for Gabi and Lucy in their antenatal narratives, where they described overt feelings of not being *normal*. Anxiety, worry and stress are often used interchangeably within anxiety-related literature (Folliard et al. 2020). Indeed, Rachman (2020) notes that a lack of distinction between anxiety and worry is common. The doctoral study participants used language of worry, stress and anxiety which mirrored this phenomenon, and so it became apparent that when exploring the idea of this 'psychological challenge', examining perinatal literature beyond that referring purely to anxiety may provide further insight.

Ayers et al. (2019) examined, using the self-penned accounts of 148 women at 6-12 weeks following birth, aspects of pregnancy, labour and the postpartum that caused *stress*. Through its design the Ayers study aimed to facilitate open expression of women's experiences with the freedom to identify any factors they regarded as stressful, without the constraints inherent in the use of measurement tools focusing on a pre-defined area of worry. This was a similar ethos to the one taken in the design of this doctoral research: to ask participants to freely express the aspects of their experiences that held greatest meaning for them. The doctoral study participants identified the anxiety inherent in 'The emotional unknown' of their experience, where they were disoriented as an emotionally labile and contradictory state contributed to the psychological challenge. Ayers et al. (2019) found similar stressors relating to the emotional challenges described by the study participants, including insensitive treatment by health professionals, difficulties in interpersonal relationships and adjustment to life with a baby, all of which featured to some extent under the GETs 'The anxious mother', 'Transformation' and 'The emotional unknown'.

An earlier study by Coates et al. (2014) positioned postpartum *distress* in terms of anxiety, post-traumatic stress disorder and depression, and within the study considered distress to be any psychological problem which disrupted daily function. In common with the study design of Ayers et al. (2019) and the doctoral study, the design acknowledged the reductionist limitations of understanding distress using measurement tools and used Interpretative Phenomenological Analysis

to explore the women's experiences. The findings of Coates et al. (2014) shared commonalities with findings from this doctoral research, such as adjustment and being overwhelmed by responsibility seen in the subthemes 'Overwhelm' and 'Burdens'. Meena, Gabi, Sam and Kate's descriptions of their maternal responsibility for protecting and shaping the lives of their unborn babies and older children was present during pregnancy, while this really came to the fore for Lucy when contemplating this responsibility postnatally. The doctoral findings build on these earlier studies which presented a solely postnatal focus, with the longitudinal approach highlighting that similar notions of stress or distress predate the birth of the baby.

Where these studies differed most clearly from the doctoral findings, was in identifying labour and birth-related distress and breastfeeding as themes. This was perhaps surprising, given that both studies collected data at similar time points to this doctoral research. It may simply be that the participants in the doctoral study were entirely unfazed by labour and birth (there were no overtly complex birth experiences within the group). Ayers et al. (2019) offer another possible explanation: that the participants in their study were primed to focus on the birth due to the name of the study which referenced birth, a potential limitation noted by the authors. However, this lack of specific focus on birth and breastfeeding gives an important clue as to the psychological challenge of perinatal anxiety for the doctoral study participants: the difference between experiencing diffuse, free-floating anxiety compared to specific labour and birth-related worries. This suggests that while worry may be a surrogate term for anxiety, there are subtle experiential differences between the two.

In the opening paragraphs of Ayers et al. (2019) the difference between worry, stress and negative emotion is articulated. The authors reference the work of Davey and Wells (2006) to highlight this distinction: that although worries are conscious and verbal cognitions that are *associated* with stressors they are an *indirect measure* of stress. Stressors may trigger negative emotions, for example anxiety, the measurement of which would indicate the psychological impact of the stressor. This is relevant when trying to understand the experience of the participants in the doctoral study, who do not necessarily associate labour and birth worries with the overall lived experience of anxiety. Within the doctoral findings perhaps worries around labour and birth were not expressed because for the participants the experience of anxiety was not about immediately conscious verbally expressed situational worries, but rather deeper negative emotions triggered by a range of stressors, some tangible (i.e. leaving the house) and others less so (i.e. the character of their future child), manifesting as the diffuse anxiety previously referenced.

Comparing these papers with the doctoral findings helps to explore the relationship between anxiety and worry in the perinatal context. This might offer a useful distinction between the concept of a 'normal' level of anxiety (the existence of worries which do not disrupt daily function) which is commonly conferred upon women in the perinatal period, and problematic anxiety responses. It is interesting to note that in the Coates paper, worry and anxiety are used in the same breath by one of the participants, saying:

"I had anxiety every time I fed her – she would go to sleep and I would build up this worry about what would happen when she woke again." (Coates et al. 2014)

This quote perfectly illustrates the interrelatedness of the concepts, as discussed above: this person expressed a clear link between the stressor of breastfeeding which triggered a worry about a future event that made her feel anxious. This is a helpful demonstration of the connectedness of these terms, articulated by this participant's experiential description.

The anxiety-inducing stressors which formed aspects of the doctoral participants' narratives were often focused on the experience of becoming a mother. This was a social adjustment which led the women to interrogate their relationship with themselves and others alongside social expectations, which formed 'The anxious mother' and 'Transformation' GETs. Notions of self-blame, guilt, needing support, responsibility and adjustment were also present in the work of Ayers et al. (2019) and Coates et al. (2014), demonstrating how the doctoral study findings strengthen the argument that the psychosocial transition to motherhood is a significant characteristic of the experience of perinatal anxiety.

Psychosocial adaptation to pregnancy

"During pregnancy and in the post-partum stage, women experience in their body and their mind a great physical and emotional turbulence, often experienced in loneliness, despite the myths associated with the idea of motherhood and reinforced by social expectations, that equate expecting a baby and being a mother with a state of complete well-being and fulfilment." (Monti in Mori and Benuzzi, 2015 p. 111)

The above discussion around the psychological challenge of perinatal anxiety touches on the relevance of the transition to motherhood within the experience of perinatal anxiety and worry. The emotions described by the women in this doctoral study align with the wider literature and suggest something

about the adaptation to motherhood is tied to the experience of perinatal anxiety. Exploration of the literature around pregnancy, birth and the journey to motherhood reveals more about this psychosocial process. The evidence base presents different epistemological lenses, for example comparing the understanding of becoming a mother and psychological wellbeing within an interpretivist paradigm, as compared to positivist, alongside existential perspectives. Throughout the analysis of the doctoral data, existential notions such as temporality, identity and freedom arose, eventually falling under the themes of 'Transformation' and 'Returning to Oneself', which demonstrated the group's positioning of themselves within this significant life change.

'It's me and only me': Guilt through a phenomenological lens

The doctoral study participants were explicit about how their relationships with themselves and others held huge emotional weight within their experiences of anxiety. The women described guilt directed towards themselves, that they were not the mother they considered they should be; and guilt over detached feelings towards the baby. They described guilt over failing family members, either from not keeping the unborn baby safe, or making increased practical and emotional demands on others due to their anxious state. Writing about maternal guilt and the first-time mother, Steele LeBeau (in LaChance Adams et al., 2020) comments on the nature of motherhood-related guilt as directed towards the mother's relationship with herself, her baby and her community. The author details the experiences of five first-time mothers with whom she conducted phenomenological interviews. The themes uncovered, related to responsibility, feeling divided, fear of the unknown and social expectations and comparisons, dialogue with the experiences of the doctoral research participants describing their anxiety, and strengthen the notion of maternal guilt as a relevant aspect of the lived experience of perinatal anxiety.

The doctoral study GET of 'Burdens' relates to the weight of shaping a new life, and a sense of being the sole person responsible for this, especially when the baby is in utero: the idea that *it's me and only me* (Gabi, AN). Post-birth, Meena, Gabi, Kate and Lucy described anxieties about caring for the new baby, with emotions focused on present concerns and future imaginings around their child's life. An inability to effectively care for the baby can cause paralysing guilt, as seen for Lucy when she felt unable to take responsibility for her newborn. The women in Steele LeBeau's guilt study also identified a connection between anxiety or fear and the responsibility of caring for a new baby. This responsibility is described several times as being 'heavy' (p. 147), which closely links with the sense of burden described in the doctoral data. In Steele Le Beau's study the burden is discussed mostly in

relation to the efforts involved in caring for the baby and oneself, alongside forward projections of a more existential nature regarding the child's future lifeworld, again drawing comparisons with the doctoral study findings.

The sense of guilt within the doctoral study is also present in reference to the women's self-conflict, seen in the GET 'Fighting with self', torn between their needs and those of their baby, and the emotional disturbance this provoked. Although not explicitly a feature of Steele LeBeau's discussion around responsibility, it is striking the frequency of reference to expectations placed on women in the mothering role. This concept is elicited in the author's discussion around the theme of the women feeling divided within a conflicted experience, including a need to perform, do things as well as they could, be productive and have high standards. Again, though not explicated in Steele Le Beau's discussion of this theme, the sense as a reader is pressure regarding behavioural expectations, linked to feelings of guilt. There is a parallel notion within the doctoral research, where fear of failure is a feature of 'The anxious pregnancy', and the question arises, on what is this pressure or expectation which induces guilt and anxiety founded?

The doctoral research provides an answer as it suggests there is a social norm to which pregnant women and new mothers should ascribe: not doing so is a failure, a trigger for guilt and hence a source of anxiety. The participants described, within the theme of 'Otherness', the emotional consequences of social comparisons, with heightened anxiety and feeling on the outside, also reflecting the concept of loneliness described above (Monti in Mori and Benuzzi, 2015). When the women in the doctoral study lose their perceived social anchor, it creates anxiety and the feeling of being in an unknown place, uncertainty which causes them to 'Grasp psychological safety' as the anxiety of the unknown weighs on them. The exploration of the origins of maternal guilt supports this idea that social conformity plays a role in heightened anxiety, showing how women internalise perceived cultural values of motherhood reflecting on the material and emotional maternal perfection that is expected (Steele LeBeau in LaChance Adams 2020). In this case an 'otherness' is inherent in the maternal experience: as the author argues, new mothers enter a social space about which they know nothing, are unprepared for, and so are naturally inclined to make social comparisons. In this unfamiliar place anxiety is tied to a lack of control over their situation and this lack of knowing among the mothers triggers initial feelings of guilt alongside the shame of not having a normal pregnancy (Pierce at al., 2022).

The doctoral findings clearly demonstrate a link between perinatal anxiety and guilt, supporting a phenomenological understanding of maternal guilt, with anxiety and fear as the precursors to this additional complex emotion. The doctoral study recognises that the experience of perinatal anxiety is one of multiple emotional dimensions, and the maternal guilt study notes the same emotional complexity, with the description of an 'Emotional kaleidoscope', fitting with the doctoral Longitudinal Experiential Concept of the same name (Steele LeBeau in LaChance Adams, 2020 p. 147).

Becoming a mother: a positivist perspective

The guilt, responsibility and associated anxiety described above is a facet of becoming mothers for the women in these studies. The notion of becoming a mother (whether new or experienced) is of distinct relevance for the participants in the doctoral study, initially most explicitly highlighted in the theme of 'Transformation', where during pregnancy the women reflect on their changing selves, sometimes experiencing a mismatch between the view of their former and current selves, as well as future projections of self. The longitudinal nature of the doctoral study reveals that this sense of becoming is a feature throughout the perinatal experience, as the women continue to make sense of whom they are, with a sense of regaining something after the baby's arrival, 'Returning to oneself' before eventually 'Moving on' in an identity characterised by interwoven elements of the person they were before pregnancy and as a mother. Throughout the narratives the transformational elements of the maternal experience are core to the lived experience of perinatal anxiety.

Lederman and Weis (2020) paint a broader view of this maternal transformation, using a mixed methodological examination of the expected behaviours and responses of pregnant women. The authors posit that social anxiety and stress are at the heart of psychosocial adaptation to pregnancy. Incorporating quantifiable biophysical responses and outcomes alongside psychological, the authors developed seven dimensions of psychosocial adaptation to pregnancy (systematic steps through which a woman *becomes* a mother), seeking to understand what they regard as adaptive and maladaptive responses to pregnancy. The authors developed a measurement scale for assessment of maternal antenatal adaptation with each dimension regarded as an adaptive challenge faced by women. The dimensions are based on a conceptual model which regards "pregnancy as a period of transition between two lifestyles, two states of being, the woman-without-child and the woman-with-child" and the elements of this transition which are significant (Lederman and Weis, 2020 p. 34). The aspects of the doctoral study data concerned with adaptation support a shift in being, as the women

navigate this uncertain time, concerned with identity and internal conflict as well as the process of growing to understand oneself, suggesting complex psychosocial processes at play.

Examination of Lederman and Weis' (2020) third dimension, identifying a motherhood role, reveals something about the perspective from which their work arose. To make a successful psychosocial adaptation to motherhood (and thereby eliminate anxiety and distress), the mother should be motivated to become pregnant, and well prepared for the birth. Citing literature from the 1960s-1980s, the authors note that errant motivations for becoming pregnant can disrupt the natural course of pregnancy, birth and mothering. For a woman with misgivings about motherhood, a supportive husband who will be a good father can help to smooth the way. Preparing for motherhood, the authors posit, is best achieved by a woman imagining herself in this new role and resolving any internal conflict she may have; this can be through fantasising, dreaming, or thinking about the maternal characteristics she wishes to possess. Women who are excessively narcissistic, lack a good role model, have poor self-esteem, or experience conflict between motherhood and their career, are less likely to successfully navigate this change. Such barriers can induce anxiety. Doubts about the ability to parent can mean that "a state of 'readiness' to make the developmental step" is not demonstrated (Lederman and Weis, 2020 p. 100). The authors summarise with a description of the ideal mother, who has identified and embraced the change in her identity, accepting the loss and relishing the new beginning.

The doctoral work confronts this view. All the women in the study fulfilled the criteria of pregnancies which were planned and much wanted, with an absolute perceived readiness for making this step and embracing change. Yet still the women experienced significant and debilitating anxiety, despite supportive partners and positive role models. Imagining themselves as new mothers or even the confidence of already being a mother did not guard against anxiety. This is counter to the view that a challenging route to motherhood identification (positioned as a maladaptive response) can cause significant anxiety. The doctoral work therefore reveals that the work of Lederman and Weis (2020) presents a simplistic view of the maternal psychosocial experience. Indeed, questionable notions around the positioning of women (referred to as 'gravida') as subjects for development in need of a supportive and encouraging husband and a prescriptive view of how women succeed or fail at becoming mothers hints at more concerning potential routes for the causation of maternal anxiety. These routes are illuminated in the accounts of the women in the doctoral work who felt huge anxiety from the pressure to appear that they were coping and behaving as successful mothers should, demonstrated through the subthemes of 'Otherness' and 'Burdens'. The doctoral work tells us that

the experience of perinatal anxiety, which involves this transformation of self, is far more complex than Lederman and Weis (2020) would believe and points to the need for a holistic view.

Seeing the whole

The phenomenological approach of this doctoral work has facilitated an idiographic and richly detailed understanding of women's experiences of perinatal anxiety and its inherent complexities. When held in stark relief to a positivist approach of rigidly categorising the maternal psychological experience, it demands the need for a more complete way of understanding this phenomenon. This is supported by the work of Sweeney and Taylor (in Beresford and Russo, 2022) who call to de-pathologise motherhood. The authors highlight the danger of medical conceptualisation of maternal challenges, which limit understanding of motherhood and make mothers fearful of talking about their experiences, for example knowing one may be diagnosed with a maladaptive psychological response. Finding the solution in medical treatment, the authors argue, distracts from essential discussion of socio-political and community influences on mental wellbeing. The authors point to the existence of mental health diagnoses as concrete and unquestionable, and while they acknowledge the value of such diagnoses for some people, they also question treatment designed to fit mothers back into society and the motherhood role, disproportionately scrutinising and policing women with 'diagnoses, emotional expressions and behaviours that we cannot accept' (p. 173).

Sweeney and Taylor raise concern that a holistic view of the impact of socio-political decision making, cultural and structural aspects on the mental state is obscured by the pathological view of motherhood, citing a woman who, after no sleep for many nights on a busy postnatal ward with constant interruptions and poor support, was diagnosed with psychosis and admitted to a mother and baby unit. Another example given is of someone from a background of poverty and social adversity being diagnosed with depression because their life circumstances cause them distress. The authors argue this view misdirects attention, meaning that social and political drivers contributing to poor mental wellbeing are not adequately addressed, and advocate for access to:

"…mutual, intentional and trauma-informed peer support outside of psychiatric systems. This is particularly important for perinatal women who can experience distress and overwhelm as the norm in a cultural context of perfect mothers, and who need a place to be honest about their difficult feelings." Sweeney and Taylor (in Beresford and Russo, 2022 p. 174).

The pressure described by the women in the doctoral study, to behave as a 'normal' pregnant woman might, echoes this sentiment and highlights the complex and multifaceted psychosocial context within which women experience perinatal anxiety. A holistic view of perinatal anxiety requires broad consideration of what it means to be a mother, encompassing the sociocultural and political alongside, as flagged explicitly in the doctoral data, existential concerns.

Existential dimensions of becoming a mother

The presence of existential themes within the doctoral data was striking, and although the participants did not use the language of philosophical dimensions, their concern with existential notions is evident in multiple themes. These include 'Transformation', 'Returning to oneself', 'The anxious mother', 'Moving on', 'The emotional unknown', 'Sets of ears' and 'Shifting sands'. These themes illuminate expressions of identity, temporality, responsibility, mortality, relationships and the unknown. The fact that these concerns are threaded through the data across the whole experiential research timeframe, resulted in the decision for the naming of the Longitudinal Experiential Concept, 'Transforming existence'. The longitudinal nature of the study, with these themes running throughout the anxiety narratives, verifies the relevance of existential notions within the complete experience of perinatal anxiety.

This finding is supported by Arnold-Baker (in Arnold-Baker, 2020), who argues that it is necessary to understand existential dimensions of motherhood to clearly see the entire maternal experience. The author notes that existential concerns are not easily recognised by new mothers, and so can lead to an intangible sense of anxiety, worry or in some cases extreme distress. In her existential phenomenological exploration of the experience of early motherhood, the author notices immediately evident practical shifts around organising one's life considering the demands of pregnancy, the care of an infant and the logistics of parenthood. However, another opaque layer of activity concerned with philosophical and existential notions also emerges. The author describes how these notions cause ontological shifts which reshape the way women understand themselves both as individual beings and within their worlds. This is a point strongly identified during this doctoral data analysis process, with an awareness while becoming increasingly immersed in the data, that there were overt, immediately conscious elements to the women's experiences, as well as obscured mechanisms at work.

Arnold-Baker's view resonates strongly with the existential focus that developed within the interpretative analysis of this doctoral work. For example, in the social dimension (*Mitwelt*) parallels with the doctoral data are in the relational bond with the baby forming over time, and the ease and joy of interaction as communication becomes increasingly reciprocal; and in the understanding of others and reflecting on close interpersonal relationships in a new light. Within the spiritual dimension (*Uberwelt*) there is a convergence with the doctoral data around the idea of existential responsibility and notions of freedom and choice: how the worry that mothers feel is borne of this existential state of responsibility. This partly arises through an increased awareness of the world in its "raw state" (Arnold-Baker in Arnold-Baker, 2020 p. 30), concern for their babies and the reality of existence, which is echoed in the doctoral themes of 'Burdens', 'New worries', and the juxtaposed 'Relief and overwhelm'.

Within Arnold Baker's discussion one element which did not align so comprehensively with the doctoral data was within the physical dimension (*Umwelt*), regarding temporality. The author's interpretation of her data revealed that new mothers live firmly in the present, with the day-to-day interaction with their baby restricting their temporal outlook. She cites the work of Binswanger (1958 p.301) to explicate how time is understood by these mothers, moving from "*experienced time* our 'objectified, thought time', i.e. how we might think about time, or how our day, week, month and year is divided up, to *lived time*, which is 'the real inner time-happening'." Arnold-Baker argues that a necessary existential focus towards the vulnerable baby allows for this narrowing of temporal view. Although similar experiences of the baby's need for attention (demonstrated in the subtheme 'Distraction') were articulated by the doctoral research participants, there was not a sense at any point over the period of interviews that their temporal focus had narrowed, hence themes of temporality being present during the pregnancy, early and late postnatal interviews.

A key strength of the doctoral research is that the longitudinal design lent this temporal focus and enabled a more robustly informed understanding of time within the context of the experience of perinatal anxiety. Where the findings of the doctoral work once again align with Arnold-Baker's is within the idea that the change in temporal perceptions "contributed to the feeling that motherhood was all consuming" (p. 21), which hints at similarities with the doctoral research themes of 'Temporal collisions' and 'Shifting sands' which are disorienting in nature.

This examination of the doctoral findings in terms of the psychological challenge within existential and phenomenological aspects of motherhood alongside wider literature confirms that the transition to motherhood as part of the experience of perinatal anxiety for the women in this study was key. This

has confirmed and connected the two elements of the attribute statement from the theoretical definition of perinatal anxiety (Folliard et al. 2020): a psychological challenge bound up in the transition to motherhood. The second attribute statement regarding the uniqueness of perinatal anxiety and specific concerns is now explored in relation to the doctoral findings and the extant literature.

6.1.2 Perinatal anxiety is not unique in clinical presentation but there is often a focus on perinatal concerns

Re-visiting the uniqueness of perinatal anxiety: perinatal Obsessive Compulsive Disorder (p-OCD)

As previously discussed, anxiety is often considered a concept interchangeable with worry and stress. Therefore, what does an examination of the doctoral findings alongside the wider literature reveal about the extent to which perinatal anxiety is truly unique?

Within this doctoral work, questions arose regarding how anxiety during the perinatal period may differ from non-perinatal anxiety. This questioning began during the early stages of study design, when considering inclusion criteria and the decision for the open approach to recruit women with or without pre-existing (prior to pregnancy) anxiety. The intention of the longitudinal perspective was to enhance this understanding, giving a richer picture of how perinatal anxiety is experienced over time. During the interviews the participants were encouraged to reflect on prior experiences of anxiety to elicit comprehension of how their perinatal experiences of anxiety may be unique. Aspects of the doctoral data which highlight elements unique to perinatal anxiety are those that concern a focus on the baby and responsibilities of motherhood. For three of the five participants this was especially pertinent, as they described intrusions around harm coming to the baby, data which strengthened the GET 'Baby as external focus' and the subtheme of 'New worries'. A second subtheme, 'Distraction', also aligned with the focus on the baby, although conversely demonstrated a flipside to the worry, with most of the participants describing affirming aspects of the baby being in their company, as a distraction from anxious thoughts. Therefore, the doctoral data revealed that the presence of the baby was paradoxically anxiety inducing and a welcome distraction.

Baby-related intrusions have been examined in the context of general anxiety and obsessive-compulsive disorder (OCD) symptomatology, providing further insight into this uniquely perinatal facet of anxiety. Barrett et al. (2016) explored the relationship between perinatal OCD and responsibility as a concept central to motherhood. The authors compared perinatal and non-

childbearing control groups, examining how they rated 'responsibility interpretations': i.e. a heightened sense of responsibility for harm occurring. The study found that responsibility interpretations regarding baby-related intrusions in the postpartum group predicted increased OCD symptomatology, compared to the general-intrusions group. The rationale for this study was the theoretical position that OCD during the perinatal period has a distinct clinical picture. It could be argued that the suggestion that perinatal anxiety is not unique in its presentation (Folliard et al., 2020), is counter to this position on OCD, which identifies a relationship between responsibility interpretations and OCD symptomology: a unique anxious perinatal presentation. However, closer examination of the work of Barrett et al. (2016) reveals the manifestation of OCD symptoms, in terms of intrusions and resulting obsessions/compulsions is experienced in a similar way to non-perinatal OCD; the difference is the direction of intrusions. The significance of baby-related intrusions supports the idea that the defining characteristic of this perinatal anxiety condition is how it relates to adjustment to motherhood, with the additional sense of responsibility for the infant a key tenet within this life change. The doctoral GETs described above, regarding anxiety connected to the baby, add weight to this position.

Consideration of the experience of the doctoral study participant, Lucy, further illuminates the work of Barrett et al. (2016). Lucy's early postnatal experience of a distinctly negative self-critical interpretation of baby-related intrusions (fearing she would deliberately harm the baby rather than that harm would come to the baby), mediated the relationship between her antenatal obsessive beliefs regarding her responsibility for the safety of the pregnancy, and her postpartum obsessive-compulsive symptoms (resulting in a diagnosis of perinatal OCD). Viewed through a cognitive behavioural lens, Lucy's OCD symptoms escalated dramatically as her thought pattern directed her behavioural response (Abramowitz et al., 2007). Some differences between the doctoral data and Barrett et al.'s study participants should be noted. This perinatal OCD symptomatology study has a purely postnatal focus with no detail provided regarding mental health history profiles and participants showed normal anxiety scores across the battery of psychometric assessments. However, when considered alongside the doctoral data, which brings a novel longitudinal focus, the critical significance of felt maternal responsibility throughout the entire perinatal period is illuminated. It is therefore the psychological impact of maternal responsibility, which underpins the doctoral Longitudinal Experiential Concept of 'Maternal eyes' that distinguishes this type of anxiety.

While OCD has a recognisable perinatal presentation due to the nature of the intrusions which characterise the condition, examining another common anxiety presentation in the context of the doctoral data, may further highlight differentiation between perinatal and non-perinatal anxiety.

Parallels between perinatal anxiety and other forms of anxiety: Generalised Anxiety Disorder (GAD)

Rachman (2020) outlines key theory about the presentation of Generalised Anxiety Disorder, which resonates with perinatal anxiety characterised as indistinct in mental and somatic presentation from general anxiety (Folliard et al. 2020). Further, exploration of Rachman's description of anxiety, reveals parallels regarding presentation which align with the doctoral research, in particular the Longitudinal Experiential Concept of 'Maternal eyes', with its focus on responsibility and worry about the baby. Presentation of GAD as described by Rachman (2020) provides a useful comparison because a key clinical feature is worry about others. The significance of responsibility as an existential notion has been discussed previously: one of the notable features of GAD is the level of responsibility people with the condition feel towards others; this fits with the focus within perinatal anxiety on the unborn and new baby highlighted in the doctoral research GETs 'Burdens' and 'New worries'. Rachman notes that other anxiety disorders which feature, for example obsessions, panic or phobia, tend to be more inwardly focused.

This notion raised by Rachman (2020) regarding sense of responsibility for others, aligns with Barrett et al. (2016) as discussed previously, to show a commonality of experience between GAD and OCD. Rachman's categorisation of obsessions as having an inward focus apparently contradicts the position that OCD and GAD are similar regarding outward-facing felt responsibility. Lucy's narrative in the doctoral data illuminates how these lines can be blurred: the subject of Lucy's anxiety was the wellbeing of the baby and responsibility for this, the obsessions were an inward focus on her mindset, beliefs about herself and actions. This is an example of how the idiographic doctoral data illuminates the nuances of the perinatal anxiety experience and reveals its complexity, in this case suggesting facets of mixed symptomatology. In turn, this challenges the relevance of focusing on a specific type of diagnosis in the phenomenological understanding of perinatal anxiety. Characteristics of the phenomenon may be shared across numerous clinical diagnoses.

The subtle nuances of emotional experience are weaved throughout the doctoral data, with the unpredictable, pervasive but fluctuating nature of perinatal anxiety described by all the participants.

This leads them to try to gain a handle on their thinking, as highlighted in the GET 'Grasping psychological safety'. The language Rachman (2020) uses to describe how anxiety is experienced as an emotion resonates with the doctoral data, explaining that it can feel hard to identify the reason for tension, with a sense of it being free-floating and intangible. The author describes the way in which anxiety differs from fear, with the most overwhelming fears classified as anxiety disorders; fear as an emotion being directed towards a very specific object is often more manageable than anxiety, which is difficult to grasp. In common with the doctoral data, the author's description of the wax and wane of anxiety along with its dogged presence closely aligns with the themes of 'State of flux' and 'Omnipresence'.

The safety sought by the participants in the doctoral study, was often from significant people in their lives or professionals, most clearly demonstrated through the GET 'Sets of ears'. Rachman (2020) notes one characteristic of GAD as a reliance on others for reassurance and support, interactions with others can provide a sense of safety and in the case of persistent GAD can lead to a potential over-reliance on the security provided by those closest to them. This was certainly a feature of the participants in the doctoral research, hence the resulting subtheme of 'Safety net', suggesting a commonality between features of GAD and perinatal anxiety. While interaction with others is overall a positive and human need, Rachman (2020) also notes the personal survival value of anxiety regarding threat detection, and that when coming across unfamiliar situations it is helpful to have an appropriate level of alert. Arguably a degree of anxiety around the uncertainty inherent in pregnancy and motherhood, certainly for first-time mothers, is a natural response. The author also notes that anxiety can stimulate individual creativity in the controlling of anxiety, which calls to mind the grounding technique of repeating her baby's name ten times, devised by Meena.

There are clear features of both OCD and GAD which align with the experiences of perinatal anxiety revealed in the doctoral data suggesting common symptomatic presentation. As discussed, the key unique feature of the experience remains the felt responsibility of motherhood and the focus on the baby, the 'Maternal eyes'. The discussion has so far explored a range of evidence from different paradigms but has not yet considered a positivist perspective concerning a measurable diagnostic differentiation between types of anxiety experienced during the perinatal period.

What diagnostic measurement reveals about perinatal anxiety

The development of perinatal specific anxiety scales indicates that among clinicians, these are valued as measures of what is regarded as a unique subset of anxiety (Sinesi, 2019). The fact that these scales have been developed to include pregnancy and postnatally-focused worries alongside general measures of anxiety presentation, supports the above discussion: that perinatal anxiety has a similar somatic and mental presentation to general anxiety but with a focus on perinatal concerns. Using insights from the doctoral study, the discussion above has revealed that the key uniqueness exists within maternal felt responsibility and a focus on the baby, as represented through the Longitudinal Experiential Concept of 'Maternal eyes'.

There are few studies which attempt to address a distinction between types of anxiety experienced perinatally. Matthey and Souter (2019) however explored whether general anxiety experienced in pregnancy and pregnancy-specific anxiety endured differently. The authors aimed to determine whether women screening positive for pregnancy-specific anxiety remained screen positive at a second screen point two to five weeks later, as studies of perinatal populations using a general anxiety scale had shown that anxiety was transient over this period. Matthey and Souter (2019) speculated that there were more reasons for pregnancy anxiety to be enduring (citing worries about labour, birth and early postnatal challenges), and therefore that screening with a tool accounting for pregnancy-related factors would show different results. Several issues were reported with this study regarding resource scarcity and therefore sample and analysis limitations. However, considering the findings alongside previous work from the same authors, the study did not support the view that pregnancy anxiety endures more than general anxiety. This study provides a comparison between general anxiety during pregnancy and pregnancy-specific anxiety, with no difference between the two in terms of their persistence.

This view is challenged by the doctoral research which, through detailed analysis using a longitudinal approach, examining the experience of anxiety from pregnancy until eight months post-birth clearly demonstrated the enduring nature of perinatal anxiety. This was evident in the subtheme 'Omnipresent', with the subtheme 'State of flux' indicating that measurement of anxiety as per Matthey and Souter's (2019) study with a short interval between data collection may have missed the opportunity to robustly test the enduring nature of perinatal anxiety. A strength of the doctoral work is that is has provided insight in this respect.

This discussion has so far focused on the uniqueness of perinatal anxiety compared to other forms of anxiety. Support for the characterisation of perinatal anxiety as not unique in its mental and somatic

presentation is provided through the alignment between the doctoral data and the wider literature where similarities regarding presentation are seen. However, this examination has revealed that elements of the experience which are unique, are those relating to felt maternal responsibility and a focus on the baby. A focus on perinatal concerns has been attributed to perinatal anxiety (Folliard et al., 2020), and it is a closer examination of this that will progress this discussion. Some aspects of specific perinatal concern have been touched on previously, for example the immediate concerns of pregnancy and worries during adjusting to the physical, practical and emotional demands of new motherhood. One aspect not yet considered, building on notions of maternal responsibility and prominent in the discourse of the doctoral research participants, is the relationship with the baby. How this features within the understanding of perinatal anxiety and evidence around bonding and attachment as key tenets of the mother-infant relationship is a useful reference for this.

Perinatal concerns: ***Focus on the baby***

The mothers in the doctoral study had varied perceptions of the relationship with their babies, ranging from the baby as a comfort and source of joy, to the baby as someone with whom the relationship was fractured. How the mothers felt about their babies was a key part of their narratives and they all described anxiety directly related to this fundamental relationship, often in terms of the impact of their anxious behaviour on their baby's future. This focus showed a clear link between anxiety and the maternal-infant relationship as the women described the ways in which anxiety influenced their interactions with their newborns, from hypervigilance hinting at potentially intrusive behaviours, to infant avoidance and a universal fear of causing the infant difficulties of their own, as noted in the subtheme 'New worries'.

Nath et al. (2019) recognised this link and explored mothers' perceptions and objective observations regarding the relationship alongside their levels of anxiety, to examine the connection between antenatal anxiety and emotional, behavioural and cognitive problems for infants and older children. The authors posited this could provide evidence for a focus on intervention supporting mother-infant interaction and parenting behaviours. In this study, 454 pregnant women were recruited and clinically assessed for the presence of an anxiety disorder at baseline, mid-pregnancy and at three months postpartum. They were assessed for depressive symptoms at baseline and mid-pregnancy. At the postpartum timepoint the participants were also assessed on self-reported bonding difficulties, while a subset of 204 mother-infant dyads completed a video recorded interaction. The authors found that the presence of an anxiety disorder did not impact the sensitivity of the mothers' interactions with

their infants (video observation), and that where there were negative perceptions (self-reported) of bonding, these were accounted for by the presence of depressive symptoms through pregnancy. Postnatal depressive symptoms were not measured.

A later study examined the relationship between anxiety and bonding and accounted for postnatal depressive symptoms (Davies et al., 2021). This study of 527 mothers of infants between birth and twelve months of age found a significant association between postnatal anxiety and depression and impaired maternal-infant bonding, alongside findings around the mediating effect of anxiety and depression between bonding and infant temperament. Of significance in the doctoral data and counter to Nath et al.'s (2019) findings, the two mothers with depressive symptoms in pregnancy (but not postnatally) did not perceive any negative experiences of bonding. The one participant with both antenatal and postnatal depressive symptoms experienced significantly impaired bonding with her newborn. The doctoral data alongside the findings of these studies, reveals important information about the significance of anxiety and depression in relation to one another. By providing a view of the maternal experience throughout the perinatal period including detailed insight into a range of lived emotion, the longitudinal data adds to the evidence in this subject area and suggests room for further interrogating the mechanisms whereby a positive mother-infant relationship is nurtured for those experiencing anxiety and depression at different perinatal timepoints.

Psychological processes not directly related to, but potentially impacting mother-infant interactions, are also relevant to this discussion, including self-perception. The doctoral data demonstrated the ways in which the participants viewed themselves, which was often with a critical eye. This came across in positioning themselves outside of what they understand as normal, the 'Otherness' they describe, the 'Burdens', and the guilt as previously discussed. Beato et al. (2022) examined the influence of self-critical behaviours on bonding, examining whether maternal self-criticism mediated the relationship between a history of anxiety and depression and mother-infant bonding. This cross-sectional survey study explored the relevance of three self-critical dimensions: inadequate-self, hated-self and reassuring-self. This study found that with a background history of anxiety symptoms, maternal self-criticism mediated the relationship with mother-infant bonding via one of these dimensions: inadequate-self. The study by Beato et al. (2022) suggests the perception of self is a perinatal concern linked to the presence of anxiety, impaired bonding and maternal worth.

In the doctoral data concern about self was front and centre, hence the formation of the Longitudinal Experiential Concept of 'Transforming existence'. Self-criticism was evident in how the women

described their feelings of being overwhelmed during pregnancy and as new mothers, with the relationships with their babies and personal influence on their babies' wellbeing a significant part of the narratives. It is perhaps little wonder that such perceived inadequacy would exist, given the long history of scientific and societal perceptions of women's ability to cause harm to their children based on their behaviours, a history which does not fully consider the "many textured aspects of the social world" (Richardson, 2021 p. 209).

Perinatal concerns: Maternal ambivalence

Maternal ambivalence is a fascinating concept to consider within the context of the social world, and one which came to the fore in the doctoral data, where the quality of the maternal-infant relationship was a significant dimension of the experience of perinatal anxiety. Understanding how mothers perceive relations with their infants can illuminate the maternal cognitions which impact parenting behaviours. The doctoral data showed this from varied perspectives: positive interactions which allayed anxieties, provided reassurance of love, and fostered nurturing behaviour, and a fractured relationship which sparked infant avoidance and was ultimately the root of complete psychological breakdown. Maternal ambivalence is relevant to the complex ways in which women feel concern towards and about their offspring, as it recognises that there may be opposing maternal emotions felt towards the child (Almond, 2010). Exploring the concept of ambivalence may help explain why perinatal anxiety is intertwined with concepts of bonding and attachment. For women, is loving their child in the 'right way' arguably the biggest psychological perinatal concern?

Maternal ambivalence is described as the state of a mother possessing both love and hate towards her child, where there are two potential outcomes (Staneva in LaChance Adams, 2020). In the case of unmanageable maternal ambivalence, the result is destructive under the weight of guilt and stigma, and ultimately the emotion becomes unmentionable. In the case of manageable ambivalence, a positive and creative state can arise, as the mother uses the dual existence of love and hate as a force for thinking about the dynamic between herself and her child, leading ultimately to growth within the relationship. Almond (2010) discusses maternal ambivalence, describing a powerful sentiment which is troublesome yet normal. Troublesome as it presents a challenge to societal perceptions of hate, which when directed towards others, whether relatives, friends or strangers is considered disagreeable or distasteful, yet when directed towards one's own child is "immoral, unnatural and evil" (Almond 2010, p. 2). Normal in its ubiquity, the author posits that maternal ambivalence is in fact a natural and shared experience of motherhood for many women. The first emotion described by the

author in relation to the feelings maternal ambivalence engenders is anxiety, grounded in cultural expectations and the fear of being a bad mother. The author notes societal expectations of mothers are matched only by the expectations they have of themselves, where perfect caregiving is the aim.

Conflicted emotion was a concept that translated strongly through the doctoral data, mostly focused on internal conflict around the contradictory thoughts, feelings, and behaviours the women experienced. The subtheme 'Fighting with self' was characterised by a disconnect between the participants' experiences, their sense of who they were prior to pregnancy and who they had become, often in relation to how they felt they should be as they became aware of their 'Otherness'. Staneva (in LaChance Adams, 2020) frames this within the idealised picture of motherhood and the distress resulting from both conflict and ambivalence. The author argues that an acceptance of the hostility towards the negative experiences of pregnancy and motherhood enables them to become manageable. The doctoral study theme of 'Acceptance', which in the data was a key feature of the participants' ability to make sense of and come to terms with their feelings and move forward, supports this. The doctoral data advocates for a greater understanding of maternal ambivalence to enable women to feel less of the inadequate self which, as previously noted, mediates their anxiety (Beato et al., 2022). Almond (2010) notes that concerns about mothering are a fundamental element of the psychology of motherhood and that a greater understanding of maternal ambivalence as a normal aspect of women's emotional lives would allow women to seek support for difficult feelings when needed. It is imperative space is provided for an emotionally literate understanding of the perinatal concerns on which perinatal anxiety is focused, acknowledging the complexity of the experience of motherhood:

"There is a narrow scope within which women seem able to engage in conversations that steer away from the 'pregnancy glow' narratives. Women lack a narrative space and adequate language to reflect experiences that contradict dominant assumptions" (Staneva in LaChance Adams, 2020 p. 77)

The doctoral data discussed so far has provided a unique perspective on perinatal anxiety due to the richness of detail and the longitudinal approach, which have added to existing perspectives in the extant literature. Exploration of aspects of convergence has highlighted four key areas of relevance. Regarding language and presentation, a need for understanding of the use of language of interrelated concepts such as worry and distress. Longitudinal insights have added to understanding of perinatal anxiety presentations: features shared with non-perinatal anxiety presentations, but an omnipresence characterised by maternal existential foci simultaneously fluctuating with perinatal-related

worries. The interaction between and implications of comorbid perinatal anxiety and depression reveals a complex picture which warrants further exploration. Finally, there is a clear need for greater understanding of existential maternal experiential concepts such as ambivalence, to encourage compassion for mothers and create the space for seeking support.

6.2 Divergence between the doctoral research findings and extant literature

Towards a deeper understanding of perinatal anxiety

There were aspects of the doctoral data which, due to their divergence with the attributes previously described as characterising perinatal anxiety (Folliard et al., 2020), further frame this discussion. These extend understanding of the phenomenon and highlight novel aspects of the experience regarding forward motion, support and recovery, as reflected in the Group Experiential Themes of 'Moving on', 'Sets of ears' and 'Shifting sands'. The understanding of perinatal anxiety as a concept unfamiliar to health professionals (Folliard et al. 2020) is not reflected in the doctoral data, which may be explained as four of the participants felt their mental health difficulties were taken seriously and they were given appropriate professional support. The participant who most explicitly felt unsupported, predominantly articulated needs around her maternity care which were unmet, rather than a sense that professionals did not understand that she was experiencing anxiety. Therefore, there was nothing in the experiential data that supported the idea of perinatal anxiety being unfamiliar to health professionals.

A previous lack of data on the lived experience of perinatal anxiety, means there is little insight into *how* people live with the condition in terms of managing daily life (Folliard et al., 2020). The divergence between the theoretical definition of perinatal anxiety and the doctoral data therefore highlights what this study adds: how managing daily life, recovery and moving forward is experienced with perinatal anxiety. Using discussion of this non-alignment to build on existing understanding facilitates a complete examination of the lived experience and is strengthened by its longitudinal approach. The idea that perinatal anxiety is a phenomenon within which concepts of moving on and support are central to the lived experience is key, and this is better understood because of examination of antenatal and early and late postnatal experiences. Crucially, in the context of this study, this supports discussion of approaches to recovery from perinatal anxiety and can inform how healthcare practitioners and systems can most effectively support women experiencing perinatal anxiety.

Good friend gone bad? The shadow of intelligence or the specter [sic] of death?

Rachman (2020) notes that modern discourse and approaches to managing anxiety position cognitive processes as a central tenet, evidenced by the promotion of cognitive behavioural therapy as the gold standard treatment for anxiety disorders (NICE, 2011). Rachman states this is valid given anxiety is concerned with core cognitive mechanisms such as reasoning, vigilance, and perception. Reilly et al. (1999, p. s18) state that with a cognitive premise the fundamental existence of anxiety is not problematic; rather that when anxiety turns from being the "good friend" to the "good friend gone bad" dysfunction occurs and addressing unhelpful hyperactive cognitive patterns can provide resolution. An earlier paradoxical notion of anxiety was offered by Barlow (1988 p.29): the "shadow of intelligence" presented alongside the "specter [sic] of death". These metaphorical representations allude to the complex nature of the condition, referencing questions around perinatal anxiety as an adaptive condition inherently linked to the perinatal state: the 'good friend' may be considered an expected feature of perinatal psychology (Lorenzo, 2022). Indeed, as noted by Matthey (in Wenzel, 2016), maternal anxiety is protective of external threats to the infant's wellbeing.

The doctoral data further explicates these notions of the good and bad friend through the GETs 'Moving on' and 'Shifting sands'. The participants experienced the 'good friend gone bad', evidenced through their uncontrolled anxious cognitive, emotional, behavioural and physiological responses. However, these latter experiential themes also revealed that a degree of manageable anxiety would continue to feature in their lives, as borne out in the subthemes 'Coping', 'Acceptance', 'Resolution' and an understanding that 'This too shall pass'. This was illuminated through the sense that the presence of anxiety would not be problematic should physiological and psychosocial function be maintained – i.e. the good friend would not become bad. Therefore, taking a non-pathological view of anxiety, such as that supported by cognitive theory, may provide a perspective which is accepting of anxiety as part of the perinatal experience, allowing appropriate response to the emergence of the 'bad friend', and ultimately nurturing a positive approach to the relationship between the individual and their anxiety.

The positive psychological notion of prospection, imagining future events and goal setting as key to the cognitive understanding of anxiety, and shifting focus from the traditional view of an illness of abnormal emotional behaviour rooted in the past, is one such non-pathological approach (Rachman, 2020). Baumeister et al. (2016) detail their theory of pragmatic prospection, which describes not merely thinking about what one wants for the future but how this can be achieved, imagining

obstacles and planning how to overcome them, starting with the belief that anything is possible before it has occurred. The authors speculate that human agency is inherent in this optimistic prediction, with evolution allowing the human brain to consider the self within predictions: what the individual wants to happen as opposed to merely what will happen. An evolutionary point within Baumeister's theory is that making choices about the future is adaptive to allow for better reproductive and survival chances, a trait which may have increased through natural selection. There is a sense of this in the way in which the doctoral participants consider that through changing their own behaviour they impact their children's future, facilitating for them a stronger psychological position, unhindered by the limitations of severe anxiety.

Temporal perspectives were present in the doctoral data from the outset, highlighted initially in the antenatal subtheme, 'Temporal collisions' as the participants described their experience in the context of past, present and future perceptions and imaginings. The later postnatal GET of 'Shifting sands' and the subtheme 'This too shall pass' indicated a reflective perspective on the overall experience with the positivity present in the subtheme 'Optimism' showing an awareness of the participants' vulnerability but crucially, the ability to maintain control of anxiety and shape the future.

This temporal focus within the data reveals the study participants were engaged in pragmatic prospection, making sense of their current situation and how they imagined the future, clear about goals and how to achieve them. For example, regarding control of their anxiety disorder (i.e. managing OCD symptoms, agoraphobia or social anxiety), making plans for a routine which would afford greater control over the unpredictable and overwhelming work of motherhood, or planning for contraceptive intervention to maintain psychological stability. All the women were active in a process of thinking about the future, weighing up potential events and planning actions accordingly. Sometimes this was short-term prospection, the routine of the coming weeks and months; at other times long-term, their newborn being an anxiety-free adult. Regarding motivation, Baumeister et al. (2016) describe the ability to imagine the positive outcome (i.e. the anxiety-free offspring), as the cornerstone for adaptive behaviours. Here we see how, among the study participants, pragmatic prospection was a helpful psychological process in enabling them to work towards a strongly desired outcome. Therefore, the cognitions, behaviours and meaning the study participants derived from experiencing perinatal anxiety were grounded in temporality; this in turn validates the Longitudinal Experiential Concepts of 'Maternal eyes' and 'Transforming existence', within which temporal perspectives of themselves as individuals and mothers are central to psychological adaptation.

Baumeister et al. (2016 p.7), argue that constructed "mental representations… serve as a guide for action" and that the meaning individuals attribute to their psychological experience is greater the further into the future prospections stretch. From this standpoint they posit that prospective thinking is of greater influence on behaviours than retrospective thinking (although acknowledge thoughts about the past are still meaningful). The doctoral data on the other hand indicates that the biggest influence on the participants was *past* experiences rather than future imaginings. The participants may not have been as strongly motivated for change had their retrospective sense making been less impactful. For example, the ways in which particularly Gabi and Lucy understood their past experiences of childhood and perinatal loss trauma significantly influenced their perinatal cognitions.

Meena also, while not revealing any significant past trauma, based her wishes for her unborn's wellness on her past experiences of living with OCD, demonstrating the interplay between past negative experience and notions of a positive future. Baumeister et al. (2016) note that the relationship between a pessimistic bias and optimism is indeed a key facet of their theory, with the ability to move between the two states fundamental to pragmatic prospection. While optimism is motivational and feels positive, pessimism drives the imagination to find solutions. The pessimistic bias for the doctoral study participants, rooted in past experience, was key to their capacity for pragmatic prospection: they actively harnessed the pragmatic effect of their pessimistic bias.

This relationship between optimism and pessimism and its temporal links is seen throughout the doctoral data, for example in pessimism about the impact of the maternal anxious state on the infant and optimism about future possibilities, hence the sometimes-contradictory nature of the experience. Despite the disorientation this sometimes caused the study participants, the desire to move forward was universal. Acknowledging that a pessimistic bias is perhaps an inevitable facet of anxiety rooted in prior traumatic or difficult experiences, is it possible to present a non-pathologising and optimistic perspective from which women experiencing perinatal anxiety can achieve psychological stability and maintain wellbeing?

Maintaining perinatal wellbeing, and issues of equity

Elements of positivity and a sense of striving for an improved situation run throughout the doctoral data, emerging antenatally as the participants engage in processes of 'Reflecting and self-understanding' which are empowering, then postnatally with an existential recalibration as the participants are 'Returning to oneself' bringing a sense of renewed stability. Finally, the GET 'Moving on' embodies a completeness of the psychological experience, as the participants reflect on their adaptation, and through a process of 'Coping', 'Acceptance' and 'Resolution', are at peace with their experiences. The strength of this longitudinal data is that it enables a complete view of lived perinatal anxiety, which in terms of overall wellbeing revealed an important experiential facet of connecting with a positive outlook regarding the anxious condition. Although the participants viewed their anxiety in pathological terms conspiring to make their pregnancies 'Lonely and unmagical', ultimately the positive foci were those that enabled them to move forward, so are arguably a helpful lens through which to view recovery from perinatal anxiety.

The positive psychology movement (in which Baumeister is positioned) centres on the theory of elements of wellbeing which may provide clues as to the significance of the doctoral data. Seligman (2011) describes five structural pillars of wellbeing: Positive Emotion, Engagement, Relationships, Meaning and Accomplishment (PERMA). As psychological thinking has shifted away from illness and towards wellbeing, an approach to demystifying the components of wellbeing has been sought and explicated; in UK health discourse this has been positioned as Five Ways to Wellbeing: Connect, Be Active, Take notice, Keep learning and Give (NEF, 2008). Both frameworks are associated with a eudaimonic philosophy of wellbeing, concerned with how an individual feels about their life in terms of their relationship with themselves, others and their environment (Waterman et al., 2010). This closely aligns with the Longitudinal Experiential Concepts from this doctoral work, as the participants' concerns are fundamentally related to this trio of relationships, with notions of self, others and society threaded throughout, from the positioning of mothers outside of 'normal' social expectations seen in 'Maternal eyes' (society), to the self-examination within 'Transforming existence' (self) and the significance of support structures within 'Emotional kaleidoscope' (others).

The women in the doctoral study came from a range of backgrounds providing varied degrees of social and economic opportunity. Reflecting on this raises an important point regarding the paradigms of wellbeing described: these are all based on a premise of access to the core tenets of wellbeing, which may be more achievable for some than others and brings to the fore the question of wellbeing and social justice. Seligman (2011) stresses that all the PERMA elements must be fulfilled for overall wellbeing to be achieved, and that choices in life should account for them comprehensively.

Responsibility for actions and achievement of wellbeing lie squarely at the door of the individual and their ability to overcome poor mental health by making improvements to their character (Seligman, 2011). However, the capability to make choices which impact wellbeing implies a social and economic freedom to choose, and therefore does not account for a universal experience (Nussbaum, 2011).

Yakushko and Blodgett (2021) critiqued the positive psychology movement from the standpoint of social justice, their overriding concern that this approach at the very least does not account for the experiences of marginalised or minority groups, and at worst is damaging to them. They cite a body of work which problematises the positive psychological approach in terms of cultural power dynamics, oppressive popular social values, perspectives grounded in typically white western culture, and the belief that the self operates outside of socially constructed systems and values. This latter point is emphasised by the authors, who argue this detracts from interrogation of systems and structures and misses the point that social justice is key to wellbeing. The doctoral data categorically illuminates the fact that the lived experience of perinatal anxiety exists within socially constructed values and systems, arguably including constructs which are damaging to the participants as they mentally surround themselves with images of social norms and expectations.

Furthermore, Yakushko and Blodgett (2021) make an interesting study of positivity suggesting that optimism and positivity can be associated with lack of empathy, less civic engagement, and poor achievement. The authors explicate the importance of negative emotion to enable the experience of a full life, the propensity for adaptive function and a tendency for solidarity for people from oppressed groups. This view speaks to the interplay between optimism and pessimism discussed previously: this yin and yang of experience could be argued is an inevitable part of the rich tapestry of human existence.

This critique begs the question, especially in the context of this doctoral work committed to examining perinatal anxiety in a form rich in idiography: is positive psychology an appropriate lens through which to view recovery from perinatal anxiety, which will disproportionately impact women from socioeconomically deprived backgrounds with less opportunity for change? Interestingly Yakushko and Blodgett (2021) refer to the positioning of positive psychological science as a naturalistic pursuit that in the interest of robustness avoids the interpretative paradigm. Of note, when Leamy et al. (2011) worked with an expert consultation group to formulate a framework for mental health recovery, they had intended to focus on group-level, top of the hierarchy, evidence. However, ultimately the authors heeded the advice of their expert consultants who raised concerns around

narrowing understanding, suggesting that for experts in the field of mental health recovery, the richness of individual experience is valued.

Leamy et al.'s (2011) systematic review and narrative synthesis of recovery in mental health facilitated formulation of a conceptual framework of recovery processes. Aiming to account for the experiences of different groups, within the systematic review a subset of studies of the experiences of Black and minority ethnic populations was examined and informed framework development. In their discussion Leamy et al. (2011) highlight that the philosophy of recovery values individual experience over nomothetic data, while a generalisable approach is favoured by mental health systems and within scientific communities. They also note that the dominant scientific view is where personal characteristics (they use patience and tolerance as examples) are sidelined and questions of identity are rooted in individualist rather than collective notions. This is an issue also raised by Yakushko and Blodgett (2021, p.113) questioning an approach which "primarily privileges cognitive-behavioural and behavioural perspectives, which emphasise rationality, control, and self-improvement rather than the primacy of personal and collective liberation, meaning or humanistic values". The paper by Leamy et al. (2011) is helpful in considering some of the questions which are raised by Yakushko and Blodgett (2021) in their critique of positive psychology, providing a thoughtful approach to their recovery framework development which accounts for some of the clinical, scientific and social challenges present.

This doctoral work has aimed to account for the importance of appreciating individual experience. It is crucial to understand that all experiences are not equal, and recovery discourse must recognise this by advocating an approach to wellbeing that addresses inequalities. The value of idiographic detail in this doctoral work provides a valuable understanding of the complexity of experience; it has presented an understanding of perinatal anxiety which highlights that inherent in the lived experience is the way in which it exists within individual, cultural and societal boundaries. The final part of this discussion positions perinatal anxiety within a broader lifeworld context by exploring social theories.

6.3 Learning from Lucy

The doctoral narratives presented multifaceted, complex, and rich experiences, with each participant's past strongly influencing their present and their imagined future. There was no sense in which these women's experiences of perinatal anxiety could be fully understood outside of the entire complexity of their lives and their social positioning as individuals and as pregnant women, becoming

mothers. Taking the case of one participant, Lucy, provides an individual focus which serves to illuminate a broader theoretical understanding of perinatal anxiety. Lucy's story was grounded in an experience of past perinatal trauma, and she came to the research having experienced multiple pregnancies but with no live children. Her anxiety was debilitating, rarely able to leave the house during pregnancy, and with little ability to function when episodes of depression simultaneously occurred. Comparing herself to other pregnant women, Lucy felt abnormal. Following birth, in contrast to the other study participants, Lucy did not feel immediate love for her baby, instead feeling overwhelmed by and intensely fearful of her level of detachment. This was not what was expected: what kind of mother does not feel love for their newborn? Initially terrified of harming her baby, she eventually turned the focus on herself, ultimately with a significant attempt to harm herself. Desperation: surely there is no place for someone with these feelings, a mother who cannot connect with and protect her infant?

Throughout Lucy's perinatal experience was intense anxiety: of another pregnancy loss; that she was not 'normal'; of how others viewed her; of doing something unthinkable; that she was not enough; for her child's future. For Lucy her fears were compounded within an experience so far removed from personal and perceived societal expectations of mothering that it almost destroyed her. Lucy's story is fundamental to the understanding of perinatal anxiety that this doctoral work brings. Held in contrast to the experiences of the other participants, none of whom felt detachment from their infants, it serves to highlight just how critical aspects of maternal social functioning are within the experience of perinatal anxiety and provides the basis on which deeper theoretical understanding can be grounded. Lucy's experience will be considered in two ways, first within aspects of the social construction of perinatal anxiety and secondly, situating perinatal anxiety within social theory.

Perinatal anxiety and the social world

Reflecting on the extent to which Lucy's anxiety was socially constructed it is helpful to consider her diagnosis of postpartum OCD in the context of a cognitive behavioural explanation for her deterioration. Despite not being the only participant with an OCD diagnosis, she was the only individual whose early postnatal experience was one of a negative interpretation of baby-related intrusions, mediating the relationship between her pregnancy obsessive beliefs and her postpartum obsessive-compulsive symptoms (Abramowitz et al., 2007). Further work by Fairbrother and Abramowitz (2007) provides clues to the social construction of postpartum OCD, as the authors highlight the perinatal experience as one of increased responsibility in-hand with the care-giving role,

a reduction in healthcare professional involvement following pregnancy, and the influence of risk discourse which impacts parental perception of danger. The alignment of these perspectives with Lucy's postpartum OCD experience, where the intensity of care-giving weighed on her and she was conscious that "*as the weeks went on and the crisis team left, and the perinatal team support went down a little bit, I just started thinking in my head I can't do it",* strengthens the view of her anxiety as socially constructed. Dowbiggin (2009) supports this, detailing the long history of anxiety and the historical perspectives which have shaped its social construction, highlighting particular contemporary cultural female norms and arguing these directly fuel increased rates of anxiety among women.

Extending the conversation regarding gendered aspects of anxiety, further clues as to its social construction are provided by Silverio et al. (in Mayer and Vanderheiden, 2021) and illuminated in Lucy's experience. The significance of motherhood to society is discussed, positioned at the heart of the reproductive success of a population and loading motherhood with an existential importance ranging from the fruitful bearing of offspring to successful nurturing of future citizens. The authors posit that motherhood ideologies are created within values of a heteronormative masculine hegemony, where women who choose not to, or are unable to, mother are othered, thus creating an unwelcoming environment for women who are childless by choice, or those who may not feel completely connected to their children. Lucy's experience of this was twofold: initially, multiple pregnancy losses threatened her ability to fulfil the reproductive role. Secondly, once the much-desired infant arrived, an inability to connect with him led Lucy to wonder what was wrong with her, "*You know. I thought I was going crazy".* Lucy hid her feelings from her partner, told herself they would go away, ashamed of the kind of mother people would think she was.

Silverio and colleagues present the familiar image of the child-centric 'good' mother and that the performance required to fulfil the role is often unrealistic and unachievable. The authors note that maternal anxiety is exacerbated by modern societal expectations of mothers (alongside fear-inducing discourse around risk), with greatest impact during the vulnerable perinatal period. They also recognise that post-birth, anxiety can stress the maternal-infant relationship to the point that reciprocity, bonding and maternal sensitivity are disrupted. In relation to ambivalence, the authors posit that the resulting polarisation of emotion can be catastrophic – this was ultimately Lucy's story. The authors note "…the act of loving one's infant can so easily be stretched and deformed by the changing societal narratives about how a woman, and more importantly, how a mother should look and act", as they express a wish for society to answer to the destruction, in all the ways described, of

the identities of women who become mothers (Silverio et al. in Mayer and Vanderheiden, 2021 p307). This is the social world in which Lucy and her fellow study participants became mothers.

6.4 A new understanding of perinatal anxiety

Perinatal anxiety and social interaction theory

Examining the lived experience of perinatal anxiety in terms of the social world, demands consideration of how the phenomenon may be understood within a social theoretical paradigm. An optimistic psychological theoretical view of perinatal anxiety can be applied to wellbeing and recovery, as previously discussed, although this is not without conflict regarding social justice and does not account for the distinctions of individual experience. It is necessary to look further to understand perinatal anxiety through a theoretical lens that accounts for these nuances, and within the context of this phenomenological doctoral work, the view of social interaction theory proposed by Turner (1988) is a fitting direction to turn. The key processes of Turner's theory related to the importance of *self*, of *feeling involved*, and of *feeling right about things*. Regarding self, Turner posits that individuals self-conceive both cognitive and emotional responses to the world. Turner argues that feelings-based experiential elements may be less immediately evident to the individual, who may recognise a cognition or behaviour more readily than understanding an emotion. This view parallels with the findings of the doctoral analysis as previously discussed, where overt cognitions and behaviours were described by the participants while the interpretative analysis uncovered a deeper existential view of the emotional self. Turner's explanation of the interplay between emotions and cognitions is mirrored in this doctoral study.

Turner (1988) describes the mechanisms involved in the negotiation between internal and external layers of self and the energy required to signal, interpret and structure social relations, noting that "the use of defense mechanisms creates ever-increasing levels of emotional energy that, in the end, will become manifest in both the cognitions and behaviour of an individual. This release of repressed energy, however, can often become a basis for further use of defense mechanisms, which merely postpones the emotional reckoning at even greater levels of intensity" (Turner 1988, p. 202). Turner argues that the eventual fallout of suppressed emotion makes the ability to engage in the social world untenable. This is a facet of the perinatal anxiety experience seen markedly in the doctoral data, as the participants, pregnant women and mothers in the social world, struggled to balance the internal and external. Turner proposed a composite model of motivation (figure 4), demonstrating the forces

sustaining self-conception, a notable central concept of which is avoiding *diffuse* anxiety, the type of anxiety previously identified as manifest among the doctoral study participants (section 6.1.1).

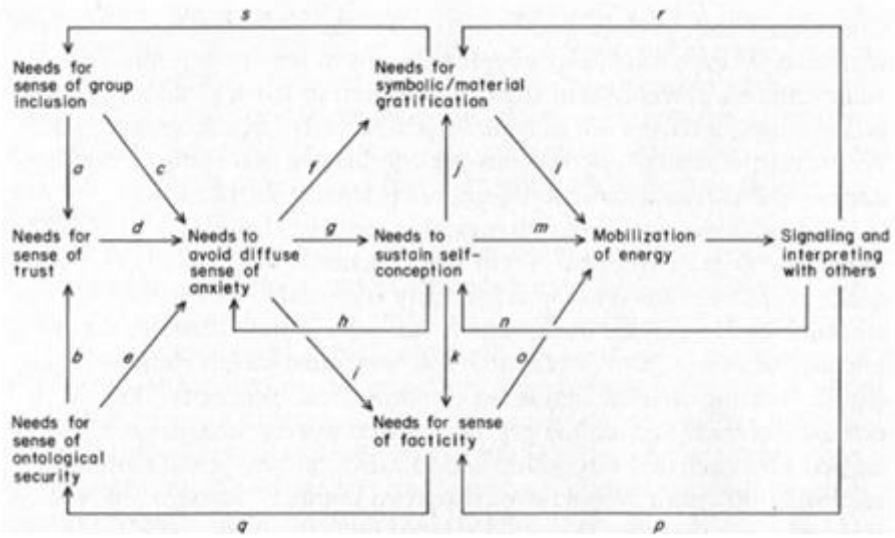

Figure 4: Composite model of motivation (Turner 1988)

Further processes of social interaction described by Turner (1988) relate to *feeling involved* and *feeling right about things*, as he noted that anxiety arises within unpredictability and mistrust when individuals feel excluded from social groups and interactions. He argues individuals have a need to feel predictability in the world around them, providing the security to accept "the symbols and objects that mark inclusion as well as the gestures that would seem to confirm self" (Turner, 1988 p. 205): that the external world matches the individual's internal world. The ways in which the social world is structured, and ontological accounts formed, provides people with the ability to be confident (*feel right*) to resume or continue interaction (Turner 1988). This is seen in the sense making from the participants in the doctoral study over time as they organise their perceptions to enable them to be included and find a place in their social world.

Elements of Turner's composite model are reflected in the doctoral findings, through the ways in which the participants understand and are motivated to modify their interactions with the world around them. For example, the focus Gabi and Lucy had on belonging among women with a normal experience of pregnancy and Kate and Sam's need for trust in their caregivers, the lack of which undermined their sense of security. Sam's self-esteem was diminished as her efforts to present evidence about her condition to the medical team were disregarded, the acceptance of this evidence would have provided gratification. The parallels between Turner's theory and this doctoral work are

seen through the ways in which perinatal anxiety manifests and the women interact with the world, with existential notions of self, belonging and security at the core.

Interpretative phenomenology sits within the social interaction theory paradigm, as experiential meaning and interpretations are derived through interactions between the individual and their social world within the specific cultural context of the individual, their pre-held beliefs and understandings (McDonnell, 2009). In this doctoral study with the primary research question focusing on lived experience, use of IPA, a scientific phenomenological method, naturally framed the interpretation of data within the social world. In developing social phenomenological theory, Alfred Schutz understood that individuals experience their lifeworld through living within it rather than reflecting on it, bringing to the fore the relational notion of intersubjectivity, a shared knowing (or consciousness) which facilitates human connection (Appelrouth 2020). How people make sense of experience is unique to each person, as individuals possess their own set of reference points and interpretations. Interpretation of the doctoral study participants' narratives through a social interaction theory lens presents perinatal anxiety as a socially constructed phenomenon. The women's narratives concerned a trio of relational components, as previously discussed, concerning themselves, others and their environment.

The data provided clues as to the cultural context of the mothers in the study, demonstrated through their intersubjective actions within their lifeworlds, and revealed perinatal anxiety to be a phenomenon concerned with societal expectations around mothering. The participants' environment can therefore be understood as the sociocultural backdrop to experience. Motherhood can also be viewed through the lens of social interaction theory, taken to mean that notions of naturalism and inherent biology are rejected; the ontology of motherhood concerns interaction with fellow social actors and cultural, political and economic constructs such as media, public health discourse and working motherhood (O'Reilly 2010). With anxiety disorders socially constructed (Dowbiggin 2009), and motherhood socially constructed, then the fabric of perinatal anxiety is where the two converge, providing perinatal anxiety with its uniqueness as an anxiety condition (see figure 5).

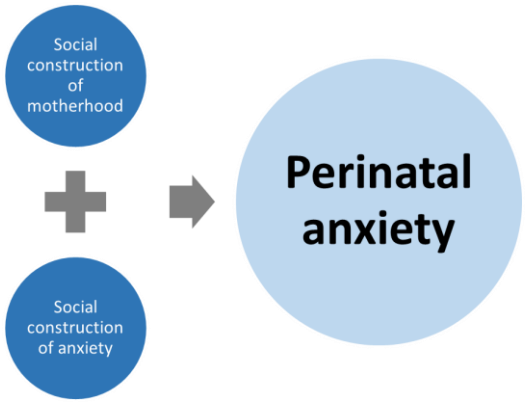

Figure 5: The social construction of perinatal anxiety

Perinatal anxiety and the social ecological model

If social interaction theory provides a basis on which to understand how perinatal anxiety manifests as individuals interact with the world, taking a view through the social ecological lens can further explicate the interplay between personal and environmental factors (Bronfenbrenner, 1979). In Bronfenbrenner's theory the most prominent influences on human development are the immediate social elements with which one interacts, for example family and friends, the *microsystem*. This paradigm is seen in the doctoral data, where although reference was occasionally made to macro influences, the primary focus of the participants was on their immediate relational experiences with family and friends, and to some degree health services. Wadephul et al. (2020) proposed a theoretical model of perinatal wellbeing based on the social ecological premise, providing a central sphere for the individual which highlighted a core of affective/emotional, psychological/cognitive and physical/embodied components (see figure 6). These concerns are positioned as internal mechanisms which are central to wellbeing.

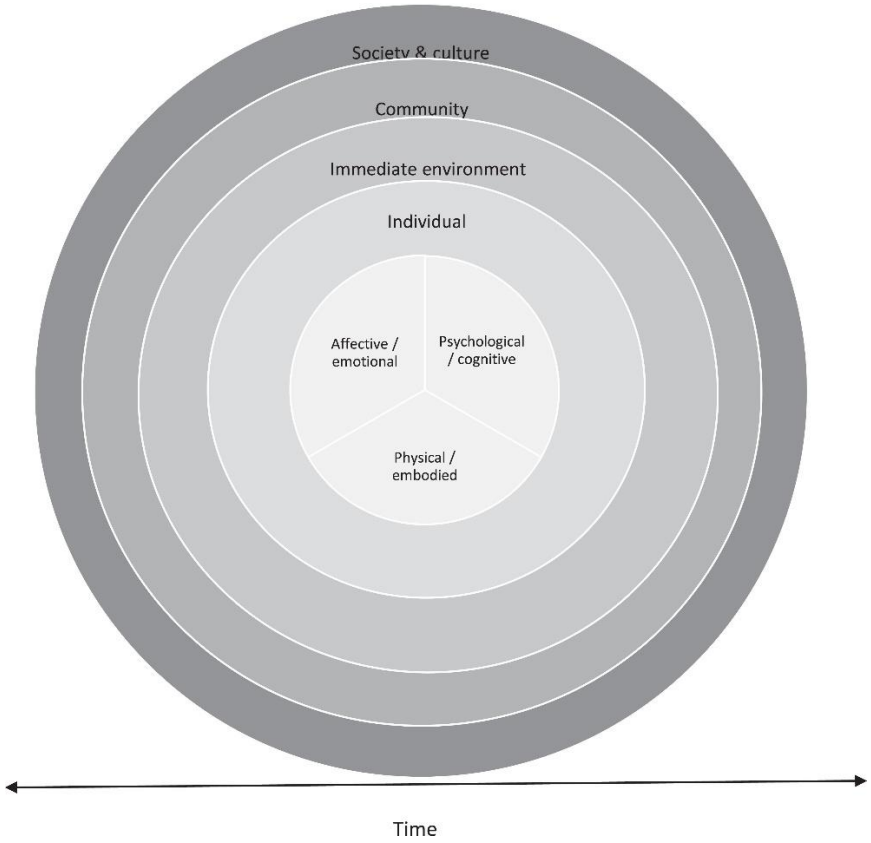

Figure 6: A tentative model of perinatal wellbeing (Wadephul et al. 2020)

Within the doctoral study, the core concepts of perinatal anxiety were identified as 'Maternal eyes', 'Emotional kaleidoscope' and 'Transforming existence'. The concepts, with their existential notions, are central to individual experience but the intersubjectivity of the individual lifeworld means they exist within a broader social ecological context. Positioning the Longitudinal Experiential Concepts within the proposed model for perinatal anxiety (figure 7), where the social construction of anxiety and motherhood are threaded through the social ecological framework, demonstrates a novel finding from this doctoral work regarding the uniqueness of perinatal anxiety as an anxious condition. No other model for anxiety would have the same constituent parts.

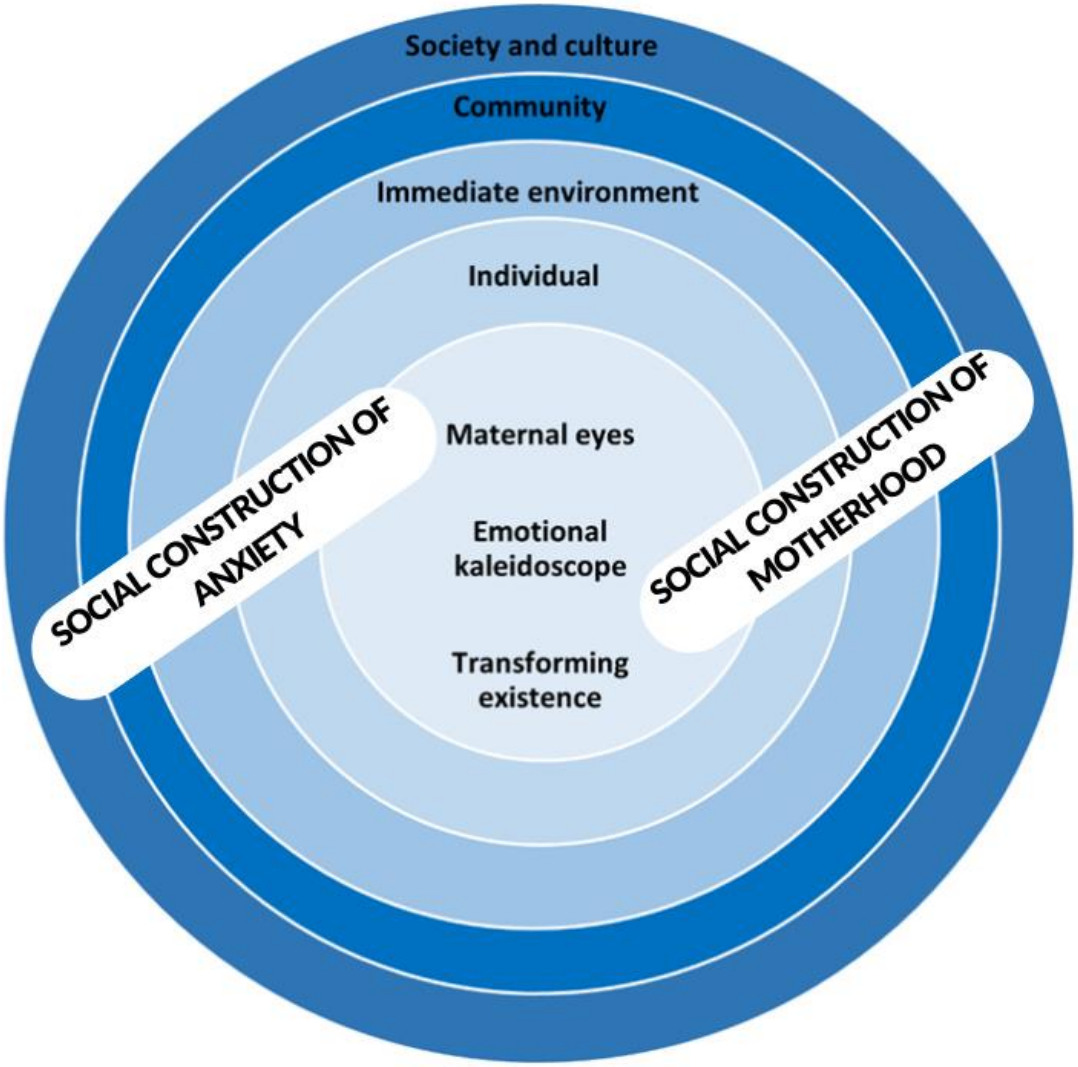

Figure 7: Proposed model of perinatal anxiety

6.5 Chapter summary

This chapter has provided detailed insight into the lived experience of perinatal anxiety by positioning this doctoral research work within the extant literature, examining convergence and divergence and considering this within a broader theoretical view. This has deepened understanding of the original research question, "how is anxiety experienced during the perinatal period?", has foregrounded the novel insights generated from this work, and has facilitated the development of the proposed model for perinatal anxiety. The following chapter ties together this body of doctoral work, considering elements of reflexivity and trustworthiness, and how effectively the research question has been answered including study limitations, before finally highlighting implications and recommendations for clinical practice, education and research.

CHAPTER 7: CONCLUSIONS

7.1 Introduction

This doctoral work has illuminated novel perspectives adding to the understanding of perinatal anxiety. These have included psychosocial viewpoints concerning adaptation to motherhood; the uniqueness of perinatal anxiety in the context of other anxiety disorders; issues of perinatal-specific concern including the relationship with the baby and maternal ambivalence; and consideration of perinatal anxiety recovery and wellbeing. Emphasis on the social experience of living with perinatal anxiety has emerged strongly and through the lens of social interaction theory the interplay between the individual and their social world can be understood. This has ultimately highlighted that the lived experience of perinatal anxiety is socially constructed, with aspects of relationships with self, others (belonging) and the world (security) key. The collision between anxiety and motherhood as social constructs serves to provide perinatal anxiety with its unique characteristics.

Looking to social ecological theory and a perinatal model of wellbeing has further explicated the phenomenon of perinatal anxiety from a theoretical standpoint and confirmed the assertion that "experiences of perinatal wellbeing do not occur in a vacuum, but exist within a complex, multi-faceted environment" (Wadephul 2020, p.8). This doctoral work has enabled ideas regarding the structure of perinatal wellbeing to be refined in the context of perinatal anxiety. The novel model for perinatal anxiety proposed highlights concepts inherent in perinatal wellbeing when anxiety is present, and that the uniqueness of the condition is amplified via the interweaving of social constructs of anxiety and motherhood through the micro and macro-influences on the individual. The doctoral data analysis and discussion positioned within extant literature has therefore been a catalyst to examine perinatal anxiety in a social context, and in doing so has highlighted some important implications for healthcare practice, further research and education.

This detailed understanding of perinatal anxiety, with central existential and social theoretical notions speaks to the significance of the condition for individuals, and to the actions of healthcare professionals and systems. It is a condition which demands greater awareness with the full significance it holds respected, rather than diminished in the light of its depression bedfellow. It should not be dismissed as merely a facet of the maternal condition to be accepted, unquestioned, trumped by the sacrosanct mothering role a society distracted by the reproductive impetus, assigns to women.

7.2 Reflexivity/reflections

The hermeneutic principles employed in this study and upon which IPA is founded have enabled the meaning of the lived experience of perinatal anxiety to be explored in detail. This has been facilitated via the initial interpretations of the participant and then those of the researcher through dynamic engagement with the data; with a fluidity moving back and forth between examination of the whole and parts of the whole (Smith et al., 2022). Reflexive practice has included the transparent positioning of the researcher, reflexive annotations during data analysis, and a reflexive research diary maintained throughout the work. Insights from the annotations facilitated contemporaneous sense checking throughout the analytical process, lending greater awareness and understanding of the root of the interpretations. The reflexive diary enabled broader insights into the research process and how sense was made of the data, alongside detailed observations of emergent ideas. Consideration of the researcher position and excerpts from the reflexive diary here provide a flavour of how the research has developed and the learning that has taken place and is a basis for next considering how effectively the study has answered the research question. The introspections are described in the first person to stay true to the feelings experienced.

Researcher position

Reflexivity has been essential to this work as I have been inextricably positioned as a midwife, researcher and mother. Experiences as a midwife interested in the perinatal psychological experience led to the focus of this doctoral research. In the years preceding the start of the work several transformational learning experiences in practice (Mezirow and Taylor, 2009) led me to seek answers to clinical questions through academic work and research (Hargreaves and Harris, 2009; Hargreaves et al. 2011; Hargreaves and Crozier, 2013), which fostered my interest in midwife-led research. Transformative experiences did not just appear in my professional life; as a new mother I experienced a sense of being disconnected from myself, as I described in a diary entry a sense of being lost and unlike myself:

"I fairly often walk around in a bit of a fug wondering what to do next. It makes me feel sad that, as someone who is generally pretty positive and energetic about stuff, I feel like this, but I think I just have to accept that this is just the way it is for me… I absolutely hate feeling like I am wishing my maternity leave away and maybe I will look back and regret that. But I suppose I can't help how I feel." *Personal journal entry January 2012*

Consequently, I entered this exploration of perinatal anxiety with some understanding of the questions of self that arise during the adjustment to motherhood, although with none of the experience of anxiety felt by the doctoral study participants. My interest in perinatal mental health developed significantly following the birth of my children, and as my professional midwifery identity became clearer my confidence grew (Wald, 2015). The securing of a specialist mental health midwife role aligned with the opportunity to undertake doctoral study, enabling me to forge a clinical academic midwifery career, while accepting the challenges that such professional routes still hold for midwives (Folliard, 2022; Miller et al. 2020). My wish to undertake postgraduate research has been driven by the knowledge that such academic practice can increase the ability of healthcare professionals to lead and find solutions to clinical problems, as well as contributing to their sense of professional identity and agency, and ability to drive change (Sethi et al., 2018; Ho et al., 2019). In the case of this doctoral work, the improvement I have considered concerns supporting women experiencing perinatal anxiety through a midwifery lens.

My journey to this doctoral work evolved through gradual self-discovery alongside acquisition of clinical and academic skills, personal experiences and my multiple roles which while distinct, have also greatly informed one another.

The unfolding of interpretations

To uncover "How do women experience anxiety in the perinatal period", a meticulous interpretative analytical process was undertaken. In the early stages of analysis, when paying close attention to the interview transcripts, this layered process of interpretation enabled the robust scrutiny of the participants' words:

"…it is so much more than reading the scripts over and again. Listening for the second and third times has been key to this, I have missed things that take on new meaning when you hear how they are expressed. I notice that on the fourth layer the move to creating the statements feels really natural – it feels a bit like squeezing an orange and the creation of the statements is satisfying because it feels like all the juice has come out." Personal reflexive diary entry 12/05/22

In revisiting the transcripts for data to support the emerging themes, the mechanism of engaging with the hermeneutic process, moving away from and then back towards the anchor of the transcript data became clearer:

"Going back and inserting the quotes from the transcript is so valuable – this is a point where you feel like you come full circle – since by this time you have gone through several layers of interpretation it is really reassuring to return to the transcript and the participant's exact words to check your interpretation… this feels like a lightbulb moment which makes the whole thing suddenly make sense." Personal reflexive diary entry 22/05/22

The back-and-forth process was the vehicle for truly climbing inside the data, the full immersion in the women's stories, which facilitated a kind of flow by the time the Group Experiential Themes were developed:

"One thing that has taken me by surprise about this part of the analysis – i.e. the development of the GET tables with the supporting quotes – is how much more inside the data I am. How much more easily interpretation and ideas come as I am organising the data. I can't even quite explain why, apart from it feels like it is just at my fingertips rather than a desperate search in the deep recesses of my brain." Personal reflexive diary entry 04/11/22

The value of this full immersion was apparent on reaching the final stage of analysis, producing the narrative account with annotations which came more easily and in greater volume than expected:

"…could not happen without the bit that I have gone through in creating the GETs. I don't think I was even expecting that I would annotate that document so heavily but it kind of just happened. The challenge with writing the narrative has been a real push for organising my thoughts in a way that means that the narrative does actually make sense and is supported by the data. It's like everything just needs to slot into place at that final point… it's not until you write the narrative that there is a real test of how well your interpretation holds up to the data, it's almost like a quality control process." Personal reflexive diary entry 04/11/22

The relationship with the data was inevitably intense, and the value of reflexive writing was in part to sense check interpretations and explore the nature of the responses. Subtle shifts in focus alongside an internal and written reflexive dialogue which challenged the interpretative voice served to keep thinking in check; this was likened to using a microscope:

"*…when you are trying to get the focus just right and you zoom out or in too far and you can't see clearly – you have to get it just right for it to come in to full focus… where I have zoomed out too far*

and made it too conceptual or abstract and where it is too far zoomed in and you lose the context around the description." Personal reflexive diary entry 22/05/22

This zooming out from the data was most challenged when trying to understand the experience of the phenomenon of perinatal anxiety over time. This necessitated standing far back and looking at the temporal experience in its entirety. The Longitudinal Experiential Concepts (LEC) were devised as an addition to the method to facilitate conceptualising perinatal anxiety over time. Additionally, this was an effort to address the way in which the data was managed, with 'themes tied to time points' rather than 'themes spanning time' (Farr and Nizza 2019). As mentioned in Chapter 5, to wait until the completion of all the late postnatal interviews before starting analysis was not practicable within the project timescales. However, the gradual iterative analytical process with sensitive refinement and validation of the Group Experiential Themes had the unanticipated outcome of crystallizing thinking around development of the LECs. The emergence of ideas which would become the LECs started early in the process of analysis, for example when reflecting on ideas about the uniqueness of perinatal anxiety, and what makes it distinct from other anxiety conditions:

"… anxiety takes on a new form. And that form is bound up in the 'being' pregnant, being a mother and everything that comes with that – it is about who women are in that moment: responsible, protecting, a vessel, worthy of being a mother, needing not to fail, fulfilling a primal function. It's the thing that distinguishes you as a woman." Personal reflexive diary entry, summer 2022

A sense emerged during the interpretative process that there was a core of experience that ran through the participants and the continuum, revealing temporal aspects alongside broader concepts that went to the heart of the lived experience:

"It's like there are these layers on top – what we outwardly see in behaviours, what we can relate that to superficially – but then it feels like there is a layer underneath which is about existence and life" Personal reflexive diary entry, summer 2022

It became clear that thoughts about these deeper layers of meaning sowed the seed for ideas around the uniqueness of perinatal anxiety as a distinct condition, the overt and hidden aspects of the experience and the exploration of existential notions which followed:

"The thing that is unique is about the person you are at that moment, not the way the anxiety manifests and the psychological themes (behaviours) you can draw from that. The 'being' a pregnant woman, a mother, is what is unique – the existing in that moment in that state." Personal reflexive diary entry, summer 2022

Climbing inside: myself within the work

Following an initial reflection on positionality, a reflexive diary was used to regularly stop and actively consider my position as a mother and midwife within the work. I described looking back over the pages of my old paper diaries, finding a distinctly white middle class mother's account of my own nervous threads, touched by the distractions and hints of maternal ambivalence I now recognised chimed with the experiences of the doctoral study participants:

"The months of absolutely crammed pages. Full of activities designed to distract – baby yoga, gym, singing, music, pilates, craft, playgroup, endless coffee and cake in endless coffee shops with endless people I no longer know. I was absolutely terrified of blank space, of being alone. And being at home with the baby was being alone. I envied Robin, how he could so easily immerse himself in the baby's world when he was around. When I just felt like the baby's world had completely consumed me and that I couldn't breathe. I loved the baby so much I wanted to eat him." Personal reflexive diary entry, summer 2022.

I reflected that the challenges of completing the analysis while working full-time, early morning and late-night opportunities snatched, had been exhausting and often felt fragmented. While at times I had wondered whether this was a weakness in the process, I began to see potential value in how this chaotic-feeling state had facilitated standing back from the data:

"The story I tell will always be part of me as well as part of the woman. I think that standing back and looking almost dispassionately at the transcripts has helped me to see them as objectively as I ever would be able to. Returning to the text over and over [while exhausted] almost made them oscillate between meaningless and prophetic. It also made the stories, and my reading of them, so firmly embedded in my head that I am not sure I can see any more where I end and they begin, [even though] objectively they are so far removed from anything I have personally experienced" Personal reflexive diary entry, autumn 2022.

This example shows how, as a mother and juggling the competing demands of my world, I was dealing with the data in a way which would be unique to me and with an inevitable firm personal stamp. This extended to my midwife lifeworld, as the stories of these women joined the hundreds of other stories shared with me over the years:

"17 years of absorbing stories, surely they do become a part of you… I have so regularly felt like a sponge. It occurs to me I have never been squeezed out. Squeezing out is something that you would think would happen as a result of reflecting on things – but in reality you're not left with less, you're just left with a different sense of things, an altered narrative imbued with everything you brought with you. You can take action to recognise where you sit in a story, but ultimately you're fully entrenched in it." Personal reflexive diary entry, autumn 2022.

Aside from how much I have learnt as a novice researcher, as an experienced midwife I have also grown. This has become apparent in my midwifery practice, and shortly after finishing the analysis two routine interactions stood out. One woman with debilitating perinatal OCD described how it felt so deeply at the core of her being, I was able to reflect and validate her experience with an understanding I did not previously have. Another woman, plagued by a lack of connection to her unborn baby, I held and facilitated with insights gained from this work. I hear differently, I understand differently. These examples are practical and I am confident, through the ways in which the women I talk with respond, they make a difference on a personal level. However, they do not address the bigger question that has been on my shoulder throughout, the 'so what' of these abstract ideas and notions:

"When the things you are considering are in the abstract – questions of being and existence – how do you bring them back to the everyday? i.e. how midwives are positioned or where the caregiver sits. What do we learn that helps the caregiver?" Personal reflexive diary entry, summer 2022.

Excerpts from my reflexive diary show how the research has developed, both in terms of the progression of ideas and the application of the methodology. This has demonstrated my learning and development, and the influence on my midwifery practice. Considering the implications of this doctoral work for clinical practice, research and education will be discussed towards the end of this chapter, but first I will consider how effectively the study has addressed the research question.

7.3 The novelty of this LIPA approach in answering the research questions

Doing justice to the interpretative process has been key to reflecting on how far the research questions have been answered: whether what is hidden within the lived experience of perinatal anxiety has been uncovered. LIPA was chosen as a method precisely to facilitate addressing this question of lived experience, and so without a process that remained true to the phenomenological scientific method, this would not have been achieved. How far the research question was answered has largely been demonstrated by the detail of the analytical process, and a robust process has delivered authentic phenomenological findings. Reflexive diary excerpts above have provided a sense of this unfolding.

Earlier, the reflexive analytical process was likened to the zooming in and out of a microscope. How effectively the research question has been answered means considering whether, through this study, perinatal anxiety has come into full focus. The ways in which it has are threefold, as it has struck a balance between the idiographic, longitudinal and cross-case aspects of the data (Farr and Nizza 2019). First through attention to the detail of the women's accounts, noticing the gems, observing the experiential threads, which when pulled at revealed the material of perinatal anxiety. These were the existential notions which began to emerge during the first set of interviews and meant an interpretative shift from the immediately conscious elements of experience, the obvious external responses to anxiety, to the more internal experiential questions. It is these notions which add gravity to the condition and move perinatal anxiety beyond natural objectively understandable perinatal-focused worries, to a threatening phenomenon of far greater existential significance.

The second and key mechanism for revealing the lived experience of perinatal anxiety came about because of the longitudinal nature of the study. Adding temporal perspectives allowed the work to conceptualise perinatal anxiety as a continuum, which is a perspective missing from theoretical discussion of perinatal wellbeing (Wadephul et al., 2020). The formulation of Longitudinal Experiential Concepts arose from noticing commonalities between the datasets/themes for each time point and sensing a need to represent these concepts as central to the temporal experience. Interpretative validity for the LECs, with their focus on the emotional lability, unpredictability and variance of the experience (Emotional kaleidoscope), the view of the anxious mother looking upon their world (Maternal eyes) and the sense of existential transformation (Transforming existence) is confirmed as each is underpinned by antenatal, early postnatal and late postnatal Group Experiential Themes and subthemes.

The third mechanism for robust answering of the research question has been through cross-case analysis, and the way in which Lucy's story shed light when held against the other cases. Lucy's story as a counterpoint to the others illuminated a facet of experience which brought sharply into view notions which, although suggested by other participants, through Lucy's narrative were revealed far more explicitly. This demonstrated how something hidden came to light through the process and the view beyond the immediately obvious gave weight to the robust answering of the research question, "How do women experience anxiety during the perinatal period?".

In line with the first study aim, to gain a deeper understanding of the phenomenon of perinatal anxiety, this study has comprehensively revealed depth to the experience. Critique of IPA (chapter 3) demanded a need to remain close to phenomenological principles through the study. This study was undertaken by a midwife rather than a student of philosophy or psychology, and the result is a piece of work combining substantial midwifery experience journeying with women alongside nascent understandings of these unfamiliar disciplines. It has demonstrated committed engagement to principles from both fields which has added to the development of ideas and facilitated valuable theoretical discussion.

The second aim of the study was to contribute new knowledge and to advance professional practice by broadening discussion on how midwives and other health professionals can most effectively support women with perinatal anxiety. The study has facilitated the articulation of implications for practice and recommendations which will be discussed below. However, to have confidence in the study findings and therefore recommendations requires consideration of how issues of trustworthiness and validity have been addressed.

7.4 Trustworthiness and validity

How reflexivity was built into the study design was detailed in chapter 4, examples of which have been described and highlight the integrity inherent in this work. Other design elements to ensure trustworthiness and validity and facilitate the reader making their own judgement on quality, include attention to markers of quality specific to IPA.

The principles that have been laid out for assessment of rigour within qualitative research, were adhered to throughout this work. For example, drawing of the work of Yardley (2017) this study has shown sensitivity to context, commitment and rigour, transparency and coherence and impact and

importance. Reference to the JARS-qual reporting standards for qualitative research (Levitt et al. 2018) shows that this study adhered to clear experiential research goals congruent with IPA; explicit detail on the selection of a homogenous (by lived experience) group of participants; clear description of the data collection methods and how this was facilitated including examples of the progression of analysis; reflection on the ability of the method to answer the research question and any collaborative process which informed the development of the work; and the data summarised in visual form through tables and figures, with clarity of analytic commentary and illustration of convergence and divergence within the narrative.

The benefit of presenting this work in its entirety is that, seen in full, it is clear how these measures of quality translate. The challenge comes in presenting the work for publication where quality must be demonstrated within the confines of the respective journal. Smith et al. (2022) note that a checklist approach to assessing quality and validity, while useful (and the JARS-qual reporting standard is advocated by Smith and colleagues), can be too crude when it comes to some methodologies including IPA, for example missing subtle aspects of the methodology such as idiographic detail. The concern is therefore that it is also important to consider measures of quality from a perspective specific to IPA.

For this we can look to the four markers of high quality in IPA, described by Nizza et al. (2021), which are: constructing a compelling, unfolding narrative, developing a vigorous experiential and/or existential account, close analytic reading of participants' words and attending to convergence and divergence. This study attended to these markers of quality first by close attention to the narratives of individual participants used to create a dialogue between participants, which taken together created a believable and logical analytical narrative account and provided depth to the analysis by attention to the meaning conveyed by the participants, rather than simply their descriptions of events. Secondly, interview material was comprehensively analysed and interpreted to build meaning, while addressing the similarities and differences between individuals.

The longitudinal design of this study lent itself to validity with prolonged engagement in the field offering immersion in the participants' experiences (Sarantakos 2013). Neale (2021) notes that integrity in longitudinal qualitative studies is twofold: temporal and interpretative. Temporal integrity is maintained through the way in which the study is true to the changing worlds of the participants, and is flexible in its approach to this, following threads backwards and forwards through time and seeking to understand how processes reoccur, finding temporal connections, and responsively

following the trail of reality, whichever direction it takes. This was demonstrated in this doctoral study through the time spent 'with' the participants, and the development of longitudinal insights.

Neale (2021) notes a balancing act between being flexible but with continuity, employing creative freedom without losing sight of the need for precision throughout the whole process. Interpretative integrity is achieved by staying close to the inner worlds of the participants and their experiences, respecting their authority and subjectivity while reflexively recognising one's own, and the generation of rich data firmly grounded in the case with strong interpretative descriptions allowing "an intimate familiarity with an unfolding life" (Neale, 2021 p. 352). The zooming in and out of the participants' lives, strong grounding in the interview data and the use of imagination around the interwoven aspects of experience strongly supported by the voices of the women, represents dedication to this balancing act.

Other aspects of this study which strengthen the validity of the process and findings include investigator triangulation, where within the doctoral supervisory team interpretations and meaning making were verified with close attention to the source data (Denzin and Lincoln 2000). The analytical documents are filed in a transparent and logical manner that provides a clear audit trail (Smith et al., 2022). Furthermore, the methodological process was presented via poster at a doctoral researcher conference, which allowed scrutiny by peers and clearly mapped the methodological process with visual examples (see appendix 7). Other important measures of validity, the analysis of negative cases and reflexivity, were also attended to with inclusion of the negative case (Lucy) and the reflexive analysis of the methodology and findings through journalling (Sarantakos 2013).

The account above shows the care and commitment taken to apply rigorous research practice in this study, which supports the reliability of the analysis, findings and conclusions. This care and commitment clearly demonstrate the work was completed with openness and integrity.

7.5 Strengths and limitations

Using IPA as a research methodology inevitably brings the researcher's own position to the work which invites the potential for bias. Situating this work in a phenomenological paradigm was due to the desire to examine lived experience, and the use of an interpretative approach taken precisely because of the researcher's position as a midwife working within perinatal mental health, and the belief that the requirements of a descriptive phenomenological approach would not be achievable. To provide

transparency within the research process and interpretations, reflexive annotation within the analysis, and journalling throughout were undertaken and used to clarify the origins of interpretations and the influence of preconceived notions, and this practice has been explicated within the doctoral thesis.

The open approach to identification of participants was deliberate, but this meant there were aspects of experience which were not known until data collection had begun and may have influenced experience. For example, previous perinatal and childhood trauma and the severity of comorbid mental and physical conditions. It was also noted that all participants gave birth vaginally at term which may have influenced their experiences of anxiety differently from a group giving birth preterm or via caesarean section. However, the study was not meant to generalise, but to explore the experience of perinatal anxiety among a small number of individuals. Due to the prevalence of the condition, perinatal anxiety will impact women with a whole range of experiences and comorbidities, so understanding the condition within a variety of contexts and still revealing commonalities has strengthened the sense that there is something shared across the lived experience regardless of other factors.

Repeating the study, it would be useful to re-think how to approach investigator triangulation. Negotiating this throughout a longitudinal study when one investigator is immersed on a different level to their colleagues is challenging. Approaching triangulation differently among investigators, or from a participant view would provide an opportunity to address this, however the practicalities of doing so may be limiting. While member checking was not employed, the longitudinal approach did offer the opportunity to revisit and clarify some aspects of the narratives, and there was an occasion where this facilitated a changed interpretation of an earlier account.

As previously discussed, carrying out the research alongside full-time work meant limited opportunity for uninterrupted immersion in the data. However, perhaps surprisingly, fragmented engagement gave some distance which proved valuable to facilitate fluidity interacting with the data, making the process dynamic. Pragmatic considerations also meant it was not possible to complete data collection prior to analysis which altered the way in which the entire longitudinal dataset could be viewed, however this provided an opportunity for creativity to address this concern, which emerged in the addition of the methodological step of creating the Longitudinal Experiential Concepts. This therefore makes a novel addition to the methodological approaches to LIPA: when time to complete a LIPA study is limited, using LECs as a means of viewing the data both vertically and horizontally can provide a rounded temporal view.

7.6 Implications for clinical practice, for education and for future research

This study has provided novel insights into the lived experience of perinatal anxiety and has revealed its significance for women who live with the condition. These findings demand attention regarding support provided by midwives and other health professionals in clinical practice, addressing educational needs and implications for future research.

Clinical recommendation 1 – Clinical practice

Midwives and other health professionals should maintain curiosity when asking women about their mental health, and when anxiety is disclosed, probe compassionately, ask women about feelings towards themselves and the unborn/newborn baby, and validate them. All healthcare professionals should provide the safe space advocated by Silverio et al. (in Meyer and Vanderheiden, 2021), enabling women to reveal shameful feelings of maternal ambivalence openly, where feelings of maternal conflict are a normalised and accepted aspect of the vocabulary of motherhood. Providing the time for non-judgemental antenatal conversations that account for the stigma women may feel about their feelings and addressing unrealistic expectations of motherhood with the provision of clear and consistent information is essential (McCarthy et al., 2021; Hore et al. 2019).

Opportunities for disclosure rely on the quality and availability of contacts and relationships. Midwifery continuity of carer is a relational model of care which enhances relationships; however, the wholesale availability of this model currently faces implementation challenges. Equally it is important that any healthcare professional can provide the opportunity for disclosure at any contact. Therefore, a pragmatic approach is needed that maximises the opportunity for disclosure at any contact and accounts for systems challenges across services.

Clinical recommendation 2: Screening and signposting

Midwives should be open to scheduling additional antenatal contacts to avoid the long gaps between contacts which were noted by some of the women in this doctoral study as unhelpful. Postnatally midwives can ask how women feel about the new baby to ensure the focus on bonding conversations which starts in pregnancy continues post-birth. A resource that foregrounds such conversations could help achieve this, recognising the depth of feeling there can be regarding conflict with self and bonding. This could be addressed by scrutinising whether the routine screening questions asked at

perinatal contacts are fit for purpose, and if modification is needed to include additional perinatal bonding and self-perception in motherhood questions (NICE 2014; Fallon et al., 2016; Somerville et al. 2014) (see below research recommendation 4).

Once perinatal anxiety is identified, there are an increasing number of sources of information and support to which women can be signposted, including Improving Access to Psychological Therapies services with perinatal pathways, specialist perinatal mental health services and online information and self-help, for example OPEN P.A.W.S. (openpaws.co.uk).

Educational recommendations: Resources for training in clinical and HEI settings

This study has discussed how the interrelatedness of concepts around anxiety can cause confusion in definition. It is crucial that perinatal anxiety is understood as different from a worry (the focus of the anxiety), and stress (which may be present without pervasive and debilitating anxiety). The diffuse intrinsic anxiety experienced by participants, with the self as a central issue, needs to be communicated to midwives and other health professionals to convey its significance and the uniqueness of perinatal anxiety as a condition, including the differentiation from and interaction with depressive states. Stigma and missed opportunities to discuss difficult feelings are recognised barriers to disclosure of perinatal anxiety (Oh et al. 2020), so health professionals need both the ability to offer opportunities for disclosure (see above, clinical recommendation 1) and an awareness of the complex nature of feelings within perinatal anxiety.

Clear educational messaging should support midwives and other healthcare professionals, as well as student midwives, to reassure women they are not alone in their experiences and that supportive social networks can provide a safety net and a sense of belonging (Staneva in LaChance Adams, 2020). The educational focus should pay closer attention to the concept of maternal ambivalence and the nuances of conflicted maternal experiences, encouraging compassion and understanding.

This messaging can be conveyed through the inclusion of a focus on perinatal anxiety within midwifery mandatory training, undergraduate midwifery educational curricula and within the online learning packages which provide perinatal mental health training to a wide range of clinicians (e-lfh.org.uk). A focus on accessible, easily digested ways to communicate these key educational messages, ratified by service users, would support this; for example the co-production of a short video or infographic for

clinicians providing three key messages about perinatal anxiety and how to support women with the condition.

Research recommendation 1: Other populations

This doctoral study focused on self-selecting women from a predominantly white ethnic demographic, where all the women were partnered and economically stable. Although not intended to be representative, it does not explore the lived experience of perinatal anxiety for women from more overtly diverse backgrounds. This is an area to address in future research and is of particular importance as perinatal mental health outcomes for women from other backgrounds are likely to be poorer with different issues of stigma and socio-cultural expectations and pressures.

Research recommendation 2: Relationship between anxiety and depression

The comorbidity of anxiety and depression, and the way in which the two interact is an aspect of the experience prominent in this doctoral study but the nuance of which remains unclear. Those participants experiencing thoughts of harm to themselves (and acting on these) had prior anxiety and this suggested an uncontrollable escalation in anxiety ultimately resulted in depression and suicidal feelings. Understanding the role of anxiety within the pathway to significant depression and suicidality is crucial and may add to the justification for improved identification of anxiety to facilitate earlier intervention and avoid life-threatening deterioration. This is also important to understand because, although anxiety alone may not impair bonding, escalation towards significant low mood may increase detachment from the baby, with significant impacts for the mother-infant relationship.

Research recommendation 3: Relationship between trauma and perinatal anxiety

A second noteworthy element of the experiences of the doctoral research participants but not explored in this study, was past experiences of trauma and how these may have impacted anxious responses in pregnancy. Research to understand the relationship between trauma and perinatal anxiety may facilitate a different approach to perinatal screening, where women with a past significant trauma history, for example of perinatal loss or sexual assault, are offered increased monitoring or a lower threshold for early psychological intervention.

Research recommendation 4: Diagnostic instruments

Finally, as mentioned above, there is an argument for further examination of the current recommendations for anxiety screening tools during the perinatal period. The value of the currently recommended GAD 2/7 questions for the perinatal population has been questioned (Nath et al. 2018), and this doctoral study supports further scrutiny due to the nature of the condition not being captured within the GAD screening tools. While other measures have been developed and are demonstrably more appropriate for perinatal use (Sinesi et al., 2022; Fallon, 2016; Somerville et al., 2014; Huizink et al., 2016), these have currently not been included in clinical guidance for routine use by midwives and other health professionals. Further examination of this including consideration of a short form measurement tool with ease of use, which can be incorporated into the practice of midwives and other healthcare professionals working in universal services is warranted.

7.7 Closing words

Perinatal anxiety is a complex multi-layered phenomenon concerned with the superficial and the existential within the social world. It sits within a temporal frame, with a basal omnipresence yet always in flux. The novel contribution of this doctoral study with its longitudinal focus has been a more complete view of lived perinatal anxiety. Examined over the course of the perinatal continuum, there are experiential threads that run throughout: the way the world is seen through the eyes of the anxious mother, how existence is transformed by anxiety and how the emotional experience is multifaceted.

This work has identified priorities for further attention through clinical, educational and research recommendations. Support from clinicians should account for the significance of perinatal anxiety, and the ability of the condition to disrupt perinatal wellbeing with potentially catastrophic consequences when levels of distress, especially in relation to feelings towards the self and the new baby, escalate. Early identification from midwives and other healthcare professionals and provision of signposting and support, where perinatal anxiety is not simply accepted as a normal and unproblematic response to pregnancy, is essential.

Appendix 1: Published concept analysis paper

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REVIEW

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"Crippling and unfamiliar": Analysing the concept of perinatal anxiety; definition, recognition and implications for psychological care provision for women during pregnancy and early motherhood

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Abstract

Aim: To clarify how perinatal anxiety is characterised within the current evidence base and discuss how a clearer definition and understanding of this condition may contribute to improving care provision by midwives and other healthcare professionals.

Background: Perinatal anxiety is common, occurs more frequently than depression and carries significant morbidity for mother and infant. The concept of perinatal anxiety is ill-defined; this can pose a barrier to understanding, identification and appropriate treatment of the condition.

Design: Concept Analysis paper.

Method: Rodgers' Evolutionary Model of Concept Analysis, with review based on PRISMA principles (see Supplementary File-1).

Findings: While somatic presentation of perinatal anxiety shares characteristics with general anxiety, anxiety is a unique condition within the context of the perinatal period. The precursors to perinatal anxiety are grounded in biopsychosocial factors and the sequelae can be significant for mother, foetus, newborn and older child. Due to the unique nature of perinatal anxiety, questions arise about presentation and diagnosis within the context of adjustment to motherhood, whether services meet women's needs and how midwives and other health professionals contribute to this. Most current evidence explores screening tools with little examination of the lived experience of perinatal anxiety.

Conclusion: Examination of the lived experience of perinatal anxiety is needed to address the gap in evidence and further understand this condition. Service provision should account for the unique nature of the perinatal period and be adapted to meet women's psychological needs at this time, even in cases of mild or moderate distress.

KEYWORDS

anxiety, concept analysis, health professionals, infant, midwives, morbidity, motherhood, perinatal anxiety, perinatal period, pregnancy

1 | INTRODUCTION

Anxiety during the perinatal period can adversely affect women's physical, emotional and social function, for example through disrupted sleep and social withdrawal as well as impacting engagement with health professionals (Highet et al., 2014; Thorsness et al., 2018). The link between maternal distress and anxiety in pregnancy and the behavioural development and emotional regulation of children in infancy and beyond is well documented (Bendiksen et al., 2015; Glover & Barlow, 2014; Porter et al., 2019). Alongside the human cost the economic burden of perinatal anxiety is also significant; each case in the UK (classified as generalised anxiety, panic disorders, phobias, obsessive–compulsive disorder and post-traumatic stress disorder, not co-morbid with depression) costs around £35k. £21k of this cost relates to the mother, taking into account increased use of public services, loss of quality-adjusted life-years and productivity losses, and £14k to the child, covering four key outcomes: preterm birth including cognitive impairment, emotional and conduct problems, and chronic abdominal pain (Bauer et al., 2014). Poor mental health can drive a 50% increase in costs of physical care (NHS-E, 2016a). During pregnancy alone, this impact can be seen in increased contact with health professionals, and care decisions made based on a picture of worsening mental health, for example the decision to medically induce labour rather than awaiting spontaneous onset of labour. This highlights the importance of containment: health professionals supporting women with psychological challenges before an escalation in mental ill-health triggers clinical interventions.

Estimates of the prevalence of perinatal anxiety are varied, with rates of 15%–21% suggested by some authors (Fairbrother et al., 2016; Heron et al., 2004), and one review indicating numbers as high as 39% (Leach et al., 2017). Challenges in establishing prevalence include heterogeneity across methodologies and a lack of validated self-report measures for perinatal populations (Leach et al., 2017; Meades & Ayers, 2011). A lack of evidence exploring the experience of perinatal anxiety further adds to inadequate understanding of the condition among health professionals and creates a barrier to identification and treatment (Goldfinger et al., 2019). Questions about the nature of perinatal anxiety include: Is anxiety a normal reaction to the perinatal period, or an irrational response, and is it triggered by psychological or biological processes? Is it a unique diagnosable condition, with symptoms that can be classified? Or is it essentially characterised in a similar way to general anxiety, but simply defined within the context of the perinatal period? Is perinatal anxiety understood differently by those who have experienced it, compared to those who treat it?

As a starting point for further examination of the phenomenon of perinatal anxiety, a concept analysis was undertaken based on Rodgers' Evolutionary Model of Concept Analysis (Rodgers, 1989).

1.1 | Aims

To clarify how perinatal anxiety is characterised within the current evidence base and discuss how a clearer definition and understanding of this condition may contribute to improving care provision by midwives and other healthcare professionals.

What does this paper add to the wider, global, clinical community?

- A deeper understanding of perinatal anxiety, a condition potentially affecting the global perinatal population.
- Discussion of pertinent considerations when caring for women in the perinatal period and implications for clinical care provision regardless of setting.
- Evidence of the paucity of evidence examining women's subjective experiences of perinatal anxiety.

2 | METHODS

Concept analysis, a method of defining the characteristics of a concept to aid understanding of its meaning and contribute to the development of theory, has been widely used in nursing (Walker & Avant, 2005). Whilst its value has been questioned by some (Beckwith et al., 2008; Bergdahl & Berterö, 2016; Draper, 2014), Meleis (2018) argues that clarifying a concept is essential in order to advance knowledge within a discipline. The "evolutionary model" of concept analysis described by Rodgers (1989) accounts for the use of a concept within the interrelationships that exist within the world, focussing on consensus, the evolutionary background to a concept with a cross-disciplinary focus, and rejecting the traditional entity (positivist) view of concepts as rigid (Rodgers & Knafl, 2000). The evolutionary view, which regards concepts as abstract ideas expressed and evolving over time, fits with how perinatal anxiety is observed, which is about the context of pregnancy and motherhood, interpretation of this period of transition, and the mind-body interaction over a distinct time period. It would be incongruent to analyse a concept which is to do with mental state from a positivist perspective, in purely physical terms with a rigid set of conditions. Tofthagen and Fagerstrøm (2010) advocate for this evolutionary view, but caution the need to be clear that a concept may be unique to a particular discipline, and that care should be taken to be explicit about the basis on which the understanding is formed. This is particularly relevant to the concept of perinatal anxiety, which will share characteristics with other psychological concepts and be described across psychological and physical disciplines, whilst very specifically applying to the pregnancy and postpartum context.

Rodgers' (1989) model describes naming the concept and identification of surrogate terms and a sample to examine. From this literature sample, the researcher identifies the attributes, references, antecedents, consequences and related concepts, and presents a model case to exemplify the concept. This initial analysis provides the starting point for both understanding the concept in practice, and for development through further testing and investigation. Rodgers

and colleagues recently conducted a review of papers using concept analysis models and concluded that the plethora of repetitive papers was an issue and that conceptual work should move beyond analysis to become solution-focussed in order to add value to nursing science (Rodgers et al., 2018). This paper uses this initial analysis as a platform for considering the clinical and research implications of the findings.

2.1 | Naming of the concept and surrogate terms

The first phase of analysis involves naming the concept of interest, in this case, Perinatal Anxiety and surrogate terms. Surrogate terms and uses are identified to address the fact that a concept may be described in several different ways across disciplines and fields and between medical and lay language. The surrogate terms identified were "worry," "pregnancy" and "postpartum." When considering surrogate terms and uses it could reasonably be asked whether perinatal anxiety is a distinct concept from nonperinatal anxiety, therefore, in addition to the main data analysis a high-level review of the literature around general anxiety was undertaken (see Figure 1).

2.2 | Sample selection

Sample selection focussed on a pool of data from a number of sources and disciplines, in order to characterise the concept using a range of voices including women with lived experience of perinatal anxiety, and the physical and mental health professionals working in the field. Literature was reviewed using a scoping approach—not to synthesise or critically appraise the evidence, but to understand how the concept is described and understood.

Anxiety as a term would be used broadly across a wide range of literature, so specific inclusion and exclusion criteria were set. Papers were those dated 1956–2020 and included a cross-disciplinary sample of qualitative or quantitative studies exploring or examining anxiety or worry during the perinatal period, prospective or retrospective studies, editorials, letters and discussion papers. Excluded were papers that were non-English language and those that primarily focussed on fathers, other psychological or physical co-morbidities, or concomitant adverse social experiences, for example examining prisoners, immigrant populations, experiences of a sick neonate or perinatal loss. This was not to undervalue the contribution of these groups, but rather an attempt to remove as many other variables as possible and focus on anxiety alone.

A search was undertaken including the CINAHL, Medline, Scopus, Psychinfo, Science Direct and Social Science Citation Index databases. Search terms were "perinatal anxiety" or "perinatal worry" in the abstract and "antenatal" or "prenatal" or "pre birth" or "pregnancy" AND "anxiety disorders" or "anxiety" or "generalized anxiety disorder" AND "postnatal" or "postpartum" or "puerperium" or "perinatal" in the title (see Figure 2 for PRISMA diagram of results returned).

Reference lists were searched for references pertaining to qualitative analysis of women's experiences, as it became apparent that these papers were underrepresented in the sample. This did not yield any further qualitative papers, but a further two papers and three books were added, making the total number of references reviewed 40 (Table 1). It was reassuring that the reference list search did not yield a significant number of additional results as this indicated the initial search strategy had been robust.

A coding sheet detailed each stage of the review process and enabled systematic extraction of data relating to each component of the analysis process. The separation of each category facilitated scrutiny of the data extraction for consistency in the type of data

A search of the terms "anxiety disorders or anxiety or generalized anxiety disorder" AND "lived experience or phenomenology or life experience" in TITLE, limited to 2008-2020, using CINAHL, Medline, Scopus, Psychinfo, Science Direct, and Social Science Citation Index databases yielded 77 results (after duplicates removed). These references were searched for studies exploring the experience of anxiety in general terms, of which there were none in this sample. Anxiety is usually studied in relation to an event or situation, rather than examined as a standalone experience. Eight papers were extracted for review, and three of these papers focussed on the lived experience of anxiety (in relation to a particular life event). Anxiety as described in these studies, showed some similar characteristics with the experience of anxiety in perinatal groups (Helverschou & Martinsen, 2011; Leone, Ray, & Evans, 2013; Sun et al., 2016). Full analysis of this work is outside the scope of this paper; however it is worth noting that the concept of anxiety in non-perinatal populations is likely to share some characteristics with the perinatal cohort.

FIGURE 1 A note about non-perinatal anxiety

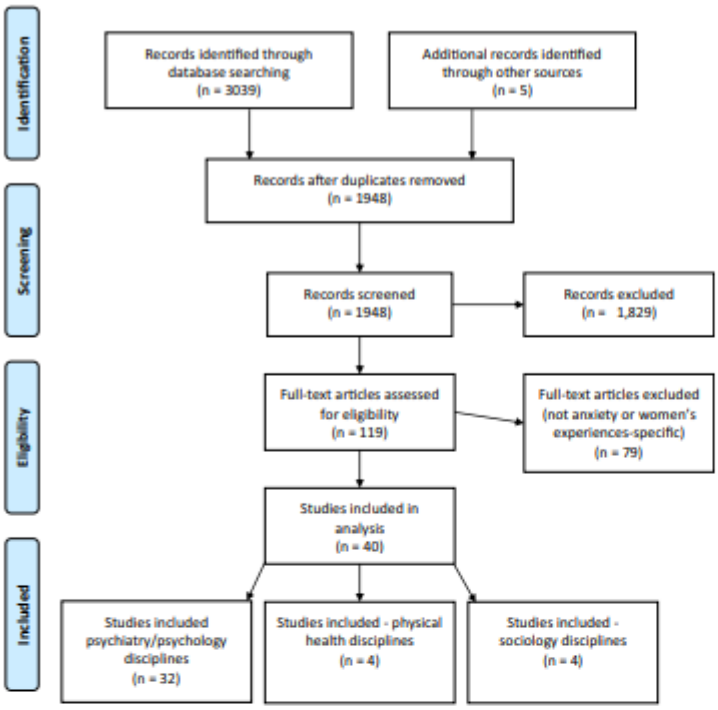

FIGURE 2 PRISMA diagram

across the different components, confirming that logic within the process was sound and consistently applied.

3 | RESULTS

3.1 | The attributes of the concept

The attributes refer to how the concept is most regularly used and offer a sense of related language and themes, with a focus on clarification rather than exploring meaning (Rodgers, 1989). The attributes chosen were derived from literature within the perinatal context, with attention to biopsychosocial aspects, based on the authors' personal understanding that the emotional and physical course of pregnancy and the postpartum is multi-dimensional. Final attributes were selected based on consensus across the sample.

Once the attribute data were extracted, it was re-examined and organised to first identify broad themes from which the final detailed attributes were chosen. The data from each discipline (psych-fields, physical health and sociology) were analysed separately before being brought back together to see whether the findings were consistent and if there was consensus across disciplines, which is important to add validity to the development of the working definition (Rodgers & Knafl, 2000).

Due to the small number of papers from the sociological and physical health fields, it would be tenuous to suggest that the concept was similarly defined across all fields; however, themes of context and diagnosis were referenced in papers from all three fields whilst the theme of presentation was not present in the sociological literature.

3.1.1 | Broad themes derived from the attributes

The three broad themes that emerged from analysis of attributes of perinatal anxiety were as follows:

- *Context*: during the transition to motherhood a degree of anxiety can be normal, but it can become debilitating if escalation occurs, and anxiety may be exacerbated by intrinsic and extrinsic pressures.
- *Presentation*: the typology of perinatal anxiety is common to that of the classified anxiety disorders, anxiety may or may not have a parenting-related focus and may be experienced by women with existing anxiety or be of new perinatal onset.
- *Diagnosis*: perinatal anxiety is not well understood in comparison with depression, with an insubstantial evidence base and issues with identification, diagnosis and treatment.

Context

The perinatal period is a time when women are at risk of mental health vulnerabilities arising from a spectrum of influencers, as the

TABLE 1 Papers reviewed

Paper	Aim	Design and sample
Psychology/psychiatry		
Aber, C., Weiss, M., & Fawcett, J. (2013). Contemporary Women's Adaptation to Motherhood: The First 3 to 6 Weeks Postpartum. *Nursing Science Quarterly*, *26*(4), 344–351. https://doi.org/10.1177/0894318413500345	To describe contemporary women's physical, emotional, functional, and social adaptation to motherhood and to examine the relations of selected demographic and perinatal variables to adaptation to motherhood in the first 3 to 6 weeks of the postpartum	Mixed, descriptive exploratory study: 313 women interviewed at 3 weeks postpartum
Anniverno R., B. A., Mencacci C. and Durbano F. (2013). Anxiety Disorders in Pregnancy and the Postpartum Period. In: *New insights into anxiety disorders*. Available at: https://cdn.intechopen.com/pdfs-wm/43758.pdf	Overview of anxiety disorders in the perinatal period	Chapter in book
Atif, N., Nazir, H., Zafar, S., Chaudhri, R., Atiq, M., Mullany, L. C., Rahman, A. (2020). Development of a psychological intervention to address anxiety during pregnancy in a low-income country. *Frontiers in Psychiatry*, *10*. https://doi.org/10.3389/fpsyt.2019.00927	To investigate the clinical, cultural and health service delivery context of perinatal anxiety; select an evidence-based approach that suited the population and health-delivery system; develop an intervention with extensive reference documentation/manuals; and examine issues involved in its implementation	Qual, in-depth interviews and focus groups: 19 women, 10 healthcare professionals
Bayrampour, H., Ali, E., McNeil, D. A., Benzies, K., MacQueen, G., & Tough, S. (2016). Pregnancy-related anxiety: A concept analysis. *International Journal of Nursing Studies*, *55*, 115–130. https://doi.org/10.1016/j.ijnurstu.2015.10.023	To clarify the concept of pregnancy-related anxiety and examine the items of current pregnancy-related anxiety measures to determine the dimensions and attributes that each scale addresses	Review: concept analysis
Bayrampour, H., McDonald, S., Fung, T., & Tough, S. (2014). Reliability and validity of three shortened versions of the State Anxiety Inventory scale during the perinatal period. *Journal Of Psychosomatic Obstetrics And Gynaecology*, *35*(3), 101–107. https://doi.org/10.3109/0167482X.2014.950218	To evaluate and compare the psychometric properties of three shortened forms of the State Anxiety Inventory scale in the perinatal period	Quant: forms evaluated using longitudinal pregnancy cohort data from 3,021 women
Blackmore, E. R., Gustafsson, H., Gilchrist, M., Wyman, C., & G O'Connor, T. (2016). Pregnancy-related anxiety: Evidence of distinct clinical significance from a prospective longitudinal study. *Journal of Affective Disorders*, *197*, 251–258.	To examine the degree to which pregnancy-related anxiety is distinct from continuous, and diagnostic measures of anxiety and worry in terms of longitudinal course, associations with psychosocial and perinatal risk, and prediction of postnatal mood disturbance	Quant, questionnaire and interview: 345 women at two points antenatally and two points postnatally
Britton, J. R. (2008). Maternal anxiety: Course and antecedents during the early postpartum period. *Depression and Anxiety*, *25*(9), 793–800. https://doi.org/10.1002/da.20325	To determine the course and antecedents of maternal anxiety during the first month postpartum and to develop a model to predict 1-month anxiety using information obtainable before perinatal hospital discharge	Quant: 296 mothers screened before hospital discharge and at 1 month postpartum
Brooks, E. J., & Wilson, D. R. (2019). Reducing Stress and Anxiety During Pregnancy. *International Journal of Childbirth Education*, *34*(1), 23–26.	To provide an overview of stress and its physiology, and to identify potential contributing factors and suggest possible ways distress might be reduced during pregnancy	Discussion paper
Buist, A., Ross, LE., Steiner, M. (2006). Anxiety and mood disorders in pregnancy and the postpartum period. In D. Castle, Kulkarni, J., Abel, KM. (Ed.), *Mood and anxiety disorders in women*. Cambridge: Cambridge University Press.	To describe aetiology, screening, prevention and treatment of anxiety disorders in the perinatal period	Chapter in book

(Continues)

TABLE 1 (Continued)

Paper	Aim	Design and sample
Byrnes, L. (2019). Perinatal mood and anxiety disorders: findings from focus groups of at risk women. *Archives of Psychiatric Nursing*, *33*(6), 149–153. https://doi.org/10.1016/j.apnu.2019.08.014	To explore knowledge of PMAD and awareness of treatment for PMAD, along with barriers to care, among an at-risk group of women during the perinatal period who reside in the Bronx	Qual, focus groups: 24 women who were pregnant or in first postnatal year
Chaudron, L. H., & Nirodi, N. (2010). The obsessive-compulsive spectrum in the perinatal period: a prospective pilot study. *Archives of Women's Mental Health*, *13*(5), 403–410. https://doi.org/10.1007/s00737-010-0154-6	To describe the phenomenology of obsessive–compulsive symptoms (OCS) and disorders (OCD) in perinatal women and to explore the relationship of OCS/OCD to postpartum depression	Quant, prospective-longitudinal study: 44 women
Coo, S., Milgrom, J., Kuppens, P., & Trinder, J. (2015). Perinatal distress, an appraisal perspective. *Journal of Reproductive & Infant Psychology*, *33*(2), 190–204. https://doi.org/10.1080/02646838.2015.1004570	To identify the particular appraisals that shape maternal distress using the theoretical framework of Appraisal Theory of Emotions	Quant, completion of distress and appraisal measures: 122 pregnant and postpartum women
Fairbrother, N., Corbyn, B., Thordarson, D. S., Ma, A., & Surm, D. (2019). Screening for perinatal anxiety disorders: Room to grow. *Journal of Affective Disorders*, *250*, 363–370. https://doi.org/10.1016/j.jad.2019.03.052	To assess the accuracy of the most commonly used and/or recommended screening tools for perinatal anxiety disorders	Quant, completion of mood and anxiety questionnaires: 310 women 3 months postpartum
Fallon, V., Halford, J. C. G., Bennett, K. M., & Harrold, J. A. (2018). Postpartum-specific anxiety as a predictor of infant-feeding outcomes and perceptions of infant-feeding behaviours: new evidence for childbearing specific measures of mood. *Archives of Women's Mental Health*, *21*(2), 181–191. https://doi.org/10.1007/s00737-017-0775-0	To test the predictive validity of the PSAS in the context of one specific perinatal outcome, infant feeding, and to examine whether the PSAS may be more efficacious at predicting infant-feeding outcomes and behaviours than the more commonly used general measures	Quant, short term prospective study of pregnancy-specific anxiety scale: 800 women postpartum 0–6 months
Furber, C. M., Garrod, D., Maloney, E., Lovell, K., & McGowan, L. (2009). A qualitative study of mild to moderate psychological distress during pregnancy. *International Journal of Nursing Studies*, *46*(5), 669–677. https://doi.org/10.1016/j.ijnurstu.2008.12.003	To explore the experiences of pregnant women who self-reported mild to moderate psychological distress during antenatal care	Qual, semi-structured interviews: 24 antenatal women
Furtado, M., Chow, C. H. T., Owais, S., Frey, B. N., & Van Lieshout, R. J. (2018). Risk factors of new onset anxiety and anxiety exacerbation in the perinatal period: A systematic review and meta-analysis. *Journal of Affective Disorders*, *238*, 626–635. https://doi.org/10.1016/j.jad.2018.05.073	To systematically review the literature on risk factors for new-onset anxiety and maternal anxiety exacerbation in the perinatal period	Review: systematic review and meta-analysis: 11 studies meeting eligibility criteria
Goldfinger, C., Green, S. M., Furtado, M., & McCabe, R. E. (2019). Characterizing the nature of worry in a sample of perinatal women with generalized anxiety disorder. *Clinical Psychology & Psychotherapy*. https://doi.org/10.1002/cpp.2413	To investigate worry content and frequency in a sample of perinatal women and age-matched nonperinatal women diagnosed with GAD	Quant: 20 perinatal and 20 nonperinatal women
Green, S. M., Donegan, E., McCabe, R. E., Streiner, D. L., Agako, A., & Frey, B. N. (2020). Cognitive behavioral therapy for perinatal anxiety: A randomized controlled trial. *The Australian And New Zealand Journal Of Psychiatry*, *54*, 423–432. https://doi.org/10.1177/0004867419898528	To evaluate the effectiveness of a cognitive behavioural group therapy protocol for perinatal anxiety	Quant, RCT: 96 pregnant women or women up to six months postpartum
Henderson, J., & Redshaw, M. (2013). Anxiety in the perinatal period: Antenatal and postnatal influences and women's experience of care. *Journal of Reproductive and Infant Psychology*, *31*(5), 465–478. https://doi.org/10.1080/02646838.2013.835037	To examine the characteristics of women with antenatal or postnatal anxiety and to investigate aspects of their care that may be associated with it.	Quant, data taken from national maternity survey on antenatal and postnatal health and wellbeing: 5,332 women
Henshaw, C., Cox, J., Barton, J. (2017). *Modern management of perinatal psychatric disorders*. Cambridge: Cambridge University Press.	Reviews current practice and new knowledge of perinatal mental disorders	Book

(Continues)

TABLE 1 (Continued)

Paper	Aim	Design and sample
Leach, L. S., Poyser, C., & Fairweather-Schmidt, K. (2017). Maternal perinatal anxiety: A review of prevalence and correlates. *Clinical Psychologist*, *21*(1), 4–19. https://doi.org/10.1111/cp.12058	To provide an update of the literature reporting on the prevalence and risk factors for maternal perinatal anxiety	Review, systematic review: 98 papers met inclusion criteria
Martini, J., Knappe, S., Beesdo-Baum, K., Lieb, R., & Wittchen, H.-U. (2010). Anxiety disorders before birth and self-perceived distress during pregnancy: Associations with maternal depression and obstetric, neonatal and early childhood outcomes. *Early Human Development*, *86*(5), 305–310. https://doi.org/10.1016/j.earlhumdev.2010.04.004	To examine the role of maternal anxiety disorders with an onset before birth and self-perceived distress during pregnancy for unfavourable maternal, obstetric, neonatal and childhood outcomes	Quant, community cohort sample using Munich-Composite International Diagnostic Interview: 992 mothers and their offspring
Martini, J., Wittich, J., Petzoldt, J., Winkel, S., Einsle, F., Siegert, J., Wittchen, H.-U. (2013). Maternal anxiety disorders prior to conception, psychopathology during pregnancy and early infants' development: a prospective-longitudinal study. *Archives of Women's Mental Health*, *16*(6), 549–560. https://doi.org/10.1007/s00737-013-0376-5	To prospectively investigate the course of pregnancy in women with and without anxiety disorders prior to conception from early pregnancy to postpartum focussing on maternal psychopathology, maternal perinatal health, and offspring outcomes that are supposed to be early indicators/antecedents for later anxiety disorders	Quant, prospective-longitudinal study: 274 women antenatal and postnatal up to 16 months
Matthey, S., Valenti, B., Souter, K., & Ross-Hamid, C. (2013). Comparison of four self-report measures and a generic mood question to screen for anxiety during pregnancy in English-speaking women. *Journal of Affective Disorders*, *148*(2–3), 347–351. https://doi.org/10.1016/j.jad.2012.12.022	To compare the screening performance during pregnancy of four self-report anxiety measures, as well as a generic mood question	Quant, completed measures of general and pregnancy-specific anxiety and diagnostic interview: 249 women
Mauri, M., Oppo, A., Montagnani, M. S., Borri, C., Banti, S., Camilleri, V., Cassano, G. B. (2010). Beyond "postpartum depressions": Specific anxiety diagnoses during pregnancy predict different outcomes: Results from PND-ReScU. *Journal of Affective Disorders*, *127*(1–3), 177–184. https://doi.org/10.1016/j.jad.2010.05.015	To describe different definitions of postpartum depression and whether pregnancy anxiety disorders are risk factors for different postpartum depressions at both 1 month and 1 year postpartum	Quant, completion of mood and anxiety measures: 1,066 women
Meades, R., & Ayers, S. (2011). Anxiety measures validated in perinatal populations: A systematic review. *Journal of Affective Disorders*, *133*(1–2), 1–15. https://doi.org/10.1016/j.jad.2010.10.009	To review self-report measures that have been validated with perinatal women	Review: of self-report measures described across 30 studies.
Osnes, R. S., Eberhard-Gran, M., Follestad, T., Kallestad, H., Morken, G., & Roaldset, J. O. (2020). Mid-pregnancy insomnia is associated with concurrent and postpartum maternal anxiety and obsessive-compulsive symptoms: A prospective cohort study. *Journal of Affective Disorders*, *266*, 319–326. https://doi.org/10.1016/j.jad.2020.01.140	To examine concurrent and prospective associations between mid-pregnancy insomnia and perinatal anxiety	Quant, prospective, population-based cohort study: 530 women
Polte, C., Junge, C., von Soest, T., Seidler, A., Eberhard-Gran, M., & Garthus-Niegel, S. (2019). Impact of Maternal Perinatal Anxiety on Social-Emotional Development of 2-Year-Olds, A Prospective Study of Norwegian Mothers and Their Offspring. *Maternal & Child Health Journal*, *23*(3), 386–396. https://doi.org/10.1007/s10995-018-2684-x	Examination of the effect of onset of pregnancy-related anxiety adjusted for confounders	Quant, prospective cohort study: 1,336 women and their infants
Sockol, L., & Battle, C. (2015). Maternal attitudes, depression, and anxiety in pregnant and postpartum multiparous women. *Archives of Women's Mental Health*, *18*(4), 585–593. https://doi.org/10.1007/s00737-015-0511-6	To assess the reliability and validity of the Attitudes Towards Motherhood Scale in a sample of multiparous women	Quant, completion of Attitudes Towards Motherhood Scale: 381 women

(Continues)

TABLE 1 (Continued)

Paper	Aim	Design and sample
Somerville, S., Byrne, S. L., Dedman, K., Hagan, R., Coo, S., Oxnam, E., Page, A. C. (2015). Detecting the severity of perinatal anxiety with the Perinatal Anxiety Screening Scale (PASS). *Journal of Affective Disorders, 186*, 18–25. https://doi.org/10.1016/j.jad.2015.07.012	To identify a severity continuum of anxiety symptoms with the Perinatal Anxiety Screening Scale to enhance screening, treatment and research for perinatal anxiety	Quant, completion of measures of anxiety and depression and diagnostic interview: 410 antenatal and postnatal women
Wenzel, A., Haugen, E. N., Jackson, L. C., & Brendle, J. R. (2005). Anxiety symptoms and disorders at eight weeks postpartum. *Journal of Anxiety Disorders, 19*(3), 295–311. https://doi.org/10.1016/j.janxdis.2004.04.001	Examination of the nature of postpartum anxiety disorders in community samples	Quant, completion of diagnostic interview and self-report inventories: 147 postnatal women
Yelland, J., Sutherland, G., & Brown, S. J. (2010). Postpartum anxiety, depression and social health: findings from a population-based survey of Australian women. *BMC Public Health, 10*(1), 771–771. https://doi.org/10.1186/1471-2458-10-771	To describe the population prevalence of postpartum depression, anxiety, co-morbid anxiety and depression and social health issues; and to examine the association between postpartum psychological and social health issues experienced in the six months following birth	Quant, population-based survey: 4,366 women
Sociology		
Highet, N., Stevenson, A. L., Purtell, C., & Coo, S. (2014). Qualitative insights into women's personal experiences of perinatal depression and anxiety. *Women and Birth, 27*(3), 179–184. https://doi.org/10.1016/j.wombi.2014.05.003	To gain insight into women's lived experience of postnatal depression and anxiety, the factors that contribute to these symptoms and the context in which they develop	Qual, interviews: 28 women
Rowe, H. J., & Fisher, J. R. W. (2015). Do contemporary social and health discourses arouse peripartum anxiety? A qualitative investigation of women's accounts. *Women's Studies International Forum, 51*, 56–65. https://doi.org/10.1016/j.wsif.2015.05.002	To investigate women's accounts of the sources and explanations of perinatal anxiety to inform clinical and public health responses	Qual, group interviews: 20 women
Rallis, S., Skouteris, H., McCabe, M., & Milgrom, J. (2014). The transition to motherhood: Towards a broader understanding of perinatal distress. *Women and Birth, 27*(1), 68–71. https://doi.org/10.1016/j.wombi.2013.12.004	To examine whether the term "perinatal distress" accurately captures the range of challenges experienced by women during the perinatal period, when the scope of "distress" is limited to the experience of depression and anxiety alone	Review: literature review, 2 papers examined
Phillips, J., Sharpe, L., Matthey, S., & Charles, M. (2009). Maternally focused worry. *Arch Womens Ment Health, 12*(6), 409–418. https://doi.org/10.1007/s00737-009-0091-4	Examination of the phenomenon of maternally focussed worry	Mixed' self-report measures and interviews: 167 women
Physical health		
Byrnes, L. (2018). Perinatal Mood and Anxiety Disorders. *The Journal for Nurse Practitioners, 14*(7), 507–513. https://doi.org/10.1016/j.nurpra.2018.03.010	To provide an overview of perinatal mood and anxiety disorders	Discussion paper
Farrell, M. L. (2017). Perinatal anxiety disorders: Assessment and management. *Women's Healthcare: A Clinical Journal for NPs, 5*(2), 19–23.	Overview of assessment and management of perinatal anxiety disorders	Discussion paper
Silverwood, V., Nash, A., Chew-Graham, C. A., Walsh-House, J., Sumathipala, A., Bartlam, B., & Kingstone, T. (2019). Healthcare professionals' perspectives on identifying and managing perinatal anxiety: a qualitative study. *British Journal of General Practice, 69*(688), e768-e776. https://doi.org/10.3399/bjgp19X706025	To explore the perspectives and experiences of healthcare professionals in the identification and management of perinatal anxiety	Qual, interviews: 23 healthcare professionals
Thorsness, K. R., Watson, C., & LaRusso, E. M. (2018). Perinatal anxiety: approach to diagnosis and management in the obstetric setting. *American Journal of Obstetrics and Gynecology, 219*(4), 326–345. https://doi.org/10.1016/j.ajog.2018.05.017	Provision of a concise summary of current research on the approach to the treatment of perinatal anxiety disorders in the obstetric setting	Discussion paper

adjustment to pregnancy and motherhood, as well as economic, work, physical and relationship stresses, can contribute to mothers' ability to recover from mental ill health (Hine et al., 2018; Steen & Thomas, 2016). It is also recognised that women from socially vulnerable and black and minority ethnic groups are more likely to experience poor mental health (Steen & Thomas, 2016). These interrelated factors have been modelled (Halbreich, 2005; Ross et al., 2004), and such models demonstrate the interaction between biological, psychological and social factors: the analysis showed that a combination of these elements could serve to trigger or worsen the condition. Regardless of sociodemographic status, perinatal distress is mismatched with a societal expectation of pregnancy and motherhood as a time full of joy (Miller, 2005), which can serve to generate a singular form of pressure and also exacerbate symptoms of anxiety.

Presentation

The analysis confirmed that the somatic presentation of perinatal anxiety is similar to that of other anxiety disorders, however, the occurrence and focus of the anxiety in the perinatal period is what makes it unique. Unlike generalised anxiety and peripartum (perinatal) depression, perinatal anxiety is not recognised as a distinct disorder in the DSM-5, nor is the peripartum considered a specifier for anxiety disorders (APA, 2013), meaning health professionals may fail to recognise the condition. This is in spite of the fact that the psychological significance of pregnancy and the postpartum are noted and the impact of adjustment on women's mental health is readily recognised (Aber et al., 2013; Mihelic et al., 2018). Anxiety is a key element of adjustment and the lack of exploration of anxiety as a component of transition to motherhood again highlights the need to understand this condition in the perinatal context (Hart & McMahon, 2006). The lack of diagnostic definition further complicates the situation when it may be hard for women themselves to recognise and describe perinatal anxiety (Segre & Davis, 2013).

Diagnosis

Illness classification may help in terms of identification and is important because diagnosis facilitates treatment; however, the value of looking beyond diagnostic parameters is also noted. Franks et al. (2017) explored women's views on factors that contribute to their mental ill health from the perspective of underlying influencers as opposed to a diagnostic lens; and note that taking a deeper view beyond the diagnostic focus aids understanding of how mental ill health is experienced outside of purely psychiatric terms. Classification of perinatal anxiety should therefore be considered alongside the broader picture of the illness, which can best be understood from the perspective of women's lived experience. Highet et al. (2014) note there is minimal qualitative research exploring women's experiences of perinatal anxiety and that symptoms are most often described in terms of psychiatric classification, when in fact both viewpoints need to be considered.

3.1.2 | Key attributes

The broad themes of *context, presentation and diagnosis* allow more concise definition of the key attributes of perinatal anxiety:

- A psychological challenge bound up in the transition to motherhood.
- Not unique from general anxiety in its somatic or mental presentation, but often with a focus on perinatal concerns.
- An unfamiliar concept to health professionals.

Psychological challenge bound up in the transition to motherhood

Anxiety in the perinatal period can be a normal and anticipated part of the transition to motherhood; indeed pregnancy is itself described by Rowe and Fisher (2015, p. 58) as "inherently anxiety arousing." However, it becomes problematic when pre-existing anxiety is exacerbated or new-onset anxiety manifests in an uncontrolled fashion, the consequences of which can be debilitating. The existence of parental-themed worries, for example to do with maternal, foetal or neonatal wellbeing, finances or returning to work is not necessarily remarkable. More notable are the societal pressures felt by women to perform as mothers, for example the ability or desire to breastfeed: the impact of such pressures is highly distressing and can increase anxiety levels. The psychological adjustment to motherhood as an attribute is represented within the literature from all three health and social fields.

Not unique from generalised anxiety in its somatic or mental presentation

The typology of diagnoses described in relation to anxiety in the perinatal period across the papers was consistent with that of the spectrum of anxiety disorders as classified in the DSM-5 (APA, 2013). Onset of anxiety may be new in the perinatal period, or there may be an exacerbation of an existing condition, and over the course of pregnancy into the postpartum period the severity of symptoms may reduce. This attribute regarding presentation was only a feature of the literature from the psychological and physical health disciplines.

An unfamiliar concept to health professionals

The literature consistently referenced the paucity of evidence solely examining perinatal anxiety, with the term "under-researched" frequently used. Many of the papers which did relate purely to perinatal anxiety detailed efforts to evaluate symptom-measurement scales, and the range of scales noted (23 in total) indicates that identification can be problematic. Regular reference was made to the comparison with depression as a condition far more thoroughly investigated, and to the frequent co-morbidity of anxiety and depression which possibly serves to further confuse perinatal anxiety as a distinct entity. This attribute was present in the psychological and sociological literature; the idea of perinatal anxiety being "unfamiliar" came directly from one of the papers

within the physical health domain, suggesting that a lack of familiarity exists among health professionals across disciplines including psychiatrists, psychologists, General Practitioners, midwives, health visitors and obstetricians.

The attributes the concept are associated with become the definition of the concept (Rodgers, 1989), and the authors' proposed theoretical definition is as follows:

> Perinatal anxiety does not have a unique somatic or mental presentation, albeit the focus of worry will often relate to parenting concerns. It is an unfamiliar concept which causes health professionals issues with identification and treatment and presents women with psychological challenges bound up in the biopsychosocial aspects of transitioning to motherhood.

3.2 | References, antecedents, consequences of the concept

References relate to the events or phenomena over which the concept is used within the real-world context (see Figure 3). In the case of perinatal anxiety, two references were established:

- Anxiety experienced during pregnancy and/or during the postpartum period up to one year after birth.
- When anxiety exists prior to pregnancy and continues during the perinatal period, or begins during the pregnancy or postpartum.

Antecedents are the events or phenomena that take place prior to the concept occurring (Rodgers, 1989), that is what is likely to have been happening before perinatal anxiety occurs. The papers reviewed described a range of situations from which perinatal anxiety might arise.

The key antecedents identified relate to events across a biopsychosocial profile. Biological antecedents may include the pregnancy itself, disordered sleep, medical co-morbidities or pregnancy conditions, or a personal or family history of a psychiatric condition. Psychological antecedents may be an unplanned or unwanted pregnancy, or intrinsic beliefs about self, the ability to cope and negative expectations about the future. Social antecedents include adverse childhood experiences, poor relationships, experience of intimate partner violence, low socioeconomic status or poor educational attainment.

All these phenomena are potentially present prior to onset or exacerbation of anxiety in the perinatal period. Therefore, the overarching antecedent could be described as:

- A trigger or triggers from the biopsychosocial spectrum, either as a single factor (e.g., hormonal changes in pregnancy), or a combination of factors (e.g., an unplanned pregnancy in the context of an abusive relationship).

Halbreich (2005) and Ross et al.(2004) proposed biopsychosocial models of the processes involved in the manifestation of perinatal mood disorders, which demonstrate the interplay between these different influencing factors. Buist et al. (2006, p. 145) also describes the roots of perinatal mood and anxiety disorders in general as "a complex, interactive aetiological pathway."

Consequences are events arising as a result of the concept. The analysis showed that consequences related to the foetus and neonate could be low birth weight, compromised bonding and attachment, and reduced breastfeeding initiation. For the infant, there may be poor cognitive and motor development and separation anxiety and the older child may have adverse socio-behavioural development. For the mother, consequences can include impaired social and occupational functioning, intrusive thoughts/obsessions, hypervigilance and infant avoidance.

A similar spread across the biopsychosocial spectrum is observed in the consequences as in the antecedents, however, consideration of the consequences builds a picture of the far-reaching nature of the concept, in terms of its repercussions beyond the individual mother to the foetus and infant. It is this broader, ultimately intergenerational impact that adds weight to the critical nature of the study of the concept of perinatal anxiety (Glover, 2007). It is also noted that some terms can potentially be an antecedent and a consequence, for example disordered sleep, which may trigger, exacerbate or result from anxiety.

In summary, the consequences of perinatal anxiety can be described as:

- Events arising from the experience of perinatal anxiety which have short, medium or long-term negative sequelae for the foetus, neonate, infant, child or mother, which may be of a biological, psychological or social nature.

The references, antecedents and consequences illuminate perinatal anxiety as a complex concept, where many factors combine with potentially far-reaching implications. The next stage of analysis moves to a slightly broader view of the concept, by examining related concepts.

3.3 | Related concepts

This step highlights concepts that may be related to the concept under analysis, and the relationships between them. The related concepts in this case were those that were notable from the emphasis given by authors in the frequency or depth of discussion. The related concepts noted within the sample were as follows:

- Depression
- Adjustment
- Stigma

Depression was frequently discussed in relation to anxiety, and consideration of it as a related concept is interesting because

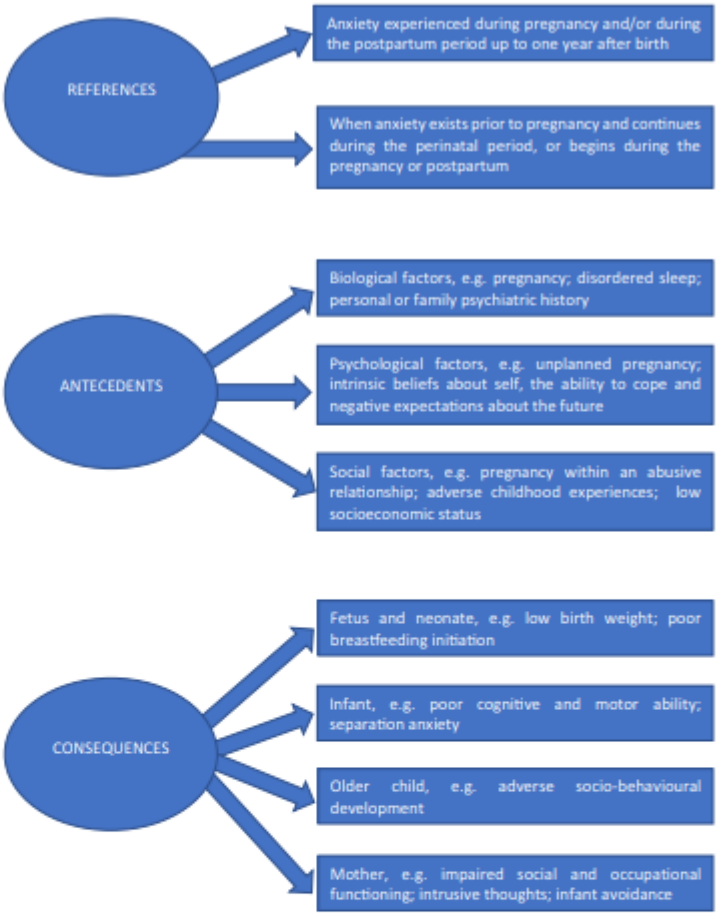

FIGURE 3 References, antecedents and consequences of perinatal anxiety

although distinct diagnoses, the two are frequently co-morbid and differentiation between them can be blurred, which can obscure the nature of anxiety and contributes to its unfamiliarity as a standalone concept, as previously highlighted. Adjustment to pregnancy and motherhood is often referenced in the discourse around maternal anxiety and it is this transition that can provide the focus of anxiety symptoms linked to frustration and loss. The stigma of suffering from perinatal mental ill health is also a recurrent theme, leading to a sense of shame and reluctance to disclose feelings of anxiety and seek help, often driven by fear of involvement from social services.

3.4 | Model case

The "Model case" aims to identify an everyday example which brings together the attributes of the concept. No model cases were present in the data, so the (real-life) case of HS is referred to as a model:

- HS was a 34-year-old woman expecting her second baby. After the birth of her first child, she had been diagnosed with postnatal depression and obsessive–compulsive disorder (OCD) and had commenced medication. At the birth of her first child, she was living far from her parents, with her husband working away for long stretches, so she became socially isolated. In the first trimester of her second pregnancy, her OCD and general anxiety symptoms rapidly escalated with extreme fear of contamination preventing her from travelling to her place of work, and repeatedly re-washing clean piles of clothes and linen. She increased her contacts with health professionals significantly, seeking constant reassurance about the wellbeing of her baby and compulsive thoughts about the need to establish a routine for her toddler. She also simultaneously re-visited thoughts of self-harm for the first time in several years.

Due to the multifactorial nature of perinatal anxiety, numerous examples could have been presented, all of which would be unique in their detail. Yet all would have a common thread, as can be seen

above: the combination of biological (symptoms starting and/or escalating during the perinatal period), psychological (the manifestation of uncontrolled symptoms) and social factors (lack of support).

As well as resonating with the biopsychosocial aspects revealed in the references, antecedents and consequences, this model case also aligns with the attributes identified: in terms of context and presentation the condition became debilitating during pregnancy and involved intrinsic and extrinsic pressures related to the wellbeing of the baby and toddler; with fears around contamination inducing behaviours common to nonperinatal OCD. Examination of the case shows that in this situation there was a clear diagnosis, however, two questions arise: first, why did the condition escalate during pregnancy so significantly that the woman's daily life and safety were compromised by her OCD symptoms and her vulnerability to respond to thoughts of deliberate self-harm? Secondly, could maternity and mental health services have responded differently in such a way that could have prevented this exacerbation? These are complex questions, which cannot be answered via superficial examination and instead warrant a detailed method of investigation.

4 | DISCUSSION

Perinatal anxiety may be the most commonly experienced mental health disorder of pregnancy and the postpartum; as a form of anxiety is clinically distinct; and has far-reaching implications for the health of the mother, foetus, infant and older child (Blackmore et al., 2016; Brunton et al., 2019). The wider consequences for the infant can be regarded through the lens of Bronfenbrenner's Ecological Systems Theory: the child's primary ecological microsystem is in utero and from birth expands so all aspects of their immediate environment begin to converge, shaping their development (Urie, 1979). If the infant's environment is compromised by poor parental mental health, then so can be their development: the biopsychosocial aspects which characterise the antecedents and consequences of perinatal anxiety play into the infant's physical health and social and emotional development.

In spite of its prevalence and sequelae, the concept of perinatal anxiety has not been clearly defined and the condition is under-researched (Furtado et al., 2019). This concept analysis has described the characteristics of perinatal anxiety, revealing it as a condition defined by biopsychosocial factors set within the unique context of the perinatal period. Questions have arisen about the perinatal period as a time of adjustment within which particular attention to mental health is warranted: issues of illness presentation, classification and diagnosis and the interplay between these factors in determining access to services may also exist within general mental health, but it is the perinatal context with its broader ramifications for women and their infants that makes it particularly pertinent. The analysis leads us to understand *what* perinatal anxiety is but leaves questions about *why* it manifests in the way that it does. Explaining the condition purely in biological, psychological or social terms as defined by health or social care professionals, may not be enough to help clinicians understand the true nature of perinatal anxiety. There is therefore a need to hear from women about how anxiety is experienced during the perinatal period and how services can best meet perinatal psychological health needs.

4.1 | Women's voices

The perspective largely absent from the discourse around perinatal anxiety is that of women living with the condition. Tools to identify and measure symptoms have been evaluated and form a critical part of effective care provision, but the lack of rich description from the voices central to the issue is striking. It is also noted that the views of health professionals have not been widely explored via qualitative research, when such an examination could help clarify why perinatal anxiety is an unfamiliar concept among those planning and providing care. In developing the concept, it is important to ensure that future research includes both the perspectives of women in the perinatal period and the health professionals involved in their care.

Women should be at the core of co-designed services; and understanding of the lived experience of perinatal anxiety would add to the body of mostly quantitative data which, whilst of great value to inform identification, is potentially reductive when it comes to understanding how it actually feels to live with the condition. Inviting women to openly describe the experience of perinatal anxiety is particularly crucial when the stigma attached to mental ill health is amplified during the perinatal period, as women struggle to live up to the behaviour and feelings that are expected of them (Dolman et al., 2013; Forder et al., 2020).

Further qualitative research is proposed to help address issues of unfamiliarity highlighted in this concept analysis as well as enabling a deeper exploration of the meaning of the concept as articulated by women. This next stage of concept development would inform how services can effectively meet the needs of women experiencing perinatal anxiety and support and empower them to manage and recover.

4.2 | Access to treatment and support

In the UK at present, specialist perinatal mental health services are available for women with moderate to severe mental ill health. The remaining women, considered to have a mild to moderate need and numbering an estimated 240,000 in the UK, fall under the umbrella of Improving Access to Psychological Therapies (IAPT) services, receiving assessment and therapy from practitioners usually with no specialist perinatal training (Hogg, 2013). Mild to moderate psychological distress in pregnancy can be highly debilitating (Furber et al., 2009) and this concept analysis has demonstrated that the perinatal period is a unique time *regardless* of the severity of a woman's mental ill health. The perinatal period offers a key opportunity to positively impact complex issues affecting generations of families, so it would be desirable for specialist mental health support to be available for women beyond the minority of those with more severe conditions.

Even if support can be accessed, there is little substantial evidence to suggest the most effective approach to reducing perinatal anxiety (Matvienko-Sikar et al., 2020), adding another layer of complexity regarding not just diagnosis but appropriate management, including which services are best placed to deliver psychological care. Health professionals and service users in the UK find that mental healthcare systems are not well integrated and are hard to navigate (NHS-E/I, 2019): this raises questions about the role of midwives, as the primary healthcare professionals during the perinatal period, in supporting integrated mental health care and/or delivering psychological therapy. As experts in facilitating holistic maternity care, midwives with enhanced skills in mental health may be in an ideal position to provide a level of psychological care that meets the needs of women with mild to moderate perinatal anxiety. Such care provided by case loading midwives could simultaneously augment the benefits already identified in continuity of carer models and complement the UK drive towards improved perinatal mental health (NHS-E, 2016b).

4.3 | Strengths and limitations

Throughout this concept analysis, a systematic method was adopted and a rationale for selection of the papers used was provided, both of which helped achieve an ethical and transparent approach. A check of reference lists added further rigour.

As described the process did not fully yield the expected results, being heavily weighted with quantitative papers, and the expectation of analysing data pertaining to first-hand descriptions of the experience of perinatal anxiety did not materialise. However, this has served to highlight a gap in the evidence which should be addressed. The data analysis was undertaken by the first author, and this process could have been strengthened with investigator triangulation.

5 | CONCLUSION

Although anxiety in the perinatal period may have a similar presentation as at other times the perinatal focus makes it unique, partly due to the potential impact on the future health of mothers and infants. The characteristics of perinatal anxiety described offer an understanding of the nature of the condition and can inform how to direct support, that is how do midwives and other health professionals mitigate biopsychosocial triggers, support women with containment and prevent the consequential range of negative sequelae for mother, foetus and infant? However, evidence that illuminates the lived experience of women with perinatal anxiety is needed in order to further understanding of this complex condition and inform service delivery that accounts for the needs of the many thousands of women who do not currently meet the criteria for specialist perinatal mental health services in the UK.

6 | RELEVANCE TO CLINICAL PRACTICE

Attention to perinatal anxiety as a unique condition is recommended, to facilitate recognition, diagnosis and appropriate treatment. This paper advances the concept of perinatal anxiety, provides evidence of the paucity of literature examining women's subjective experiences and suggests further research to address this gap in knowledge and aid understanding of how clinicians can effectively support women to manage and recover from the condition.

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CONFLICT OF INTEREST

The authors have no competing interests to declare.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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Appendix 2 - Interview topic guide

- What has been your experience of anxiety during pregnancy/postpartum?
- How does it feel to live with PA?
- What has your experience of PA been like?
- How has PA impacted on your experience of pregnancy?
- How has PA impacted on your experience and new motherhood?
- How has PA impacted on your relationships – with unborn baby, newborn/partner/friends/family/child or children
- How has PA affected your bonding and attachment with your unborn/new baby?
- How has PA influenced your experience of becoming a mother?
- How have you been able to access support, if you have done so?
- How has the experience of support with your anxiety been for you?
- If you have had therapy/treatment/support, how has this been?
- How could your experience of PA have been easier to deal with/more manageable?
- Is there anything you would like to add?

Appendix 3 – Summary of PPI activity

Gained really useful feedback from 10 women at GMOTFW meet. The women were from a range of ethnicities and included three women with no mental health history through to two women who had had postnatal admissions and one treated at home with psychosis. Eight of the women had experience of anxiety, from mild to severe.

Would you have felt comfortable talking to someone about your mental health during pregnancy/postnatally, for the purpose of research?

Yes – ALL
No
Might have felt shame though, but can see value in talking
Happy to talk as long as to professional person

Do you think one-to-one interviews would be a good way to find out about women's experience of anxiety (rather than focus groups/questionnaires etc.)?

Yes - ALL
No (please explain)
Able to be more open
Might feel shy in group
Particularly if your baby is young
A group is daunting
Groups can be helpful to understand what others are also going through
A group makes you feel pressured

At what point during pregnancy and postnatally would it best to interview women?

Second trimester x 1
Third trimester x 4
Any of the above x 1
Postnatal 3-6m x 6
Postnatal 6-9m x 2

Would you have felt comfortable being approached by me about the research whilst attending the hospital antenatal clinic? If yes, would you have preferred I was in uniform or normal clothes?

Yes - ALL
Uniform x 3
No
Non-uniform x 3
Important to know I was a health professional
Uniform would feel official
Non-uniform might feel more relaxed
Doesn't matter – either x 2

Where would be best to carry out the interview?

Home - ALL
Hospital
Other (neutral) venue
Should be individual choice
I would have been worried about going out
Two people also said would be happy with hospital

Is there anything that you imagine would make you feel worried about taking part?

I would be worried about how I would be viewed as a mum, and that Children's Services might be told how I feel.

Worry about how the information would be used and would I be judged.
'What is it being used for?' You doubt yourself – where does it (the interview data) go?
'Shame would be a barrier'
Worry about being judged – 'always worry about being judged in case you do it wrong'
Having a mental health 'tick' on my medical record. A previous episode of PND seems to crop up constantly on my records which is very frustrating as it added to midwife concerns leading to me being consultant led care.
I might be worried about taking part depending on what else was going on in my life at the time.

Do you have any other comments or suggestions?

"From my own experience I would want you to be aware that when I was unwell I felt really paranoid and I think I would have felt paranoid about why you wanted to talk to me."
"Anxiety is such an individual experience, you can't assume everyone is affected in the same way."
"There is huge stigma around mental health. Mums are too anxious to come forward – things like this are so beneficial."
"We need to talk more about it."
"I think this is so important. PND is widely known about but anxiety definitely has a stigma still and often mums don't know they are suffering from anxiety until it becomes severe. Research and education could make a huge difference."
"I thought I had depression. It wasn't until I learnt about anxiety that I realised it was that that was causing my low mood."
"Anxiety is crippling, the better the understanding from the start the better chance of fighting potential postnatal anxiety."
"It is important to understand anxiety so other mums don't feel alone and that their anxieties are a normal part of motherhood."
"It's important to learn more about it because many women won't know they are suffering from anxiety. It's a strange feeling and support could help us better understand it."
So some useful stuff in terms of practicalities. A few surprising things – that they were quite keen on the uniform and knowing it was a health professional approaching them. Reassuring that they all felt it was acceptable to interview women about this, most keen on home setting. Surprised that they seemed most in favour of third trimester and 3-6m postnatal – some described feeling at their most anxious during third trimester so this is when they would have been most able to talk about the feeling.
Quite overwhelming how much stigma featured. That took me by surprise that they pretty much all mentioned it. And the fear of how the information they give could be used – I will need to address that in my information sheet. Really useful the person who mentioned the paranoia. I will build in something about aborting the interview if I have concerns about the current stability of their mental health/they experience any distress and wish to stop.
Really good to hear the feedback about the study of anxiety being worthwhile. And the idea that it is not well understood or necessarily recognised for what it is by the women suffering from it.

Appendix 4 – Participant Information Sheet

Researcher name: Kelda Folliard
Supervisors: Prof Kenda Crozier and Dr Meghana Kamble
IRAS no. 279813

Study Title: The Lived Experience of Perinatal Anxiety
I am inviting you to take part in this study, which is part of my doctoral research. Before you decide whether to take part it is important that you understand what is involved and why the research is being undertaken. Please take time to read the following information carefully and to discuss it with family/friends or people you trust. Please feel free to contact me (details below) with any queries you may have or if anything is not clear.

What is the purpose of the study?
This study aims to learn more about women's experiences of living with anxiety during pregnancy and the first year after having a baby.

Why have I been invited to take part?
You have been invited because you are pregnant and are currently experiencing a level of anxiety which you feel impacts negatively on your daily life. You may or may not have experienced anxiety before becoming pregnant.

What will happen if I take part?
If you choose to take part, you will be invited to complete three interviews with me, Kelda Folliard. I am undertaking a Professional Doctorate in Health and Social Care at the University of East Anglia. I am also a midwife.
The first interview will take place when you are between 5 and 8 months pregnant. The second interview will be when your baby is 2-6 months old and the third when they are 6-12 months old. The interviews will be about your experiences of pregnancy and early motherhood while living with anxiety. We know that anxiety is common during this time, and that it is less well understood than other conditions such as depression. Your experiences will be valuable in helping improve this understanding.
In the interviews I will ask you to speak freely about your experiences, but I may give you some prompts to talk about parts of your experience. This could include the kind of support you have received or how, if at all, anxiety has affected your relationships and your life. You will not be asked to discuss anything you are not completely comfortable talking about.
The interviews will either take place remotely (online/telephone), in person at your home, or at the Norfolk and Norwich University Hospital (in line with restrictions arising from Covid-19). If taking place remotely you may wish to choose a time when you will have privacy, and I will be in a private room where I cannot be overheard. If meeting face to face we will discuss the most suitable location with privacy in mind, which may be your home or at the hospital and this will be your choice.
Before the first interview begins, I will go through the study and answer any questions you may have. I will ask you to complete a consent form (online if we are not together in person), and before the second and third interviews I will check you are happy to continue taking part. I expect each interview to last for 45-60 minutes.
The interview will be audio recorded and will be transcribed (written up) by myself or using an approved and confidential professional transcription service. The recording will be permanently deleted after the transcript has been completed. Any details that can identify you, including places, will be removed from the transcript. I will ask that when discussing any other individuals you do not identify them. If you accidentally do, this will be removed from the written transcript of the interview.

Do I have to take part?
Taking part is completely voluntary. You can choose not to take part and if you choose not to take part you will not be disadvantaged in any way. If you are unsure about whether or not you wish to take part, please contact me and I can answer any questions you have. You can also discuss the study with someone you trust.

Will I receive any compensation for taking part in this study?
You will not receive any compensation for taking part in this study.

What are the possible risks of taking part?
Some of the things you talk about in your interviews may be sensitive. There may be things that you have not discussed with anyone else and you may discover that you find this upsetting. I will not ask you to talk about anything you are not completely comfortable discussing, and you will be able to stop talking about a subject at any point if you wish. You may feel that you have a need for some psychological support that you have not received previously, in which case I will provide you with details of signposting information after the interview is completed.

What are the benefits of taking part?
There will not be any direct benefit to you from taking part in the interviews, although you may like having the opportunity to share your experiences. I plan to publish the findings of the research which I hope will raise awareness of perinatal anxiety among women and professionals. I hope this research will help inform guidance around support for women living with perinatal anxiety.

What if I change my mind about taking part?
You may withdraw from the study at any time without giving a reason. You are free to withdraw your interview data from the study up until a month after your final interview, when the analysis will be written up.

Will my information be kept confidential?
Yes. Your data will be handled in accordance with General Data Protection Regulation (GDPR). Your anonymised interview transcripts will be kept separately from your name, contact details and consent form. Your name and contact details for the study will be stored on an encrypted laptop and the file will be destroyed once the study ends. No information that could identify you will be published.
The only time I would share your information would be if you were to tell me about a current life-threatening risk of harm to yourself or someone else (including a child). If this happened I would talk to you about it, and discuss with a clinical colleague at the Norfolk and Norwich University Hospital regarding sharing the information with another agency in order to safeguard your/another individual's wellbeing.

Data protection (GDPR) statement
The interview transcripts will be kept for ten years from study completion and will be stored on the secure University of East Anglia server (OneDrive); after which they will be deleted.

How will we use information about you?
We will need to use information from you for this research project.
This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.
People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.
We will keep all information about you safe and secure.
Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information

1. at www.hra.nhs.uk/information-about-patients/
2. our leaflet available from www.hra.nhs.uk/patientdataandresearch
3. by asking one of the research team

- by sending an email to researchsponsor@uea.ac.uk, or
- by ringing us on 01603 591574.

How is this project being funded?

The first two years of tuition fees have been funded by a RCN Foundation Professional Bursary and a Florence Nightingale Foundation Scholarship.

What will happen to the results of the study?

The results of the study will be written up for my doctoral thesis as part of my Professional Doctorate. They may also be published in peer reviewed journals and presented at conference or in forums with professionals and service users with an interest in perinatal anxiety. You will not be identifiable in any of the summarised data that is shared in this way.

You are able to request to receive a summary of the results by newsletter if you wish; there will be space for you to opt to do this on the consent form.

Who should I contact for further information?

If you have any questions or require any further information about this study, you can contact me using the following details:

Kelda Folliard
k.folliard@uea.ac.uk

What if I have further questions, or something goes wrong?

If this study has caused you any harm or you wish to make a complaint about the conduct of the study please contact:

Patient Advice and Liaison Service
pals@nnuh.nhs.uk
01603 289036 or 01603 289045
The PALS Manager
Norfolk and Norwich University Hospitals NHS Foundation Trust
Colney Lane, Norwich, NR4 7UY

Thank you for reading this information sheet and considering taking part in this research.

Appendix 5: Approved consent form

CONSENT FORM	University of East Anglia
Title of project: The lived experience of perinatal anxiety	
IRAS ID: 279813	Name of researcher: Kelda Folliard
Centre no.:	Participant Identification Number:

Please initial box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that relevant sections of my medical notes, may be looked at by the Researcher, where it is relevant to my taking part in this research. I give permission for this individual to have access to my records. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
4. I am willing to talk about my experience of living with anxiety during the perinatal period for the purpose of these research interviews. ☐
5. I consent to being audio recorded for this study. ☐
6. I understand that the researcher may be obligated to break confidentiality and provide relevant information to a clinician or other agencies if I disclose risk of harm to myself or others (including a child). ☐
7. I understand that the information collected about me will be used to support the findings of the study and that the findings may be shared anonymously in the publication and dissemination of the research. ☐
8. I agree that anonymous verbatim quotes may be used in research reports. ☐
9. I would like to receive a summary of the study results. ☐
10. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix 6: Example of initial analysis of transcripts showing colour coding (participant 4, antenatal)

Initially starting with a focus on what she is describing and her use of language, before moving on to conceptual notes. Staring with initial notes and re-visited the transcript three times for further noting, leaving left hand box empty for eventual Personal Experiential Themes after the third round of noting and completion of reflexive notes.

First noting – black (had listened to recording twice), tried to make this as simplistic and descriptive as possible with minimal interpretation.

Second noting – blue and carried out while re-listening to the audio recording in chunks. Second time round let myself be more interrogative and try to develop more of a dialogue with the participant.

Third noting – green and moving towards development of Experiential Statements
Fourth – red, developing the Personal Experiential Statements.
Sticky notes added for reflexive thinking (alongside reflexive journaling)
Next will be clustering the experiential statements to make Personal Experiential Themes which are then named and organised into a table. Once these steps are complete for all cases we then use the Personal Experiential Themes to create Group Experiential Themes across the cases.

Experiential statements	Original transcript	Exploratory comments
Anxiety becomes abnormal when it causes poor	Interviewer: How was your experience of anxiety from when you first started feeling anxious – so that might have been before either of your pregnancies, is it something you experienced in general life? Participant: No so outside of pregnancy I have never had any anxiety, any mental health concerns really, I'm usually quite a laid back person. I had what I'd consider normal anxiety in my first pregnancy, being a first time mum and being diagnosed with obstetric cholestasis and what comes with that. But I didn't have any referrals or any treatment or anything, it was just the unknown. This pregnancy is where I've really, really suffered um like lost sleep, felt ill through anxiety.	Idea of there being a 'normal' level of anxiety for women in their first pregnancy. Sounds very confident in her response – not in any doubt about whether she has had anxiety before The normal anxiety is distinct from an anxiety which causes physical symptoms or disturbance. Felt ill through anxiety. The unknown.

physical health. P4ANPg1/2 The unknown creates uncertainty. P4ANPg2	Interviewer: Ok, so in your first pregnancy you said that was a normal kind of anxiety – how would you say that felt? Participant: So it was just the unknown, obviously being a first time mum, first pregnancy, obviously every appointment was very unknown, I didn't know what each appointment was gonna bring and then when I got the diagnosis, um, there is very little information given to you about… looking back about everything that happened, I wasn't told everything that could happen. I was kind of treated like a normal pregnancy. Even little things like sitting down writing the birth plan when, in reality, when you're under consultant led delivery, you don't really have a say much in what happens because medically they intervene almost immediately if they need to. Interviewer: Ok so that was how it felt at that time – like you didn't really have a say in what was going on? Participant: No, my birth wasn't anything like what I wrote in my birth plan and obviously it was done to get my daughter here safely. But it was never explained to me, the difference between being in the midwife led birthing unit to a consultant led delivery, that my birth plan was… I dunno how to say it… that what I would like to happen, but wasn't really going to be listened to because their opinion was going to be over my opinion if that makes sense. Interviewer: Yeah so tell me a bit more about that felt, the birth planning and lead up to your birth first time round? Participant: So I felt very confident going into labour and my induction and everything because I had this birth plan and when I was actually in labour and everything started going a little bit wrong and everyone was kind of making decisions for me and that's when I felt a little out, out of control, um, it was a very scary time, I don't really remember most of my birth, um just the bits my husband has told me. Um, and I felt disappointed that, I	The idea of the unknown when things were uncomplicated, but then a need for more information when things became complicated, which wasn't met. Wanted to be told everything. Sense a loss of control because she didn't have a say. *I was treated like a normal pregnancy* – disconnect from herself as an individual. They intervene if they need to – no self-determination. Describing her expectation compared to the reality of what happened at her birth. Would have been reassured by knowing everything. She noticed a hierarchy in whose opinion counted the most, and it wasn't hers. She seems to describe the reassurance she felt by having a plan and outside of the plan was where she lost the control. People making decisions for her. Lack of control is scary.

Having a birth plan gives a sense of control. P4ANPg2 Understanding what might happen is reassuring. P4ANPg3	wish someone had sat down and said ok in an ideal world what would the birth look like. Ok, that's what you'd like but we need to make you aware that these are the things that could happen and this is what would happen in that situation because when I was at my most vulnerable, mid-contractions, I was having people throw forms in front of me saying I had to have a c-section, but c-sections were never on my birth plan, things like that. So I wish someone had sat me down and said this is not a normal pregnancy, they told me what the complications of my condition were but not what the limitations of my labour were gonna be. I think that was the only way I can describe it. Interviewer: And so you said about not understanding about what things might be that could happen, you feel like it was not understanding that made it hard? Participant: Yeah definitely, because you can't really take much information in while you're in actual labour and there's alarms going off and I think there was, there was 13 people in my room at one point and I was being told not to get off the bed and having forms put in front of me and my husband was being told things and it was all very chaotic. And obviously all of that had to happen to get my daughter here safely, but if someone had sat me down prior to my induction and said these are the things that might happen and these are the people that might have to get involved and this is what it could look like, it wouldn't have been so stressful for me. Interviewer: Did that then become a different thing for you, in terms of anxiety, different from what you had felt during pregnancy? Participant: Up until my induction I only had the first, the new mum worries. So like what is a labour going to feel like. Am I going to be a good enough mum. All those things. It was in that room where yeah, it became a very very stressful and anxious time and obviously after her birth when she ended up in NICU, that just added to it. That experience has added to this	She thinks that this situation would have been improved if she had fully understood the various eventualities. It was about being listened to not just knowing everything. She recognised her vulnerability in labour and that this was not the right time to think about what might happen, she would have liked to have done that before. Her expectations were that this was a 'normal pregnancy' and the reality was that it was not 'normal' (in her view) and that this meant things changed but she was never aware of the implications of that. She would have been reassured knowing that the plan might include some of these other things. The need to understand in the right environment – which wasn't labour. Knowledge is reassuring for her. Distinction between what a new mum normally worries about and the worry that she then experienced.

A level of anxiety in pregnancy is expected. P4ANPg4	pregnancy's anxiety. That's the only thing I can say. My anxiety in that pregnancy was nothing like how it has been in this pregnancy, but a lot of it has rooted from that experience, knowing that I could be in for that again. Interviewer: And so actually the cholestasis diagnosis didn't so much cause the anxiety in your first pregnancy, it was more that that led to you having the induction and it was that experience which was difficult? Participant: Yeah. Like I was given loads of information about the cholestasis and that there wasn't really much information and the risk of still birth and that they were inducing me, I was given all the information but no-one told me how different a consultant led delivery would be. You have this little ideal… you're gonna be in there with a midwife and it's going to be like one Born Every Minute kind of thing. And it was nothing like that, it was a medical procedure and I just felt like that should have been explained more. Interviewer: And I guess that the induction was about cholestasis but what happened during labour was about what was happening during labour rather than the cholestasis. Participant: Yeah my cholestasis didn't affect my labour, it was the complications that happened in labour that led to, and the fact that she was being induced early, but yeah there wasn't… I know you can't plan for every eventuality but there must be… I feel if you are inducing people early, I feel there must be a certain tick list of things that could go wrong. That should be discussed, not while a woman's having a contraction and you're trying to put an epidural in her back that she doesn't want. Interviewer: Ok. And so you said about the NICU stay. So that was I guess a difficult time? Participant: Yes so she was in NICU for 24 hours, she was under NICU care for 3 days. So she was discharged to the ward under their care. What made	Her birth experience and that need to understand which wasn't met – has this impacted how she has responded to uncertainty in this pregnancy? An accumulation of anxiety. Layers of anxiety. Describes birth as 'a medical procedure' and how far removed this was from what she was expecting. Ideal would be just with the midwife and the additional people were not expected. Again highlights that need she had to be prepared. Accepts you can't know everything but she still needed something more than she had.

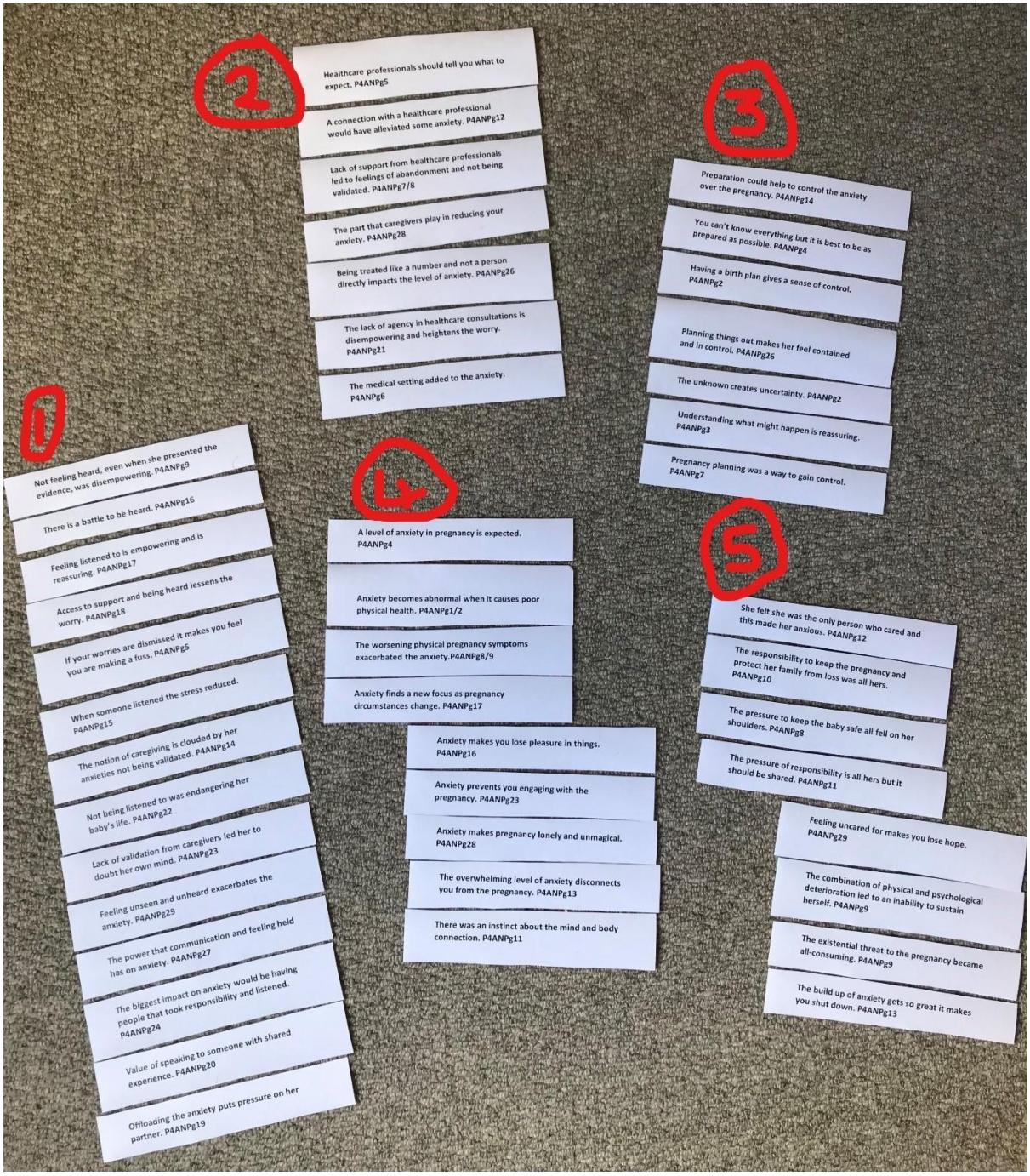
	that stressful is I was made to feel stupid that I was saying to the nurses, they were discharging me and I was saying there's something not right with my baby and I was being ignored. I was saying look she's really sleepy, she's not waking up, she's barely feeding, why are you discharging me. And it took me a long time to get somebody to test her and then two people misread her test results so we were literally putting her in the car seat when they realised the mistake. And it went from you're going home to she's going to NICU care and I was just made to feel like I was being a hypochondriac new mother when actually that's my child and although I've only been a mum for a few hours, she should be awake and wanting to feed. You know, she's a new baby, they tell you your baby is going to want feeding all the time and she wasn't. And so then she ended up in NICU, and so that was hard, being on a ward where you can hear babies crying and your baby's not there. That was hard, you know. And there was nowhere else I could be, I was in the middle bay on the ward and I had five babies around me and my baby was down the hallway in NICU and I wasn't allowed to do anything for her. Interviewer: And do you remember back then feeling particularly anxious or was it more emotionally just naturally difficult? Participant: I felt anxious for her as in, you don't expect your child to end up in NICU because nobody had told me there was a risk of her going to NICU. I felt, I don't know what the word is, I just felt very alone um. I remember because my husband had been sent home, and I was on a ward, none of the nurses on the night shift were the ones I'd seen in the day when I'd come to the ward from delivery, and I remember just sitting in the dark on my bed in the middle bay and just hearing five babies around me and just crying like where's my baby? Why is my baby not here and why am I being forced to sit amongst other mums when my baby is there on NICU. Why is there nowhere else where I'm not near a baby, because that was hard. All your hormones from delivery, all your stress of your child's in NICU and not really knowing what's going on there, I wasn't allowed to change	At this point she starts to talk more about not feeling heard and that this made her feel stupid. She describes wanting to follow her instincts but being undermined and then the fact that her worries turned out to be valid was very powerful and reinforced the experience of not feeling listened to. She had to take responsibility to push for what was needed (test results being checked) Not being heard – her thoughts were never validated. HCPs were making her feel a certain way. The experience undermined her as a mum and it's not even just that it goes against what she felt needed to happen but also against the advice she was aware of that your baby should want to feed. Describes feeling powerless, the separation from her baby compounding her feelings of lack of influence on anything. Powerlessness. Again refers to not knowing in advance that this could happen. But suggests again anxious in a way that you would expect to be with a baby in NICU, so 'normal' anxiety. There is a responsibility that healthcare professionals have to make sure you know what to expect. Describes the anguish of the separation and again not understanding the situation or why she would be left in the bay surrounded by the other babies.
If your worries are dismissed it makes you feel you are making a fuss. P4ANPg5		

Healthcare professionals should tell you what to expect. P4ANPg6	her nappy, I wasn't allowed to feed her, I wasn't allowed to pick her up and then I had to sit there listening to other mums. And I was like I need to be with my baby but I can't be with my baby because there's nothing I can do for my baby. If I had just been able to be put in another room so I didn't have to hear the babies that would have… so I don't know if it was anxiety but it was a very negative emotion that first night. Interviewer: Yes well that's a hugely distressing situation to be in, particularly as you say made worse by hearing everybody else's babies and feeling even further away from your own. Participant: Yeah. Interviewer: Ok, so then once you were back home with her and ticking along… she's four now isn't she? Participant: Four and a half yeah. *Interview continues to 31 pages, (sample script for thesis appendix only)*	Importance of familiarity with caregivers. Complete lack of control over anything. Again powerless, can't do anything for her baby. Feeling forced and with no choice about what is happening. The transcript so far focuses on the previous birth experience, and gives some insight into the value that the participant places on information sharing, control and autonomy. These are also highly relevant in her experience of her next birth and possibly frame the context of the escalation of her anxiety.

Appendix 7: Example of development of Personal Experiential Themes

(Participant 4, antenatal)

Images show development of Personal Experiential Themes (from clustering of Personal Experiential Statements, numbered 1-5), table of Personal Experiential Themes and example of initial work identifying narrative data to support the theme of 'Feeling heard'.



Personal Experiential Themes – participant 4, antenatal
1. Feeling heard **2. Healthcare interactions** **3. Preparation for control** **4. Normal anxiety sub-theme Lonely and unmagical** **5. All on her shoulders, sub-theme Giving up**

1. FEELING HEARD (personal experiential statements listed with supporting quotes in italics)

Not feeling heard, even when she presented the evidence, was disempowering.P4ANPg9
"we did loads of research into ICP and the effects it has on stillborn and things like that, you know we went to the source and we were reading the papers we were reading the studies. So I was clued up on all this knowledge that some professionals don't even know and they didn't want to know, they were going like no it's not that, and I was like it is that, it might not have been that but have you looked at this more recent study – like here's the research study I can put it under your nose. And everyone was just going you've got to be 28 weeks, you've got to be 28 weeks."

There is a battle to be heard. P4ANPg17
"So having (the specialist midwives), having someone back me up in an appointment, because obviously my husband hasn't ever been able to come to an appointment because of Covid restrictions, so having somebody else in the room that's on my side has helped. I've still had to battle to the point where it has been arranged that (the specialist midwives) are gonna be there but the consultant who's seeing me hasn't bothered to read my notes before he's walked in the room so hasn't told (the specialist midwives) that he's starting my appointment. So it's like, read my notes, just take that time just to know who you are about to see."

Feeling listened to is empowering and is reassuring. P4ANPg18
"…she was the first consultant I had spoken to who had sat down and said what do you want and let me say what I needed and then she said what they could do and we came to a working compromise. I wasn't being dictated to, I felt listened to…"

Access to support and being heard lessens the worry. P4ANPg19
"(things changed) once I had people listening to me, doing the tests, monitoring me and I had access to MAU. Because you can't even go to MAU before you're 29 weeks and things like that. Once I had access to people to go to – like I've been up to MAU several times for different things, so yeah it's just having those people there. It's definitely the second trimester bit when no-one is listening to you that is worst for me. And I think there's a lot of attention when you're first pregnant, getting you registered and everything, and then it's like yeah we'll see you if you make it to the third trimester."

If your worries are dismissed it makes you feel you are making a fuss. P4ANPg5
"What made that stressful is I was made to feel stupid that I was saying to the nurses, they were discharging me and I was saying there's something not right with my baby and I was being ignored. I was saying look she's really sleepy, she's not waking up, she's barely feeding, why are you discharging me."

When someone listened the stress reduced. P4ANPg16
"Probably end of August/beginning of September, was when like I started being able to eat a little bit better. But again that's when (the specialist midwives) got involved so that took some of the stress off me because somebody started listening."

The notion of caregiving is clouded by her anxieties not being validated. P4ANPg14

"Literally defeated. I thought why, why am I trying to have a second child. I just felt like I'd been written off. She's obviously not going to make it so…that's the only way I can describe it is that nobody thought I was going to make it. So they thought we'll just keep palming her off since eventually she won't be on our books. Nobody treated me like I was having a baby."

Not being listened to was endangering her baby's life. P4ANPg24
"It's like someone has to listen to me because my baby's life could be at risk."

Lack of validation from caregivers led her to doubt her own mind.P4ANPg23
"I felt like I was going crazy. I started to believe them, like maybe I'm not, maybe this is all in my head, maybe I am just being a hypochondriac and maybe… and then you think I can't think like that because if I am right I'm putting my child's life at risk… I was laying awake for hours playing through the conversation, questioning myself, like am I actually going insane right now. And is what everyone is telling me right, or is what I know I'm feeling, what I know is right?."

Feeling unseen and unheard exacerbates the anxiety. P4ANPg30
"I have felt like, even though I was pregnant, I felt like I was a medical complication that nobody wanted to deal with. And my pregnancy is not even that complicated compared to some. I feel like people hid behind red tape. No-one has shown any empathy… There hasn't been any support, really. And I didn't feel like anyone was, not celebrating my pregnancy, but on board with my pregnancy."

The power that communication and feeling held has on anxiety. P4ANPg28
"I feel like I am on someone's radar. There's a date booked, something planned in. People are aware I'm coming in and having a baby and I am going to have that one-on-one care because it's planned."

The biggest impact on anxiety would be having people that took responsibility and listened. P4ANPg25
"Just having someone who would listen to you. And it's been the being pushed from pillar to post and that I'm nobody's concern. I'm not the doctors' (GP) concern because I'm pregnant, I'm not the midwife's concern because it's not a routine appointment because I've got complications in pregnancy but I'm not the consultant's concern because I'm not at the point where they'll intervene yet. And I'm not MAU's concern because I'm not 29 weeks, so whose concern am I? In that period whose concern am I?!"

Value of speaking to someone with shared experience. P4ANPg21
"And it's really hard to speak to them because I haven't got anyone who has been through obstetric cholestasis. No-one understands what it's like to literally want to rip your skin off because it's itching, they're like oh yeah I itched in pregnancy, I'm like you didn't itch in pregnancy, you might have had a little scratch one day. I'm like itching for five days straight, I've literally got welts on my skin where I've itched it so hard and nobody understands , nobody understands that when you're sitting there at 3 o'clock in the morning and there's nothing you can do to stop the itching."

Offloading the anxiety puts pressure on her partner. P4ANPg20
"I've taken a lot of my stress out on my husband because he has been the only one here to listen to me. There's been no-one else to talk my problems to and all my frustrations when I've come out of appointments that he hasn't been allowed in have been vented at him."

Appendix 8: Example of development of Group Experiential Themes

The first table shows the original Personal Experiential Themes for each participant, and how these translated across to the Group Experiential Themes following the identification of supporting narrative data (example from **feeling heard** seen in appendix 7). The labelling of the Group Experiential Themes developed as this iterative process unfolded, the strike throughs indicating a change in wording for the theme, with the final theme names highlighted in green (Superordinate theme) and yellow (subordinate theme).

Below the first table is an example of the narrative data identified across participants in support of the superordinate Group Experiential Theme, 'The Anxious Mother'.

Personal Experiential Theme ORIGINS	**Group Experiential Theme (finalised)**
UNIQUENESS OF ANXIETY DURING PREGNANCY **P1** Influence of the baby **P1** THE ANXIOUS MOTHER IS OTHER **P2** Maternal burdens **P2** ANXIETY AND THEN PERINATAL ANXIETY **P2** BABY AS A CONNECTED BEING **P3** HINDERED SOCIAL EXPERIENCE **P3** Compliance and judgement **P3** 'NORMAL' ANXIETY **P4** ALL ON HER SHOULDERS **P4** THE NATURE OF ANXIETY DURING PREGNANCY **P5** The context of pregnancy loss **P5**	~~**THE ANXIOUS MOTHER IS OTHER**~~ ~~Focus of perinatal anxieties~~ ~~Maternal burdens~~ ~~Unborn connection~~ THE ANXIOUS MOTHER Otherness Burdens
SELF-EFFICACY AND PERSONAL TRANSFORMATION **P1** OPTIMISM **P2** BODY AND MIND SYMBIOSIS **P3** The future **P3** BEING SET APART **P5** Apart from oneself **P5** ANXIETY TEMPORALITY **P5** ***nothing from P4 here, what is her divergence? *** *P4 didn't reflect on transformation here, all that came postnatally*	**TRANSFORMATION** ~~Body and mind~~ ~~Existential questions~~ ~~Temporality~~ TRANSFORMATION Fighting with self Temporal collisions
MULTIPLE FACETS OF SUPPORT **P1** Professional support serves a specific function **P1** Family support is unconditional **P1** The support of a partner is paramount **P1** NEED FOR CONNECTION **P2** NOT KNOWING AND BEING ALONE **P3** Professional containment **P3** THERAPEUTIC RELATIONSHIPS COME IN MANY FORMS **P3** Feeling cared for **P3** **FEELING HEARD** **P4** HEALTHCARE INTERACTIONS **P4** MODES OF REASSURANCE **P5**	~~**NOT KNOWING AND BEING ALONE**~~ ~~Functions of support~~ ~~Modes of reassurance~~ ~~Connections~~ SETS OF EARS Reflecting and understanding Feeling heard ~~Holding~~ Safety net
NEGATIVE MANIFESTATIONS OF ANXIETY BEHAVIOURS **P1** UNCERTAINTY, CONTROL AND SAFETY **P2** THE COMPLEXITY OF PSYCHOLOGICAL MANIFESTATIONS **P3**	~~**LONELY AND UNMAGICAL**~~ ~~Negative manifestations~~

PREPARATION FOR CONTROL **P4** Lonely and unmagical **P4** Giving up **P4** BEHAVIOURAL IMPACTS OF ANXIETY **P5** Reaching crisis **P5** Apart from one's baby **P5**	~~Uncertainty, control and safety~~ THE ANXIOUS PREGNANCY Lonely and unmagical Grasping psychological safety

Example of narrative data supporting Group Experiential Theme, 'The Anxious Mother'.

GET (superordinate) BOLD UPPER CASE, subthemes of GETs bold lower case. *Personal experiential statements in brackets italicised. Quotes from data italicised in speech marks. Reflexive annotation in comments boxes.*

1. THE ANXIOUS MOTHER (this is describing the otherness that they feel, outside of what is normal or expected by others or by them)

1.1 Otherness

Wanting to be 'normal'

P2ANPg22 *(There is conflict between anxiety feelings and presenting that there is a 'happy little life going on')*
"And I think I never just looked at someone and thought they've got a happy little life going on because I could look as normal as they come and yet I have this every day."

P2ANPg37 *(Anxiety is both a shared and an isolating experience)*
"There's anxious and then there's completely anxious. And people get anxious every day when they start a new job but I feel like my anxiousness is a hundred times higher and that's without starting a job."

P2ANPg27 *(Mothers are responsible for the impact of their anxiety on others)*
"I wouldn't have gone to these appointments on my own. There would be occasions where my mum can't come with me so he's had time off work, if I had just been normal I could have just gone by myself."

P4ANPg29 *(Part of the anxiety is about wanting to have the same experience that others have)*
"Yeah I think at this stage of pregnancy well we've had the scans and everything and they measure the weight and movements I think it's all a big reassurance that it's like every other pregnancy."

P5ANPg16 *(Anxiety makes pregnancy an entirely different experience)*
"It's really I guess saddening to not be able to do all of the things that you want to do during pregnancy like you want to be able to go out with your friends and go baby shopping and for it to be really exciting and go out for little coffee dates and just the normal sorts of things during pregnancy and it just holds you back."

What other people think:

P2ANPg21 *(It is shameful to not want to attend appointments)*

"I can't go into appointments on my own, I have to have someone there, if not I make some lame excuse that I can't get there or whatever."

P5ANPg13 *(You have to be fake rather than reveal how the anxiety makes you feel)*
"And other people are excited for you and just want to buy things for the baby and actually you are putting on a bit of a fake side of ooh I'm so excited blah blah blah, but actually it's just a constant worry about everything."

P3ANPg3 *(The judgement of others is a worry)*
"I think it was the initial shock more than anything of oh my god I'm pregnant, how do I sort of handle this kind of thing, sort of, how do I tell people, what are people gonna think."

P1ANPg8 *(There is an optimal emotional state for pregnancy)*
"Yep so um there have been times where.. I have thought to myself, erm, probably I shouldn't be carrying now (because of the anxiety)."

P5ANPg29 *(The pressure of how pregnancy is portrayed adds to your worry when you feel differently)*
"I think a lot of women do put it out there that it's the most amazing, magical time and every day you should be grateful and not complain about how you're feeling. Stuff like that and I think when you've had a really difficult experience where the pregnancy isn't that easy, it should be a little bit more normalised I guess that it's really OK to not enjoy it."

How anxiety sets you apart from others (this is part of the 'otherness'):

P1ANPg4 *(There's a point where she will choose solitude over support)*
"Other times I can reach to that panic attack level, you know like extreme level where no matter what anybody says erm, I'm not receptive to that."

P2ANPg23 *(The anxious mother is other)*
"So I got out the car and I was like 'come on then mum' and I put on my brave face, but my husband did make sure that he parked straight in front of the A&E so we just stood at the window. We weren't sitting down like everyone else normally would sit down I was just stood by the window just watching the car…"

Queries THESE WERE NOT INCLUDED IN FINAL NARRATIVE ACCOUNT:

P5ANPg15 (*Anxiety in pregnancy feels unpredictable)*
"… you've got people saying Oh you're just over prepared and you're over planning things, let things be and just go with the flow. But it's really difficult to just go with the flow when you've got the anxiety to that sort of scale."

P5ANPg27 *(There's isolation in feeling differently about the pregnancy from how others think you should)*
"…you see other people going ooh I can't wait to meet my baby and this and that and all you're so loved already and obviously it is but I don't know you don't see it every day and you try to do the things that people advise like you know you talk to it or let it listen to music and stuff like that and I sit and I think well is it doing anything, is it bonding with me? Given that there's all the, not necessarily even just the worries, but when it's here is it gonna bond with me, is it gonna like me?"

P5ANPg25 *(Anxiety has isolated her from others)*
"I think relationships with other people have been quite difficult when you think about it. Normally I guess you don't think about it day to day, but I guess it probably has affected a few relationships, maybe how I feel towards certain people or things like that."

Appendix 9: Health Research Authority approval letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mrs Kelda Folliard
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Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

16 June 2021

Dear Mrs Folliard

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**An interpretative phenomenological analysis of the lived experience of perinatal anxiety.**
IRAS project ID:	**279813**
REC reference:	**21/EE/0104**
Sponsor	**University of East Anglia**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **279813**. Please quote this on all correspondence.

Yours sincerely,

Amber Ecclestone

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Polly Harrison*

Appendix 10: poster presentation of methodological process

Longitudinal interpretative phenomenological analysis of the lived experience of perinatal anxiety - methodological process

Kelda Folliard, Prof Kenda Crozier, Dr Meghana Wadnerkar Kamble

University of East Anglia

NHS Norfolk and Norwich University Hospitals NHS Foundation Trust

This poster details the analytical steps undertaken in this perinatal anxiety LIPA study. 5 women were interviewed at 3 perinatal timepoints to produce 15 datasets.

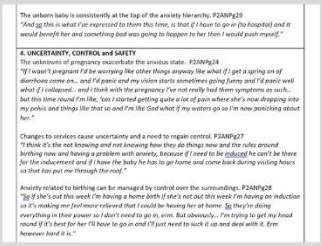
An early example of cross-case Group Experiential Themes and Longitudinal Experiential Concepts is shown.

Reading and re-reading. Annotating transcripts with a focus on comments from a descriptive, linguistic and conceptual viewpoint and formulating **Personal Experiential Statements**.

Organising and clustering Personal Experiential Statements and developing **Personal Experiential Themes**.

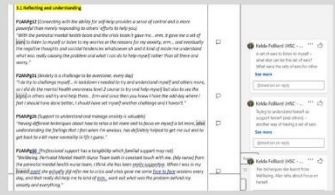
Searching for connections across emergent themes using strategies including abstraction, polarisation and contextualisation.

Interrogating interview narrative for data in support of Personal Experiential Themes.



Development of Group Experiential Themes through interrogation of narrative data across the entire dataset for each timepoint, with further interpretative comments.

Looking for patterns across cases.



Antenatal GET development, with PET origins shown.

MULTIPLE FACETS OF SUPPORT P1 Professional support serves a specific function P1 Family support is unconditional P1 The support of a partner is paramount P1 NEED FOR CONNECTION P2 NOT KNOWING AND BEING ALONE P3 Professional containment P3 THERAPEUTIC RELATIONSHIPS COME IN MANY FORMS P3 Feeling cared for P3 FEELING HEARD P4 HEALTHCARE INTERACTIONS P4 MODES OF REASSURANCE P5 NEGATIVE MANIFESTATIONS OF ANXIETY BEHAVIOURS P1 UNCERTAINTY, CONTROL AND SAFETY P2 THE COMPLEXITY OF PSYCHOLOGICAL MANIFESTATIONS P3 PREPARATION FOR CONTROL P4 Lonely and unmagical P4 Giving up P4 BEHAVIOURAL IMPACTS OF ANXIETY P5 Reaching crisis P5 Apart from one's baby P5	~~NOT KNOWING AND BEING ALONE~~ ~~Functions of support~~ ~~Modes of reassurance~~ ~~Connections~~ SETS OF EARS Reflecting and understanding Feeling heard ~~Holding~~ Safety net ~~LONELY AND UNMAGICAL~~ ~~Negative manifestations~~ ~~Uncertainty, control and safety~~ THE ANXIOUS PREGNANCY Lonely and unmagical Grasping psychological safety

Table showing **Group Experiential Themes** across all time points.

ANTENATAL GETs	EARLY POSTNATAL GETs	LATE POSTNATAL GETs
THE ANXIOUS MOTHER Otherness Burdens	BABY AS EXTERNAL FOCUS Comfort Distraction Optimism New worries	MOVING ON Coping Acceptance Resolutions
TRANSFORMATION Fighting with self Temporal collisions	RETURNING TO ONESELF Finding the way back Looking forward	SHIFTING SANDS This too shall pass Omnipresent
SETS OF EARS Reflecting and self-understanding Feeling heard Safety net	THE EMOTIONAL UNKNOWN Relief and overwhelm State of flux	LUCY (outlying case)
THE ANXIOUS PREGNANCY Lonely and unmagical Grasping psychological safety		

Narrative analytical account: validating Group Experiential Themes through demonstration of supporting data.

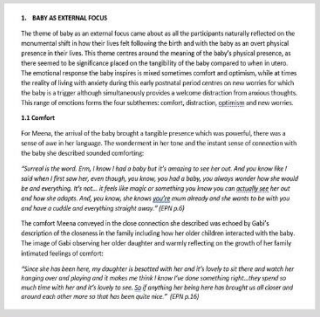
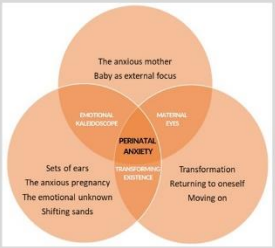


Table showing **superordinate and subordinate themes** arranged by **Longitudinal Experiential Concept** demonstrating incorporation of antenatal, early postnatal and late postnatal timepoints.

MATERNAL EYES	TRANSFORMING EXISTENCE	EMOTIONAL KALEIDOSCOPE
THE ANXIOUS MOTHER (AN) Otherness Burdens	TRANSFORMATION (AN) Fighting with self Temporal collisions Reflecting and self-understanding	SETS OF EARS (AN) Feeling heard Safety net
BABY AS EXTERNAL FOCUS (EPN) Distraction New worries	RETURNING TO ONESELF (EPN) Finding the way back Looking forward	THE ANXIOUS PREGNANCY (AN) Lonely and unmagical Grasping psychological safety
Omnipresent (LPN)	MOVING ON (LPN) Coping Acceptance Resolutions	THE EMOTIONAL UNKNOWN (EPN) Relief and overwhelm Comfort Optimism State of flux
		SHIFTING SANDS (LPN) This too shall pass

Longitudinal Experiential Concepts (overarching conceptual themes relating to the group experience over time) and superordinate Group Experiential Themes.



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